# HEALTHY START INITIAL CONTACT

HEALTHY START COORDINATOR NAME: _____ PHONE:_____
ADDRESS:_____
HEALTH CARE PROVIDER NAME:_____ PHONE:_____
ADDRESS:_____
Healthy Start score ____ Referred for other factors ___ Community referral____ Date_____ Self Referral ___ Self Referral Date_____ Date of original screen _____ Date screen received by CHD_____ by Care Coordinator _____
Date, method, and comments on attempts to contact: 1st _____
2nd _____ 3rd _____
Date Healthy Start Initial Contact completed: _____ Method: ❒phone ❒face-to-face ❒ home visit ❒other

1. Healthy Start risk factors identified are checked below:

| √ | **Risk Factor(s)** | Risks, intervention and/or referrals as discussed with participant along with plan of care: |
|---|---|---|
| | Age<18 or unknown | |
| | Maternal Race Black | |
| | Mother unmarried | |
| | <12 or GED education | |
| | Mother's Body Mass Index (BMI) | |
| | Tobacco Use | |
| | Poor Pregnancy Timing | |
| | Chronic Illness | |
| | ≥2nd trimester care | |
| | Poor Pregnancy Outcome | |
| | Alcohol/other drug use | |
| | First Pregnancy | |
| | Felt down, depressed, hopeless | |
| | Pregnancy interval <18 months | |
| | Abnormal condition | |
| | Infant's wt.<2000 grams (4lbs,7oz) | |
| | Principal source of payment Medicaid | |
| | Father's name not present or unknown | |
| | Prenatal visits less than 2 or unknown | |
| | | |

2. Additional family needs/strengths to be addressed by the participant and the Healthy Start care coordinator:

_____
_____

3. Participant able to access comprehensive prenatal or infant health care: Yes _____ No _____
4. Additional health education or referrals provided during initial contact marked below. **R=referral; E= education**

| | | | | | |
|---|---|---|---|---|---|
| PTL Danger Signs | | WIC/ Nutrition Counseling | | Immunizations | |
| Shaken Baby Prevention | | Childbirth Education | | Parenting Support/Education | |
| SIDS Risk Reduction | | Baby Spacing/Family Planning | | Psychosocial Counseling | |
| Breastfeeding | | | | | |
| | | | | | |

5. Name and phone number of Healthy Start contact person provided to participant: ❒
6. **❒Plan of Care:** **❒Level: _____**

_____Will follow-up with participant to track receipt of referrals.
_____Participant scheduled for further Healthy Start assessment on (date)_____.
_____Plan ongoing Healthy Start care coordination with participant.
_____Participant declines further services from the Healthy Start program.
_____Participant needs no further services from Healthy Start at this time; please refer again if situation changes.
_____Participant receiving care coordination from CMS Early Steps. Closed to Healthy Start.
_____Participant receiving care coordination from (specify) _____. Closed to Healthy Start.
_____No response from participant after documented attempt(s) to contact – participant closed to Healthy Start.

7. Healthy Start initial contact information with cover letter sent to above noted health care provider on (date)_____.

❒ **See progress notes**

Healthy Start Signature/Title: _____ Date: _____

Updated 12/29/2011

**Name:** _____
**ID No:** _____
**Date of Birth:** _____

# INSTRUCTIONS FOR DOCUMENTATION OF INITIAL CONTACT

**This form is to be used by the provider to document all initial contact activities. A copy will be entered into the participant's record and a copy may be sent to the health care provider. This form will document all of the information for the initial contact which is required by the Healthy Start Care Coordination Rule (64F-3, F.A.C.). It is not an assessment tool. Any additional information may be provided on a progress note.**

**Complete the Healthy Start care coordinator and health care provider name, phone and address.**

**Note the participant's Healthy Start screening score or check whether the participant was referred for factors other than score or was self referred. Provide appropriate dates.**

**All the dates and methods of attempted contact should appear on this form, thereby eliminating the need for more than one form.**

1. **Check all risk factors from the Healthy Start Screen which resulted in initial contact. List risk factors discussed at the initial contact other than those identified on the Healthy Start screen, including those identified through your professional judgment or participant conversation. Write in your intervention or referral in the table to the right of the risk factor.**
2. **List additional needs/strengths to be addressed, such as concerns, priorities, assets and resources that are identified by the participant. Concerns might include lack of education or a job; priorities might include child care or WIC; and resources might include family or friends' support, Medicaid, etc.**
3. **Indicate whether the participant is able to access comprehensive prenatal and infant health care (e.g. periodic screening, diagnosis and treatment; necessary laboratory tests; immunizations; WIC; family planning; health education and counseling; acute care; and referral for needed services).**
4. **Mark all the appropriate boxes for additional health education or referrals provided during the initial contact. R=referral; E= education. Use blanks for "write in" health education or referrals provided during the initial contact.**
5. **Check if the contact person's name and phone number were supplied to the participant.**
6. **Check plan of care box and the appropriate plan of care based on the participant's concerns, priorities, strengths and resources. Enter date of planned assessments. Check the level box and document level.**
   - **Check "track receipt of referrals" if tracking is planned at this time.**
   - **Check "scheduled for further Healthy Start assessment" if initial assessment planned within 10 days.**
   - **Check "Plan ongoing Healthy Start care coordination with participant" if initial contact and assessment completed and participant will continue with care coordination services.**
   - **Check "declines further services" if participant verbally declined services even though coordinator feels services are warranted at this time.**
   - **Check "needs no further services" if participant and care coordinator jointly agree no further care coordination services are needed at this time.**
   - **Check "coordination from CMS Early Steps or other specified provider if appropriate.**
   - **Check "no response from participant after documented attempt(s) to contact" if participant closed as unable to provide initial contact or assessment or unable to locate after multiple attempts to contact.**
7. **Complete the date when the cover letter and a follow-up on the Initial Contact was sent to the primary or prenatal health care provider. Enter the signature and phone number of the person providing the initial contact and the date.**