# AHCCCS Arizona Health Care Cost Containment System

#### AHCCCS MEDICAL POLICY MANUAL

## POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

The Arizona Health Care Cost Containment System (AHCCCS) EPSDT Tracking Forms shall be used by all providers offering care to AHCCCS members under 21 years of age to document age-specific, required information related to EPSDT screenings and visits. Only AHCCCS EPSDT Tracking Forms may be used; paper form substitutes are not acceptable. However, providers may choose to utilize an electronic EPSDT Tracking Form generated through AHCCCS (once available) or the provider's electronic health record system, so long as the electronic form includes all components present on the AHCCCS EPSDT Tracking Form. These components include, but are not limited to:

- 1. Documentation of comprehensive physical exam (including appropriate weights and vital signs)
- 2. Age-appropriate screenings (vision, hearing, oral health, nutrition, developmental, nutritional, tuberculosis (TB) and lead)
- 3. Developmental surveillance
- 4. Anticipatory guidance (Age Appropriate Education and Guidance)
- 5. Social-emotional health (Behavioral Health) surveillance
- 6. Age-appropriate labs and immunizations, and
- 7. Medically necessary referrals including those to the member's dental home starting at 1 year of age, or sooner as needed, for routine biannual examinations.

Refer to AMPM Chapter 400 for EPSDT responsibilities and services.

Contractors are required to print two-part carbonless EPSDT Tracking Forms (a copy for the member's medical record and a copy for providers to send to the Contractor's MCH/EPSDT Coordinator) and distribute these forms to their contracted providers. Providers may also choose to print the EPSDT Tracking Form from the AHCCCS website.

A copy of the completed EPSDT Tracking Form(s), signed by the clinician, should be placed in the member's medical record. Depending on the member's enrollment status, an additional distributed copy of the EPSDT Tracking Form may be required, as detailed below:

- 1. For members enrolled with a Contractor: A copy of the completed and signed form shall be sent to that Contractor.
- 2. For AHCCCS Fee-For-Service members [e.g., enrolled in the American Indian Health Program (AIHP)]: The provider shall maintain a copy of the EPSDT Tracking Form in the member's medical record, but does not need to send a copy elsewhere.

Contractors and providers may reproduce EPSDT Tracking Forms as needed. All others may reproduce the forms with permission of AHCCCS via an approved written request directed to:

#### **AHCCCS**

Division of Health Care Management CQM/Maternal and Child Health 701 E. Jefferson, Mail Drop 6700 Phoenix, AZ 85034 (602) 417-4410

NOTE: The Centers for Medicare and Medicaid Services require AHCCCS to provide specified services to our EPSDT population. These EPSDT Tracking Forms have been designed to ensure that needed services are performed, and that our members are provided an opportunity to receive preventive care. Do NOT alter or amend these forms in <u>any</u> way without discussion with our Maternal and Child Health Manager at the address above. Contact information for AHCCCS Contracted health care plans may be found at www.azahcccs.gov.

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Effective Dates: 03/01/19, 05/07/19



## POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

#### 3-5 DAYS OLD AHCCCS EPSDT TRACKING FORM

Date	Last N	ame			First N	ame	AHO	CCCS ID #	<u> </u>	OOB	Age
Primary Co	are Provider		PCP ph. #		Health P	lan	Accompanie	ad Ry (Na	ma)	Relations	hin
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Admitted to ☐ Yes	NICU: (Birt	1) Currer	nt Medications	s/ v itamins	/Herbai	Supplements	:	-	Temp:	Pulse:	Resp:
Allergies:	L 110			Birth W	/eight•	Wei	ght•	Lei	ngth:	Head Circ	cumference:
incigies.				ll		lb oz		cm	Ĭ	cm	%
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			☐ ABR ☐ OA  If 2 <sup>nd</sup> Needed/C							nknown s□ Refer □	Unknown
FAMILY/SO	CIAL HISTO	ORY: (Curren	t Concerns/ Foll	ow-Up on P	reviously	Identified Conc	erns)				
PARENTAL	CONCERNS	: How are you	ı feeling about b	aby? Do yo	u feel safe	e in your home?					
ORAL HE	ALTH: 🗆 D	aily Gum (	Cleaning with	Washclo	th or In	fant Toothbri	ısh (Parent F	Education	Completed	d)	
NUTRITIO	ONAL SCR	EENING:	☐ Breastfeed	ling Freq	uency/I	Ouration:		Supp	lements:_		□ Vit D
☐ Formula	Type:	Amo	unt/Duration:			_Adequate V	Veight Gain	□ Yes □	□ No □ R	eceiving W	<b>ICServices</b>
DEVELOP	MENTAL	SURVEIL	LANCE:	Rooting R	eflex 🗆	Startle  Suc	k & Swallow	Other			
			PROVIDED			☐ Emergency				Gun Safety	<i>I</i>
Drowning P				noking Pro			,				,
_		ear-Facing	;) □ Safe	_			evention		Bathing/W	ater Temper	rature
□Passive Sn	noke 🗆 S	Safety at Ho	me/Child-Pro	oofing	$\square$ Sun	Safety	Pacifier Use	□Bot	tle Proppin	g □ Infa	ant Bonding
□Support Sy	ystems/Reso	urces	☐ Infant Cryir	ng/Approp	oriate In	terventions	☐ Other:				
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Mouth/Thr	oat/Teeth					Extren					
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Effective Dates: 03/01/19, 05/07/19



## POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

#### 1 MONTH OLD - AHCCCS EPSDT TRACKING FORM

Date I	Last Name		First Name	<b>;</b>	AHCCCS ID	)#	DOB	Age
Primary Care Pro	ovider	PCP ph. #	Health Plan	Acco	mpanied By (N	ame)	Relations	ship
Admitted to NICU			/Vitamins/Herbal Sup			Temp:	Pulse:	Resp:
□Yes □N	, ,		•	•		•		•
Allergies:	<u> </u>		Birth Weight:	Weight:	L	ength:	Head Circ	cumference:
			lb oz	lb oz	% cı	m %	cm	%
Hospital Newborn	Hearing Screen:	□ ABR □ OAE:	Rt. Ear Pass	Refer Lt.	ear 🗆 Pass 🗆 Ref	fer □ Ur	ıknown	•
Second Newbor	rn Hearing Screen (	(If 2 <sup>nd</sup> Needed/0	Completed): ☐ ABR ☐ (	OAE: <b>Rt. Ear</b> 🗆 I	Pass □ Refer Lt.	. Ear 🗆 Pass 🗈	🛘 Refer 🗆 Un	known
FAMILY/SOCIAL	HISTORY: (Current	Concerns/ Follo	ow-Up on Previously Iden	tified Concerns)				
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			requency/Duration:			plements:_		□ Vit I
Formula Type:_	Amou			equate Weight				
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Awake For 1 Ho ANTICIPATOR Car/Car Seat Saf Passive Smoke COCIAL-EMOTION Infant Hands to M COMPREHENS Skin/Hair/Nails Eyes/Vision/Red Ear Mouth/Throat/Te Nose/Head/Neck Heart ASSESSMENT/I	ety (Rear-Facing)  Safety at Hone NAL HEALTH (OBSE Couth/Self -Calming IVE PHYSICAL  WNL  Reflex  PLAN/FOLLOW  2nd Arizona Ne Results of 2nd  DATE 1 <sup>ST</sup> HEPB/2  Given at Today  Shot Record Up  ALTCS Auc	PROVIDED:  □ Dro □ Safe me/Child-Pro ERVED BY CLINI g □ Appropria EXAM:  Abnormal  V-UP:  Ewborn Scree AZ Newborn Provided □ Entered Herbard Herbard Hology □ Azie	Deprivation   Epowning Prevention   Sleep   Shaker   Shak	Baby Preventicety Pacific Pamily Adjustive to Needs Lungs Lungs Abdomen Genitourinar Extremities Spine Neurological  (5 – 10 Days of Add (If No, What Fole) Lungs Abdomen Delayed Dece of Immunizate Dental Early	Choking Prevon Safeer Use Bostment/Parent R Postpartum Dep  WNL  y  ge or First PCP V low Up Taken: (Not Previously eferred Reastions Discussed y Head Start	rention The Bathing/Wottle Propping The Besponds Pour Pression    Abnorm  Abnorm  Tisit)    Other Ty Administer On:    Parent Re OT    PT    The Bathing/Wottle Propping The Bathing/Wottle Pression    The Bathing Pression	VaterTempe ng	rature ant Bonding nild es below)  or
AWAKE FOR 1 HO ANTICIPATOR Car/Car Seat Saf Passive Smoke COCIAL-EMOTION Infant Hands to M COMPREHENS Skin/Hair/Nails Eyes/Vision/Red Ear Mouth/Throat/Te Nose/Head/Neck Heart ASSESSMENT/I CABS ORDERED: EMMUNIZATIONS ORDERED: REFERRALS:	ety (Rear-Facing)  Safety at Hone NAL HEALTH (OBSE Couth/Self -Calming IVE PHYSICAL  WNL  Reflex  PLAN/FOLLOW  2nd Arizona Ne Results of 2nd  DATE 1 <sup>ST</sup> HEPB/2  Given at Today  Shot Record Up  ALTCS Auc	PROVIDED:  □ Dro □ Safe me/Child-Pro ERVED BY CLINI g □ Appropria EXAM:  Abnormal  V-UP:  Ewborn Scree AZ Newborn Provided □ Entered Herbard Herbard Hology □ Azie	Deprivation Sleep Shaker Sofing Sun Safe Scient Sc	Baby Preventicety Pacific Pamily Adjustive to Needs Lungs Lungs Abdomen Genitourinar Extremities Spine Neurological  (5 – 10 Days of Add (If No, What Fole) Lungs Abdomen Delayed Dece of Immunizate Dental Early	Choking Prevon Safeer Use Bostment/Parent R Postpartum Dep  WNL  y  ge or First PCP V low Up Taken: (Not Previously eferred Reastions Discussed y Head Start	rention The Bathing/Wottle Propping The Besponds Pour Pression    Abnorm  Abnorm  Tisit)    Other Ty Administer On:    Parent Re OT    PT    The Bathing/Wottle Propping The Bathing/Wottle Pression    The Bathing Pression	VaterTempe ng	rature ant Bonding hild es below)  or
Awake For 1 Ho ANTICIPATOR Car/Car Seat Saf Passive Smoke SOCIAL-EMOTION Infant Hands to M COMPREHENS Skin/Hair/Nails Eyes/Vision/Red Ear Mouth/Throat/Te Nose/Head/Neck Heart ASSESSMENT/I	ety (Rear-Facing)  Safety at Hone NAL HEALTH (OBSE Couth/Self -Calming IVE PHYSICAL  WNL  Reflex  PLAN/FOLLOW  2nd Arizona Ne Results of 2nd  DATE 1 <sup>ST</sup> HEPB/2  Given at Today  Shot Record Up  ALTCS Auc	PROVIDED:  □ Dro □ Safe me/Child-Pro ERVED BY CLINI g □ Appropria EXAM:  Abnormal  V-UP:  Ewborn Scree AZ Newborn Provided □ Entered Herbard Herbard Hology □ Azie	Downing Prevention Sleep	Baby Preventicety Pacific Pamily Adjustive to Needs Lungs Lungs Abdomen Genitourinar Extremities Spine Neurological  (5 – 10 Days of Add (If No, What Fole) Lungs Abdomen Delayed Dece of Immunizate Dental Early	Choking Prevon Safeer Use Bostment/Parent R Postpartum Dep  WNL  ge or First PCP V low Up Taken: (Not Previously eferred Reastions Discussed by Head Start Safe New)	rention The Bathing/Wottle Propping The Besponds Pour Pression    Abnorm  Abnorm  Tisit)    Other Ty Administer On:    Parent Re OT    PT    The Bathing/Wottle Propping The Bathing/Wottle Pression    The Bathing Pression	VaterTempe ng	rature ant Bonding hild es below)  cr Completed VIC

