







Child Name: \_\_\_\_\_ Today's date \_\_\_\_\_

Was child referred?  No  Yes: Regional Center \_\_\_\_\_

## THE IOWA ENHANCED CARE COORDINATION TOOL

1. Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?	Yes <input type="checkbox"/> Go to Question 1a No <input type="checkbox"/> Go to Question 2
1a. Is this because of ANY medical, behavioral or other health condition?	Yes <input type="checkbox"/> Go to Question 1b No <input type="checkbox"/> Go to Question 2
1b. Is this a condition that has lasted or is expected to last for <i>at least</i> 12 months?	Yes <input checked="" type="checkbox"/>  1 Point No <input type="checkbox"/>
2. Does your child need or use more medical care, mental health or educational services than is usual for most children of the same age?	Yes <input type="checkbox"/> Go to Question 2a No <input type="checkbox"/> Go to Question 3
2a. Is this because of ANY medical, behavioral or other health condition?	Yes <input type="checkbox"/> Go to Question 2b No <input type="checkbox"/> Go to Question 3
2b. Is this a condition that has lasted or is expected to last for <i>at least</i> 12 months?	Yes <input checked="" type="checkbox"/>  1 Point No <input type="checkbox"/>
3. Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?	Yes <input type="checkbox"/> Go to Question 3a No <input type="checkbox"/> Go to Question 4
3a. Is this because of ANY medical, behavioral or other health condition?	Yes <input type="checkbox"/> Go to Question 3b No <input type="checkbox"/> Go to Question 4
3b. Is this a condition that has lasted or is expected to last for <i>at least</i> 12 months?	Yes <input checked="" type="checkbox"/>  3 Points No <input type="checkbox"/>
4. Does your child need or get special therapy, such as physical, occupational or speech therapy?	Yes <input type="checkbox"/> Go to Question 4a No <input type="checkbox"/> Go to Question 5
4a. Is this because of ANY medical, behavioral or other health condition?	Yes <input type="checkbox"/> Go to Question 4b No <input type="checkbox"/> Go to Question 5
4b. Is this a condition that has lasted or is expected to last for <i>at least</i> 12 months?	Yes <input checked="" type="checkbox"/>  1 Point No <input type="checkbox"/>
5. Does your child have any kind of emotional, developmental or behavioral problem for which he or she needs or gets treatment or counseling?	Yes <input type="checkbox"/> Go to Question 5a No <input type="checkbox"/> Go to Question 6
5a. Has this problem lasted or is it expected to last for <i>at least</i> 12 months?	Yes <input checked="" type="checkbox"/>  1 Point No <input type="checkbox"/>
6. Supplement (do not read—this is based on interviewer assessment): Are there additional family or social circumstances that are present that may require enhanced medical coordination services?	Yes <input checked="" type="checkbox"/>  2 Points No <input type="checkbox"/>

Examples: social determinants of health such as literacy issues, limited English speaking proficiency, geographic isolation; or ACE factors such as child abuse or neglect, household substance use problems, divorce, domestic violence, criminal behavior or family member who is incarcerated.

\*Total points (sum):

**\* Score of 3 or more above indicates child is eligible for enhanced care coordination services.**