KERN COUNTY MVCCP – DATA FORM

Medically Vulnerable Care Coordination Project

Harli Smith (office) 661-868-0334 (fax) 661-868-1291

FOR MVCCP USE	
	Insight #
	Mother's Insight#
	Zip Code

DEMOGRAPHIC INFORMATION

Today's Date: ***(please attach relevant face sheets, referrals, summaries, and/or discharge notes)***

Infant's Last Name	Infant's First Name	MI	Mother's Last Name	Mother's First Name	MI

Current Address, City and Zip Code	Phone Number	Foster Y/N	Current Address	City, State, Zip Code	Phone Number

☐M ☐F	DOB	Ethnicity	City	Insurance	DOB	Prim Language	G	P

Synagis?	Birth Hosp/ pt #	BW	GA	APGAR	Hx of preterm labor? *(y/n/unk)*	Interval btw pregnancies <6m? *(y/n/unk)*	Hx of fertility txt? *(y/n/unk)*	Known Hx of Cocaine, ETOH, Meth, tobacco use? *(y/n/unk)*

NICU Hosp	NICU LOS	PCP / Clinic	Mult Birth?	If Multi Birth List Name(s)	Known Hx of amnio fluid/ lower GU tract infxn? *(y/n/unk)*	Known Hx of HTN, diab, lupus? *(y/n/unk)*

MVCCP ELIGIBILITY *(please fax if the following criteria are met)*

☐ Less than 37 weeks GA ***OR*** ☐ BW <5.5lb (2500g)	***AND / OR** is at risk due to:*	☐ Has family issues that may affect the patient receiving proper and timely care ☐ Has condition that requires medical/developmental screenings and follow-up care over the first year or longer	➡ ***Please fax to MVCCP Care Coordinator 661-868-1291***

ACUITY AND SERVICES

(1=Strongly Disagree 2=Disagree 3=Unsure 4=Agree 5=Strongly Agree)

Medical Coverage

1) Select if present ☑	☐ Uninsured medical expenses					
2) Rating ***(circle most appropriate)***	The parent(s) understand health insurance and CCS coverage	1	2	3	4	5
	The parent(s) will enroll in health insurance (i.e. Medi-Cal and/or CCS) in a timely manner	1	2	3	4	5
	The parent(s) are currently able to pay for medical expenses of the infant *(including copay if applicable)*	1	2	3	4	5

3) Indicate Services ✓

Medi-Cal	CCS	SSI	WIC	Non-Profit Payer	Other Medical Coverage Resource:

Community Resources

1) Select if present ☑

☐ Unfamiliar with options/ procedures for obtaining services	☐ Limited access to care / services / goods
☐ Transportation barrier	☐ Dissatisfaction with services
☐ Difficulty understanding roles / regulations of service providers	☐ Unable to use / has inadequate communication devices
☐ ***(circle)*** Language barrier / Cultural barrier / Educational Barrier	☐ Inadequate/ unavailable resources

2) Rating ***(circle most appropriate)***						
	The parent(s) are knowledgeable of local community resources *(i.e. WIC, Family Resource Centers, etc.)*	1	2	3	4	5
	The parent(s) are consistently and appropriately using community resources to assist their child	1	2	3	4	5
	The parent(s) have no problems or barriers connecting to community resources	1	2	3	4	5

3) Indicate Services ✓

Family Resource Center (name)	Head Start (location)	Search and Serve	Caring Corner	Non-profit	CPS	Other Community Resources

Healthcare Supervision

1) Select if present ☑

☐ Fails to obtain routine/preventative health care	☐ Inconsistent source of health care
☐ Fails to seek care for symptoms requiring evaluation/treatment	☐ Inadequate source of health care
☐ Fails to return as requested to health care provider	☐ Inadequate treatment plan
☐ Inability to coordinate multiple appointments / treatment plans	

2) Rating ***(circle most appropriate)***						
	The parent(s) are knowledgeable about the healthcare providers, appointments, and treatment plan	1	2	3	4	5
	The parent(s) are consistent in taking their child to all scheduled medical appointments	1	2	3	4	5
	The parent(s) will continue to receive appropriate and timely health care for their infant	1	2	3	4	5