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Effective Dates: 03/01/19, 05/07/19



## POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

#### 2 MONTHS OLD -AHCCCS EPSDT TRACKING FORM

Primary Carc Provider											
Admitted to NICU: (Busin)   Yes   No   No   Nicure   No   Nicure	Date	Last Nam	e		First N	ame	AHC	CCCS ID #	ŧ D	ОВ	Age
Allergies:   Birth Weight:   Weight:   Length:   Itendent   Itende	Primary C	are Provider		PCP ph. #	Health Pl	an	Accompanie	ed By (Na	me)	Relations	hip
Birth Weight:   Weight:   Length:   Head Circumference:	Admitted t	o NICU: (Birth)	Current	Medications	/Vitamins/Herbal	Supplements	:		Temp:	Pulse:	Resp:
Risk Indicators of Hearing Loss:   Yes   No   No   Rit Ear   Pass   Refer   Li, Ear   Pass   Refer   Unknown   No   No   No   No   No   No   No   N	□ Yes	□ No									
Risk Indicators of Hearing Loss:   Yes   No   Hospital Newborn Hearing Screen:   DABR   OAE:   Rt. Ear   Pass   Refer   Lt. Ear   Pass   Refer   Unknown   Second Newborn Hearing Screen (  T2** Needed/Completed):   DABR   OAE:   Rt. Ear   Pass   Refer   Lt. Ear   Pass   Refer   Unknown   Park   Pass   Refer   Unknown   Pass   Pass   Refer   Unknown   Pass   Pass   Refer   Unknown   Pass   Pass   Refer   Unknown   Pass   Pass   Pass   Refer   Unknown   Pass   Pass   Pass   Pass   Refer   Unknown   Pass   Pass   Pass   Pass   Pass   Refer   Unknown   Pass   Pas	Allergies:				Birth Weight:	Wei	ght:	Lei	ngth:	Head Circ	umference:
Hospital Newborn Hearing Screen:   ABR   OAE:   Rt. Ear   Pass   Refer   Lt. Ear   Pass   Refer   Unknown					lb oz	lb o	2 %	cm	%	cm	%
Second Newborn Hearing Screen (If 2nd Needed/Completed): \( \to ABR \) \( \to AE: Rt. Ear \) \  \to Pass \  \text{Refer Lt. Ear \} \  \to Pass \  \text{Refer \} \] \( \text{Unknown} \) \  FAMILY/SOCIAL HISTORY; (Current Concerns) Follow-Up on Previously Identified Concerns)    PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?    PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?    PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?    PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?    PARENTAL SURVEILLANCE: \] \  Daily Gum Cleaning with Washcloth or Infant Toothbrush (Parent Education Completed)   Pormula Type: \  Amount/Duration: \  Adequate Weight Gain \  Yes \  No \  Receiving WIC Services   DEVELOPMENTAL SURVEILLANCE: \] Some Head Control \  Tummy Time/Lifts Head, Neck With Forearm Support \  Social Smile \  Cocos \  Begins Imitation of Movement and Pacial Expressions \  Makes Eye Contact \  Fixes/Follows With Eyes to Midline \  Startles At Loud Noises \  Other \  ANTICIPATORY GUIDANCE ProVIDED: \  Emergency/911 \  Gun Safety \  Drowning Prevention \  Car/Car Seat Safety (Rear-Facing) \  Safe Sleep \  Shaken Baby Prevention \  Safe Bathing/Water Temperature \  Passive Smoke \  Safety at Home/Child-Proofing \  Sun Safety \  Daeiffer Use \  Bottle Propping \  Infant Bonding \  Support Systems/Resources \  Infant Crying/Appropriate Interventions \  Parent Reads to Child \  Other \  Social-Emotional Health (Observe by Culsician/Parent Report): \  Family Adjustment/Parent Responds Positively to Child \  Appropriate Bonding/Responsive to Needs \  Infant Hands to Mouth/Self-Calming \  Bijosy Interacting With Others \  Postpartum Depression \  Other \  Genitourinary \  Mouth/Honal/Teeth \  Spine \  Berremitted \  Spine \  Berremited \  Spine \  Berremitted \  Spine \  Berremitted \  Spine \  B	Risk Indica	itors of Hearing	Loss:	es □ No							
PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?											nknown
PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?											
NUTRITIONAL SCREENING;   Breastfeeding   Frequency/Duration:   Adequate Weight Gain   Yes   No   Receiving WICServices					•		,				
Formula Type:								cation Co	ompleted)		
DEVELOPMENTAL SURVEILLANCE:   Some Head Control   Tummy Time/Lifts Head, Neck With Forearm Support   Social Smile				_					·		
Coos   Begins Imitation of Movement and Facial Expressions   Makes Eye Contact   Fixes/Follows With Eyes to Midline   Startles At Loud Noises   Other											
Infant Crying/Appropriate Interventions	☐ Coos ☐ ☐ Startles A  ANTICIPAT ☐ Car/Car S	Begins Imitation that Loud Noises ORY GUIDANC eat Safety (Rea	on of Mov Othe E PROVII ar-Facing)	vement and I r DED: □ Ei D □ Safe S	Facial Expressions mergency/911 leep  Shaken Ba	S ☐ Make	s Eye Contac y □ Dro n □ Safe Bath	et □ F owning Pr ning/Wate	ixes/Follovevention er Tempera	Sws With Eye  ☐ Choking ture ☐ Passi	s to Midline g Prevention ve Smoke
SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT):   Family Adjustment/Parent Responds Positively to Child   Appropriate Bonding/Responsive to Needs   Infant Hands to Mouth/Self-Calming   Enjoys Interacting With Others   Postpartum Depression   Other   COMPREHENSIVE PHYSICAL EXAM:   WNL   Abnormal (see notes below)   WNL   Abnormal (see notes below)									□ Su	pport Syste	ms/Resources
Appropriate Bonding/Responsive to Needs   Infant Hands to Mouth/Self-Calming   Enjoys Interacting With Others											
Postpartum Depression   Other   COMPREHENSIVE PHYSICAL EXAM:    WNL   Abnormal (see notes below)   WNL   Abnormal (see notes below)									-	•	Child
COMPREHENSIVE PHYSICAL EXAM:    WNL   Abnormal (see notes below)   WNL   Abnormal (see notes below)		-	-		Infant Hands to M	outh/Self-Ca	alming	Enjoys I	nteracting \	With Others	
WNL   Abnormal (see notes below)   WNL   Abnormal (see notes below)	=	=									
Skin/Hair/Nails   Lungs     Eyes/Vision/Red Reflex   Abdomen     Ear   Genitourinary     Mouth/Throat/Teeth   Extremities     Nose/Head/Neck   Spine     Heart   Neurological     ASSESSMENT/PLAN/FOLLOW-UP:    Labs Ordered:	COMPRE	HENSIVE PH			1/	`		***	1 4 7	1 / 1	
Eyes/Vision/Red Reflex   Abdomen   Ear   Genitourinary	C1 :/II . :/	NT. 11.	WNL	Abnorma	l (see notes belov	,		WNL	Abnorm	al (see note	s below)
Ear							non				
Mouth/Throat/Teeth	_ •	ni/Red Reliex									
Nose/Head/Neck   Spine   Heart   Neurological    ASSESSMENT/PLAN/FOLLOW-UP:  LABS ORDERED:   2 <sup>nd</sup> Arizona Newborn Screening Bloodspot Test (If Needed)   Other     Results of 2 <sup>nd</sup> AZ Newborn Screening Received (If No, What Follow Up Taken:		roat/Teeth					•				
Heart							11105				
LABS ORDERED: 2 <sup>nd</sup> Arizona Newborn Screening Bloodspot Test (If Needed) Other Results of 2 <sup>nd</sup> AZ Newborn Screening Received (If No, What Follow Up Taken:    MMUNIZATIONS							ogical				
Results of 2 <sup>nd</sup> AZ Newborn Screening Received (If No, What Follow Up Taken:  IMMUNIZATIONS	L.	ENT/PLAN/F	OLLOW	<u>-UP:</u>		<b>,</b>			•		
ORDERED:  Given at Today's Visit Parent Refused Delayed Deferred Reason: Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed  REFERRALS: ALTCS Audiology AzEIP CRS DDD Dental Early Head Start OT PT Speech WIC Specialist: Developmental Behavioral Other  PROVIDER'S		□ Resul	ts of 2 <sup>nd</sup>	AZ Newbor	n Screening Rece	ived (If No, W	hat Follow Up	Taken:			)
□ Shot Record Updated □ Entered in ASIIS □ Importance of Immunizations Discussed □ Parent Refusal Form Completed  REFERRALS: □ ALTCS □ Audiology □ AzEIP □ CRS □ DDD □ Dental □ Early Head Start □ OT □ PT □ Speech □ WIC Specialist: □  Developmental □ Behavioral □ Other  PROVIDER'S											
REFERRALS:	ORDEREI		-			•					
PROVIDER'S	REFERRAL	S: ALTO	CS 🗆 Audi	ology 🗆 AzE	IP □ CRS □ DDD						•
	PROVIDER'										
					NPI:		Dat	e:			

