Texas Health and Human Services
Case Management for Children and Pregnant Women

FAMILY NEEDS ASSESSMENT

SITE OF ASSESSMENT ☐ HOME ☐ CLINIC ☐ OTHER, SPECIFY ______________________

NAME: ______________________ DOB: __________ MEDICAID NUMBER: __________

IS THIS A MIGRANT FAMILY? ☐ YES **(IF YES, MUST COMPLETE CPW-02A)** ☐ NO

Indicate other household members receiving case management services with an asterisk (*).

NAMES OF HOUSEHOLD MEMBERS	RELATIONSHIP TO CLIENT	AGE	NAMES OF HOUSEHOLD MEMBERS	RELATIONSHIP TO CLIENT	AGE

CLIENT INFORMATION		
MEDICAL AND OTHER SERVICES	**DOCUMENT NAME OF PROVIDER AND CURRENT STATUS**	**Check if Needs Assistance/Enter Need on SP**
PCP/MEDICAL HOME IMMUNIZATIONS: CURRENT ☐ YES ☐ NO TEXAS HEALTH STEPS/WELL-CHILD EXAMS: CURRENT ☐ YES ☐ NO		☐
OBSTETRICIAN DUE DATE: __________ EXAMS CURRENT ☐ YES ☐ NO		☐
PHYSICIANS OTHER THAN PCP		☐

Client Name: ________________________ Medicaid # :__________________

CLIENT INFORMATION		
MEDICAL AND OTHER SERVICES	**DOCUMENT NAME OF PROVIDER AND CURRENT STATUS**	**Check if Needs Assistance/Enter Need on SP**
DENTIST EXAMS CURRENT ☐ YES ☐ NO		☐
HOME HEALTH PROVIDERS (ATTENDANT CARE, THERAPY, NURSING)		☐
LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITY (LIDDA) IS THE CHILD ON A MEDICAID WAIVER PROGRAM? (CLASS, DBMD, HCS, TXHML, MDCP) ☐ YES ☐ NO		☐
MEDICAL/ADAPTIVE EQUIPMENT SUPPLIES/ NUTRITIONAL SUPPLEMENTS ☐ NONE		☐
MANAGED CARE ORGANIZATION (MCO) / OTHER MEDICAL INSURANCE		☐
SUPPLEMENTAL SECURITY INSURANCE (SSI) ☐ YES ☐ NO		☐
OTHER SERVICES		☐

HEALTH STATUS - CLIENT		**Check if Needs Assistance/Enter Need on SP**
DESCRIBE HEALTH CONDITION, HEALTH RISK OR HIGH-RISK CONDITION. LIST ANY DIAGNOSIS, IF APPLICABLE.		☐
MEDICATIONS ☐ NONE		☐

Client Name: ______________________ Medicaid # :________________

DEVELOPMENTAL - CLIENT		Check if Needs Assistance/Enter Need on SP
MOTOR SKILLS (FINE AND GROSS)		☐
VISION		☐
SPEECH/LANGUAGE		☐
HEARING		☐
SELF-HELP SKILLS FEEDING/DRESSING/OTHER ACTIVIITES OF DAILY LIVING		☐
MENTAL HEALTH/ BEHAVIORAL/SOCIAL SKILLS		☐
TRANSITION PLANNING TO ADULTHOOD/GUARDIANSHIP		☐

EDUCATIONAL/VOCATIONAL - CLIENT		Check if Needs Assistance/Enter Need on SP
☐ ECI ☐ HEAD START ☐ SCHOOL (PPCD-12) ☐ SPECIAL EDUCATION/ 504 ☐ VOCATIONAL/TRADE/ COLLEGE	DOCUMENT AGENCY/SCHOOL ATTENDING /CURRENT ISSUES	☐

Client Name: ______________________ Medicaid #: ________________

FAMILY INFORMATION		Check if Needs Assistance/Enter Need on SP
MEDICAL ☐ NO NEEDS		☐
DENTAL ☐ NO NEEDS		☐
MENTAL HEALTH/COUNSELING ☐ NO NEEDS		☐
EMPLOYMENT/FINANCIAL ☐ NO NEEDS		☐
UTILITIES ☐ NO NEEDS		☐
FOOD ☐ NO NEEDS		☐
HOUSING/ACCESSIBLITY ☐ NO NEEDS		☐
EMERGENCY/DISASTER PLAN ☐ NO NEEDS		☐
TRANSPORTATION ☐ NO NEEDS		☐
LEGAL ISSUES/CHILD SUPPORT ☐ NO NEEDS		☐
PARENTING SUPPORT ☐ NO NEEDS		☐
EDUCATION ☐ NO NEEDS		☐
COMMUNITY/FAMILY SUPPORT SYSTEMS/ CULTURAL ISSUES ☐ NO NEEDS		☐

TEXAS Health and Human Services
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Aug 2022

Client Name: ________________________ Medicaid #: __________________

	FAMILY INFORMATION	Check if Needs Assistance/Enter Need on SP
CHILDCARE/RESPITE CARE ☐ NO NEEDS		☐
FAMILY VIOLENCE ☐ NO NEEDS		☐
SUBSTANCE ABUSE ☐ NO NEEDS		☐
CHILD PROTECTIVE (CPS) /ADULT PROTECTIVE SERVICES (APS) ☐ NO NEEDS		☐
OTHER PSYCHOSOCIAL CONCERNS ☐ NO NEEDS		☐

ADDITIONAL COMMENTS: ____

CASE MANAGER SIGNATURE: ______________________ DATE: ______________________

CASE MANAGER PRINTED NAME: ____