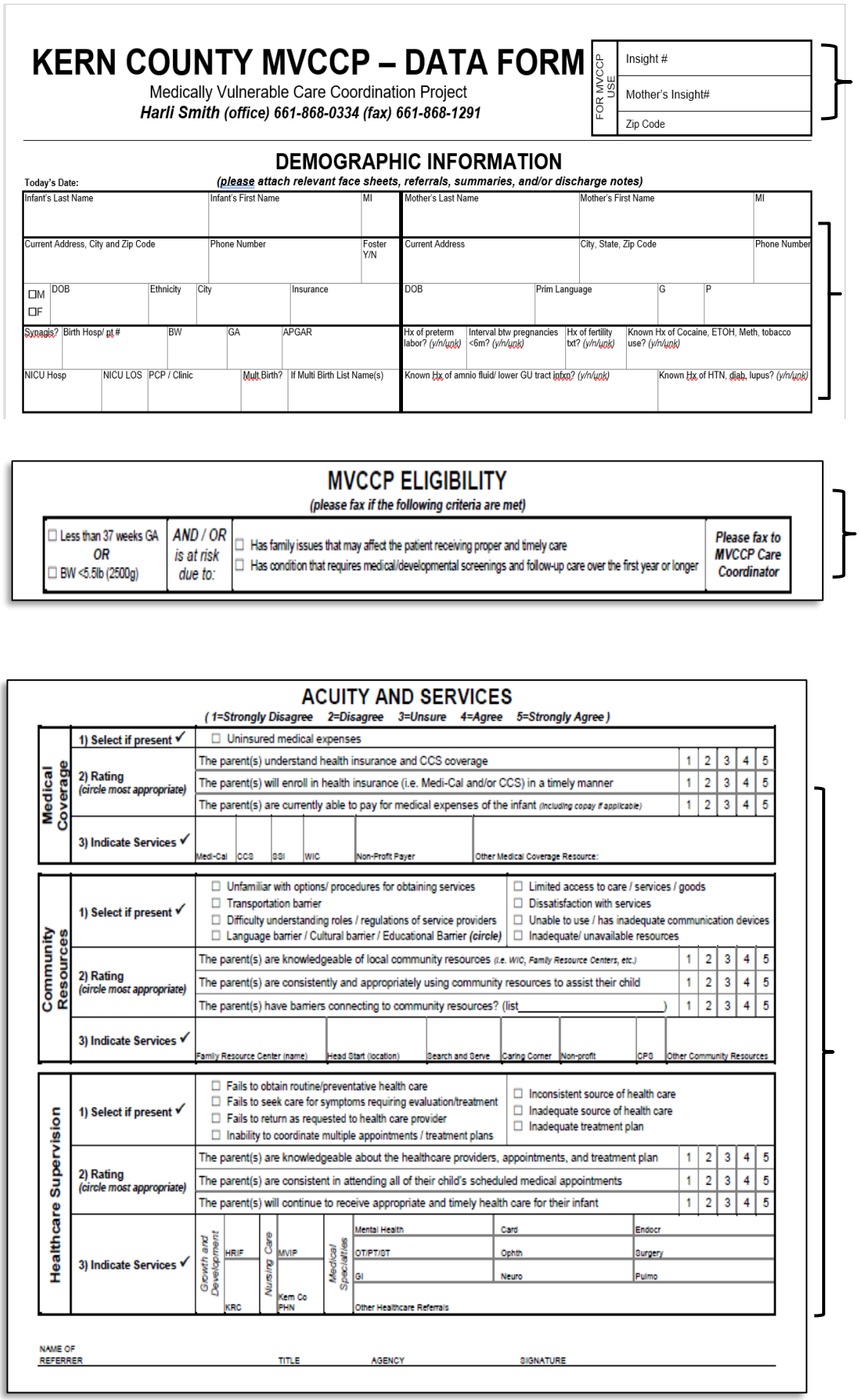
3) Indicate Services ✓

Growth and Development		*Nursing Care*		*Medical Specialties*			
HRIF		MVIP		Mental Health	Card	Endocr	
				OT/PT/ST	Ophth	Surgery	
				GI	Neuro	Pulmo	
KRC		Kern Co PHN		Other Healthcare Referrals			

NAME OF REFERRER | TITLE | AGENCY | SIGNATURE

MVCCP DATA FORM INSTRUCTIONS

(Note: this side does not need to be included when faxing)



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DEMOGRAPHIC INFORMATION

Today's Date: *(please attach relevant face sheets, referrals, summaries, and/or discharge notes)*