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Effective Dates: 03/01/19, 05/07/19



## POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

#### 4 MONTHS OLD - AHCCCS EPSDT TRACKING FORM

Date	Last Na	me		First	Name	1	AHCCC	S ID#	DOB	A	.ge
Primary C	are Provider	]	PCP ph. #	Heal	th Plan	Accom	panied By	(Name)	F	Relationsh	nip
Admitted t	o NICU: (Birth)	Current l	Medications/Vita	amins/Herbal Suppl	lements:	Risk Indicators	s of Hearing	Loss:	Гетр:	Pulse:	Resp:
□ Yes	□ No					☐ Yes	□ No				
Allergies:				Birth Weight:		Weight:	Le	ngth:	Hea	d Circun	nference:
				lb oz	lb	oz %	cn	n %	•	cm	%
FAMILY/SO	OCIAL HISTORY	Current (	Concerns/ Follow	v-Up on Previously Io	dentified C	oncerns)					
PARENTAL	CONCERNS: Ho	ow are you f	eeling about bab	y? Do you feel safe i	n your hon	ne?					
				shcloth or Infant							
				quency/Duration:							
☐ Formula '	Туре:	Amoun	t/Duration:			Weight Gain	$\square$ Yes $\square$	No □			
	ype:			Introduce Solids						Soda/Juio	
				and Coos □ Lau							
	Head Well			☐ Interest in Mi	rror Ima	ges 🗆 Pushe	s Down W	ith Legs	When F	Feet on Su	ırface
	ate Eye Contact										
				rgency/911 $\square$			ning Preve				
				Sleep ☐ Sha							
				fing □ Sun Safe							
-				Discuss Child To	_			-		_	
				th Night (Greater							
				CIAN/PARENT REPOR							
	nds to Mouth/Se		-	les When Hears I							
-		-	-	de World □ Post	partum 1	epression	Other _				
COMPRE	HENSIVE PH						I			_	
C1: TX:	D. T. 11	WNL	Abnormal	(see notes below			WNL	Abnor	mal (se	e notes b	elow)
Skin/Hair/					Lur	•					
Eyes/Visio	)II					lomen iitourinary					
Mouth/Th	root/Tooth					remities					
Nose/Head					Spi						
Heart	d/TVCCK					rological					
	ENT/PLAN/FO	OLLOW.	<u>-UP</u>		1100	noiogicai					
LABS ORDI	ERED: Other										
IMMUNIZA	TIONS   HepB	□ DTal	P 🗆 Hib		PCV [	Rotavirus	Other				
<b>ORDEREI</b>	<b>D:</b> ☐ Given	at Today	's Visit □ I		□Delaye						
	☐ Shot R	Record Upd	lated  Entered	l in ASIIS □ Impor	-		iscussed [	Parent Re	efusal F	orm Com	oleted
REFERRAL				EIP   CRS   D							
				☐ Behavioral ☐		·				•	
PROVIDER'SIGNATURE	'S			NPI:		Da	ıte:				
				1111		D					

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Effective Dates: 03/01/19, 05/07/19



## POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

#### 6 MONTHS OLD - AHCCCS EPSDT TRACKING FORM

Date	Last Na	me		First	Name		AHC	CCS ID#	DOB	Ag	e
Primary C	Care Provider	I	PCP ph. #	Heal	h Plan	Accom	npanied 1	By (Name)	R	elationship	)
Admitted	to NICU: (Birth)	Current !	Medications/Vitami	ns/Herbal Supp	ements:	Risk Indi	icators of	Hearing Loss:	Temp:	Pulse:	Resp:
☐ Yes	No					□ Yes	1	No	Temp.	I disc.	тевр.
Allergies:				Birth Weight:		Weight:		Length:	Н	ead Circun	nference:
Timer gress				lb oz	lb		%	cm	%	cm	%
			Concerns/ Follow-U	Jp on Previously	Identified C	concerns)		, , ,	- 12		- ,,
					-			' II'1. D'	1.7: 0	1	N.
			Child At Risk  Ye								
			Baby's Gums With								
			astfeeding Frequence					Supplemen			□ Vit D
			nt/Duration: ☐ Plan to Intr							ving W1C _□ Soda/J	
DEVELOPM	MENTAL SURV	EILLANCE	: Using A Str	ing of Vowels	Rolls	Over $\square$ T	ransfers	Small Object	s 🗆 🗸	Vocal Imit	ation
☐ Sits With	Support $\square$	Explores V	With Hands and I	Mouth □ P	eek-a-Bo	o/Patty Ca	ıke [	Other			
☐ Sun Safe ☐ Wary of Social-EM	ty Refra Strangers   MOTIONAL HE	in From Ju Introduce	) ☐ Safe Sleep ☐ Imp Seat/Walker Board Books  SERVED BY CLINICIA to Needs	☐ Sleep/☐ Parent Reac	Wake Cycls to Child	ele □ I l □ Otl Family Ac	ntroduce her djustmer	e Cup	Begin Usi onds Pos	ng High Cl itively to I	hair Baby
	_	-	Play Postp	_		-		-	•		——
COMPRE	HENSIVE P	HYSICAI	<u>LEXAM:</u>								
		WNL	Abnormal (se	e notes belov	7)		WN	L Abnor	mal (see	notes belo	w)
Skin/Hair	/Nails				Lung	gs					
Eyes/Visio	on				Abd	omen					
Ear					Geni	tourinary					
Mouth/Th	roat/Teeth					emities					
Nose/Hea	d/Neck				Spin						
Heart						ological					
ASSESSM	IENT/PLAN/	FOLLOW	V-UP:		·			·			
LABS ORD	ERED: Blo	od Lead T	Cesting (Child At	Risk) 🗆 Fing	er Stick (I	Result:	_) 🗆 Ve	enous 🗆 Ot	her		
IMMUNIZA	TIONS   Hep	B □ DTaF	P ☐ Hib	□ IPV □	PCV	Influenza	a 🗆 R	otavirus 🗆 O	ther		
ORDERE	<b>D:</b> ☐ Giver	n at Today'		ent Refused	□Delaye	d □Def	ferred	Reason:	Pafucal E	orm Comp	leted
REFERRAL			iology  AzEIP								
			velopmental $\square$			itai 🗆 Dall	., 11cud			, , , , , , , , , , , , , , , , , , ,	
Provider': Signature				NPI:			Date:				

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Effective Dates: 03/01/19, 05/07/19



