Title: Document for Standardized Community Navigation Intake Form
Date Created: 03/17/2017
Date Modified:
Date Approved by Board of Directors:
Clinical Guideline #CGC-CG- 38

Project 2ci: Community Based Navigation aims to provide community-based health navigation service to assist patients to access healthcare efficiently. Community Health Advocates guide patients through the healthcare system by eliminating barriers to timely access to healthcare services. Barriers to accessing care include financial, logistical, clinical, cultural and blending the communities between healthcare systems and community based organizations. Guidance can be through phone calls, in person, or web-based.

Purpose: The purpose of this document is to integrate and standardize intake for Navigation services across the PPS, specifically Community Based Organizations (CBOs). With this intake form, the navigator will be able to identify navigation services needed as well as other healthcare needs. This form also integrates the PAM survey completion and level so that the Navigator can start the process of Coaching for Activation. This intake form will serve as a guide for the Navigator that can also be utilized to communicate within organizations and across organizations.

Additional Notes: The intake form will be a living document. There is an opportunity for all representatives to note other items that will need to be communicated to the primary care physician and care team, navigators, their agency or even notes to follow up with Care Compass Network on feedback with the project implementation plan.

When PPS clinical protocols and pathways are developed through the Clinical Governance Committee(s) of the PPS and approved by the CCN Board of Directors and are applicable to Partner Organization's delivery of health care services and project participation, such protocols and pathways shall not (1) override the professional judgment of Partner Organization and its licensed health care professionals in treating patients in individual cases or (2) interfere with the governing body/established operator of any licensed health care facility or its medical staff in overseeing the provision of clinical services to patients and the quality of care

Clinical Guideline Board Approval History:

Clinical Guideline Revisions:

Date	Revision Log	Updated By

3/17/2017	Original Creation	Emily Balmer
4/3/2017	Edit Policy Number	Emily Balmer

This Clinical Guideline shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, Care Compass Network's senior management, Federal and State law(s) and regulations, and applicable accrediting and review organizations.

CARE COMPASS NETWORK

(1) Demographic Information

Candidate Name: _____ Phone Number _____ Gender ____ Date of Birth: _____

Street Address _____ City _____ State _____ Zip Code _____ County _____

Health Care Proxy_____ Power of Attorney_____

Personal Care Representative_____

(2) Patient Activation Measure Assessment Level

PAM Assessment Completed: Yes ☐ No ☐ N/A ☐ PAM Level: 1 ☐ 2 ☐ 3 ☐ 4 ☐

(3) Medicaid/Commercial Eligibility Information	**(4) Diagnostic Eligibility Information**
Insurance Pending: ☐ Secondary Insurance:_____ Medicaid CIN:_____ Medicaid Managed Care Name if applicable:_____ Commercial Insurance:_____	Chronic Condition 1:_____ Chronic Condition 2: _____

(5) Risk Eligibility (Check all that apply)

Health Insurance and/or Financial Concerns	**Transportation**	**Support Needs**	**Communication and/or Cultural Needs**
□ Lack of or no insurance coverage □ Need financial assistance from Medicaid □ Need for prescription assistance □ Need for medical equipment or supplies □ Need explanation of financial paperwork □ Difficulty paying bills □ Underinsured □ Other:_____	□ Public transportation assistance needed □ Private transportation assistance needed □ Medicaid taxi transportation needed □ Volunteer transportation needed □Other:_____	□ Child/Elder Care □ Housing □ Food access □ Clothing □ Vocational support (i.e., job skill, employment skills) □ Extended care needs (i.e., home care, hospice, long-term care) □ Other:_____	□ Primary language other than English □ Spanish □ Arabic □ Chinese □ Italian □ Other _____ □ Inability to read/write □ Poor health literacy □ Other: _____

(6) Documents		
□ Advanced Directives	□ Cultural help completing a living will	□ Needs a power of Attorney
□ Health Care Proxy	□ Other:_____	
(7) Referral Agency Information		
Contact Name _____ Contact Number _____ Does this Candidate have a Primary Care Physician? □ Yes □ No		
Name Primary Care Physician and Facility_____ Date of Last Visit with PCP_____		
What other Providers or Organizations is the patient currently working with? _____		