Infant's Last Name	Infant's First Name	MI	Mother's Last Name	Mother's First Name	MI
Current Address, City and Zip Code	Phone Number	Foster Y/N	Current Address	City, State, Zip Code	Phone Number
☐M ☐F DOB	Ethnicity	City	Insurance	DOB	Prim Language	G	P
Syngis?	Birth Hosp/ pt #	BW	GA	APGAR	Hx of preterm labor? *(y/n/unk)*	Interval btw pregnancies <6m? *(y/n/unk)*	Hx of fertility txt? *(y/n/unk)*	Known Hx of Cocaine, ETOH, Meth, tobacco use? *(y/n/unk)*
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MVCCP ELIGIBILITY

(please fax if the following criteria are met)

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ACUITY AND SERVICES

(1=Strongly Disagree 2=Disagree 3=Unsure 4=Agree 5=Strongly Agree)

Medical Coverage

1) Select if present ✓ ☐ Uninsured medical expenses

2) Rating *(circle most appropriate)*

The parent(s) understand health insurance and CCS coverage	1	2	3	4	5
The parent(s) will enroll in health insurance (i.e. Medi-Cal and/or CCS) in a timely manner	1	2	3	4	5
The parent(s) are currently able to pay for medical expenses of the infant *(including copay if applicable)*	1	2	3	4	5

3) Indicate Services ✓ Medi-Cal | CCS | SSI | WIC | Non-Profit Payer | Other Medical Coverage Resource:

Community Resources

1) Select if present ✓

☐ Unfamiliar with options/ procedures for obtaining services ☐ Transportation barrier ☐ Difficulty understanding roles / regulations of service providers ☐ Language barrier / Cultural barrier / Educational Barrier *(circle)*

☐ Limited access to care / services / goods ☐ Dissatisfaction with services ☐ Unable to use / has inadequate communication devices ☐ Inadequate/ unavailable resources

2) Rating *(circle most appropriate)*

The parent(s) are knowledgeable of local community resources *(i.e. WIC, Family Resource Centers, etc.)*	1	2	3	4	5
The parent(s) are consistently and appropriately using community resources to assist their child	1	2	3	4	5
The parent(s) have barriers connecting to community resources? (list_____)	1	2	3	4	5

3) Indicate Services ✓ Family Resource Center (name) | Head Start (location) | Search and Serve | Caring Corner | Non-profit | CPS | Other Community Resources

Healthcare Supervision

1) Select if present ✓

☐ Fails to obtain routine/preventative health care ☐ Fails to seek care for symptoms requiring evaluation/treatment ☐ Fails to return as requested to health care provider ☐ Inability to coordinate multiple appointments / treatment plans

☐ Inconsistent source of health care ☐ Inadequate source of health care ☐ Inadequate treatment plan

2) Rating *(circle most appropriate)*

The parent(s) are knowledgeable about the healthcare providers, appointments, and treatment plan	1	2	3	4	5
The parent(s) are consistent in attending all of their child's scheduled medical appointments	1	2	3	4	5
The parent(s) will continue to receive appropriate and timely health care for their infant	1	2	3	4	5

3) Indicate Services ✓

Growth and Development: HRIF | KRC

Nursing Care: MVIP | Kern Co PHN

Medical Specialties: Mental Health | Card | Endocr | OT/PT/ST | Ophth | Surgery | GI | Neuro | Pulmo

Other Healthcare Referrals

NAME OF REFERRER _____ TITLE _____ AGENCY _____ SIGNATURE _____

MVCCP USE

This section is for Kern County Public Health use only.

DEMOGRAPHIC INFO

If attaching a face sheet, you only need to enter the name.

The next area is data MVCCP needs to track. Please try to complete or attach notes, referrals, and/or discharge summaries that contains as much of the information as possible.

MVCCP ELIGIBILITY

If the infant is <37 weeks gestational age or <5.5lbs at birth, **AND / OR** is at risk due to medical or family issues, please fax referral

ACUITY AND SERVICES

(Three parts for each subject)

1) Select all that are present in patient/family

2) Rating Scale: Based on interactions with the parent/guardian, please circle the appropriate number on how confident you agree with the statements.

3) Referrals Made: Please check all referrals you have made as well as programs you know the patient to currently be a part of.

At the end, print your name, title, and date. When completed, please fax to the number indicated.