#### 9 MONTHS OLD - AHCCCS EPSDT TRACKING FORM

Date	Last Nan	ne		First I	lame		AHCC	CS ID#	DO]	B Ag	e
Primary C	Care Provider	P	CP ph. #	Healtl	Plan	Acc	ompanied B	y (Name)		Relationship	)
Admitted	to NICU: (Birth)	Current M	/ledications/Vitam	ins/Herbal Supple	ments:	Risk I	ndicators of l	Hearing Loss:	Temp	: Pulse:	Resp:
☐ Yes	$\square$ No					☐ Yes	s $\square$	No			
Allergies:				Birth Weight:		Weig	ht:	Lengt	h:	Head Circu	mference:
				lb ox	ı lb	oz	%	cm	%	cm	%
FAMILY/SO	OCIAL HISTORY	(Current C	Concerns/ Follow-U	p on Previously Id	entified Cor	ncerns)		.N		Į.	
PARENTAL	. CONCERNS: Ho	w are you fo	eeling about baby?	Do you feel safe in	your home	?					
DEVELOPMI	ENTAL SCREENI	NG TOOL	COMPLETED:	$\Box$ ASQ $\Box$	PEDS						
VERBAL LE	AD RISK ASSESS	SMENT: C	Child At Risk 🗆	Yes □ No (If Yes,	Appropriat	e Action	to Follow) L	ives in High	Risk Z	ip Code □ Y	es 🗆 No
ORAL HEAD	LTH: White Spot	s on Teeth	n: □ Yes □ No □ P	Parent Cleaning E	aby's Gur	ns With	ı Infant Toot	hbrush			
☐ Fluoride S	Supplement	□Fl	uoride Varnish b	y PCP (Once Eve	ry 6mo)						
NUTRITION	AL SCREENING:	Breastf	feeding 🗆 Form	ula Amount:		Suppl	lements:	Vit D 🗆 <b>Rec</b> e	eiving W	<b>TCServices</b>	
Adequate W	eight Gain 🗆 Yo	es 🗆 No 🗎	Plan to Introduc	ce Table Foods_				<b>Drinks Fron</b>	n Cup	□Soda/Ju	aice
DEVELOPMI	ENTAL SURVEIL	LANCE:	Sits Independer	$\square$ Pulls to S	and/Crui	sing 🗆 🗈	Plays Peek-	A-Boo □ Us	es Word	ls "Mama/D	ada"
☐ Waves By	e-Bye Wary of	Strangers	☐ Immature Pinc	er Repeats So	unds/Gest	ures fo	r Attention [	Explores E	nvironm	ent 🗆 Other _	
ANTICIPATO	ORY GUIDANCE	PROVIDE	<b>D:</b> □Emerg	ency/911	Gun Sa	fety	☐ Drow	ning Preven	tion		
	revention/Soft T							afe Sleep		en Baby Prev	vention
	noke 🗆 Safety at							reen Time			
Redirection	n/Positive Paren	ting	☐ Language/Rea	ad to Child/Intro	duce Boar	rd Bool	ks 🗆 Fol	low Child's	Lead in	Play	_
Parent Cor	mmunicates to C	hild "Wh	· 1771	(D. 11. G . E.							
			at Things Are"	(Ball, Cat, Etc.	$\square$ Other					•	
	OTIONAL HEAL		_	•			ıstment/Par	ent Respond	ds Positi		d
SOCIAL-EM	OTIONAL HEAL	TH (OBSER	RVED BY CLINICIAN	N/PARENT REPORT	:□ Famil	y Adju		-		vely to Chil	
SOCIAL-EM  Appropriat		TH (Obsertonsive to	RVED BY CLINICIAN Needs  Self-C	N/PARENT REPORT	:□ Famil	y Adju		-		vely to Chil	
SOCIAL-EM  Appropriat  Cries Whe	TOTIONAL HEAL' te Bonding/Resp	<b>TH (OBSER</b> onsive to giver Leav	Needs Self-C	N/PARENT REPORT	:□ Famil	y Adju		-		vely to Chil	
SOCIAL-EM  Appropriat  Cries Whe	OTIONAL HEAL te Bonding/Resp on Primary Careg	<b>TH (OBSER</b> onsive to giver Leav	Needs Self-Coves Postpartures XAM:	N/PARENT REPORT	: ☐ Famil ving Inde Other: _	y Adju		s Preference	for Cer	vely to Chil	Toys
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/	te Bonding/Resp en Primary Careg HENSIVE PHY	TH (OBSERT ON SIVE TO SICAL E	Needs Self-Coves Postpartures XAM:	N/PARENT REPORT Calming  Grov m Depression	:   Familying Indepotent of them of them of them of them of the th	y Adju penden	nce Show	s Preference	for Cer	vely to Chil tain People/	Toys
SOCIAL-EM  Appropriat  Cries Whe  COMPREH	te Bonding/Resp en Primary Careg HENSIVE PHY	TH (OBSERT ON SIVE TO SICAL E	Needs Self-Coves Postpartures XAM:	N/PARENT REPORT Calming  Grov m Depression	: ☐ Famil ving Inde Other:  Lungs Abdo	y Adju penden	wn WN	s Preference	for Cer	vely to Chil tain People/	Toys
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear	te Bonding/Respon Primary Carego HENSIVE PHYS	TH (OBSERT ON SIVE TO SICAL E	Needs Self-Coves Postpartures XAM:	N/PARENT REPORT Calming  Grov m Depression	: ☐ Famil ving Inde Other:  Lungs Abdo Genit	y Adju pender s men ourinar	wn WN	s Preference	for Cer	vely to Chil tain People/	Toys
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear Mouth/Th	te Bonding/Respen Primary Careg HENSIVE PHY  (Nails on	TH (OBSERT ON SIVE TO SICAL E	Needs Self-Coves Postpartures XAM:	N/PARENT REPORT Calming  Grov m Depression	Extre	y Adju pender s men ourinar mities	wn WN	s Preference	for Cer	vely to Chil tain People/	Toys
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear	te Bonding/Respen Primary Careg HENSIVE PHY  (Nails on	TH (OBSERT ON SIVE TO SICAL E	Needs Self-Coves Postpartures XAM:	N/PARENT REPORT Calming  Grov m Depression	: ☐ Famil ving Inde Other:  Lungs Abdo Genite Extre Spine	y Adju pender s men ourinar mities	WN WN	s Preference	for Cer	vely to Chil tain People/	Toys
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear Mouth/Th	te Bonding/Respen Primary Careg HENSIVE PHY  (Nails on	TH (OBSERT ON SIVE TO SICAL E	Needs Self-Coves Postpartures XAM:	N/PARENT REPORT Calming  Grov m Depression	: ☐ Famil ving Inde Other:  Lungs Abdo Genite Extre Spine	y Adju pender s men ourinar mities	WN WN	s Preference	for Cer	vely to Chil tain People/	Toys
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear Mouth/Thr Nose/Head	te Bonding/Respen Primary Careg HENSIVE PHY  (Nails on	rh (Obser onsive to civer Leav SICAL E WNL	RVED BY CLINICIAN Needs	N/PARENT REPORT Calming  Grov m Depression	: ☐ Famil ving Inde Other:  Lungs Abdo Genite Extre Spine	y Adju pender s men ourinar mities	WN WN	s Preference	for Cer	vely to Chil tain People/	Toys
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear Mouth/The Nose/Heac Heart ASSESSMI	te Bonding/Respon Primary Caregon Proat/Teeth d/Neck	TH (OBSER onsive to civer Leav SICAL E WNL	RVED BY CLINICIAN Needs	N/PARENT REPORT Calming □ Grown Depression □ ee notes below	Extress Neuro	y Adju pender s men ourinar mities	WN WN	s Preference	e for Cer	vely to Chil tain People/	Toys
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear Mouth/The Nose/Hear Heart ASSESSMI	te Bonding/Respen Primary Caregon Primary Care	TH (OBSER onsive to civer Leav SICAL F WNL	RVED BY CLINICIAN Needs	t Risk)  Finge	Extree Spine Neuro	y Adjupender	wnice Show	L Abnor	e for Cer	vely to Chil tain People/	Toys
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear Mouth/The Nose/Hear Heart ASSESSMI LABS ORD	te Bonding/Respen Primary Caregon Primary Care	TH (OBSER onsive to civer Leav SICAL F WNL	RVED BY CLINICIAN Needs	t Risk)   Finge	Extrement Spine Neuro	y Adjupender  men ourinar mities  llogica	wNi WNi II	Abnor	e for Cer	vely to Chil tain People/	Toys
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear Mouth/The Nose/Hear Heart ASSESSMI	te Bonding/Respen Primary Careguen Prima	TH (OBSER onsive to giver Leav SICAL F WNL	RVED BY CLINICIAN Needs	t Risk)   Finge	Extrement Spine Neuro	y Adjupender  s men ourinar mities ologica  esult: Influe	wN  WN  Ty  Il  Deferred	Abnor  Abnor  Ous He Other  Reason:	e for Cer	vely to Chil tain People/ e notes belo	Toys  Dw)
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear Mouth/The Nose/Hear Heart ASSESSMI LABS ORD	te Bonding/Respen Primary Careg HENSIVE PHY  (Nails on roat/Teeth d/Neck  ENT/PLAN/FO  DERED: Blood ATIONS Hep E CD: Giver	onsive to giver Leave SICAL E WNL  LLOW- LLOW- at Today Record Upon	RVED BY CLINICIAN Needs	t Risk)   Finge   IPV   Irent Refused in ASIIS   Impo	Extrement Spine  Stick (Record of Interest)	y Adjupenden  s men ourinar mities blogica  esult: Influe Emmuniz	WN  Ty  Il  Operations Discussions	Abnor  L Abnor  Abnor  Other  Reason:  Ssed Pare	e for Cer	vely to Chil tain People/ e notes belo  Other	Toys  ow)  pleted
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear Mouth/Thi Nose/Heac Heart ASSESSMI LABS ORD IMMUNIZA ORDERE	te Bonding/Respen Primary Careg HENSIVE PHY:  (Nails on roat/Teeth d/Neck  ENT/PLAN/FO  DERED: Blood ATIONS HepE CD: Giver Shot F	onsive to giver Leave SICAL E WNL  LLOW- LLOW- at Today Record Upo	RVED BY CLINICIAN Needs	t Risk)   Finge   IPV   Irent Refused   Impo   Impo   Impo   Irent Refused   Impo   Irent Refused   Irent Refu	Extrement Spine  Stick (Record Delayed tance of In DD Delayed	y Adjupenden  s men ourinar mities blogica  esult: Influe Emmuniz	WN  Ty  Il  Operations Discussions	Abnor  L Abnor  Abnor  Other  Reason:  Ssed Pare	e for Cer	vely to Chil tain People/ e notes belo  Other	Toys  ow)  pleted
SOCIAL-EM Appropriat Cries Whe COMPREH Skin/Hair/ Eyes/Visio Ear Mouth/Thi Nose/Heac Heart ASSESSMI LABS ORD IMMUNIZA ORDERE	te Bonding/Respen Primary Caregon Primary Care	onsive to giver Leave SICAL E WNL  LLOW- LLOW- at Today Record Upo	RVED BY CLINICIAN Needs	t Risk)   Finge   IPV   Irent Refused   Impo   Impo   Impo   Irent Refused   Impo   Irent Refused   Irent Refu	Extrement Spine  Stick (Record Delayed tance of In DD Delayed	y Adjupenden  s men ourinar mities blogica  esult: Influe Emmuniz	WN  Ty  Il  Operations Discussions	Abnor  L Abnor  Abnor  Other  Reason:  Ssed Pare	e for Cer	vely to Chil tain People/ e notes belo  Other	Toys  ow)  pleted

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Effective Dates: 03/01/19, 05/07/19



### POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

#### 12 MONTHS OLD - AHCCCS EPSDT TRACKING FORM

☐ Yes ☐ No Allergies:  Vision Screening: Corre  FAMILY/SOCIAL HISTORY: (0)  PARENTAL CONCERNS: How a  BLOOD LEAD LEVEL REC  ORAL HEALTH: White Spots of First Dental Appointment ☐ Co  NUTRITIONAL SCREENING: ☐ Adequate Weight Gain ☐ Solid  DEVELOPMENTAL SURVEILLE	PCP ph. # Healt ent Medications/Vitamins/Herbal Suppler    Birth Weight:   lb o     cted:   Yes   No   Automated     Device       current Concerns/ Follow-Up on Previously     e you feeling about baby? Do you feel safe     DUIRED   Teeth:   Yes   No   Daily Brushing (*)   mpleted   Scheduled   Dental Hom     Breastfeeding   Whole Milk Amou	Risk Ir  Yes  Weight: DZ   Ib   OZ  Right:   Pass   Refer  Identified Concerns)  in your home?  (see below)  Twice by Parent)   Fluctore: Provider Name unt_	%  Left:  Pas Refer  oride Supples	Length: cm % ss Both:  Refer  ment   Fluori	Pass UI Perf	: Resp:  ofference:  % nable to orm
Admitted to NICU: (Birth)  Yes No Allergies:  Vision Screening: Corre  FAMILY/SOCIAL HISTORY: (CORRENTAL CONCERNS: How a BLOOD LEAD LEVEL RECORAL HEALTH: White Spots of First Dental Appointment Correspond to Corr	Birth Weight:    Birth Weight:   Ib o     Sted:   Yes   No   Automated     Device       Current Concerns/ Follow-Up on Previously     Every concerns of the step o	Risk Ir  Yes  Weight: DZ   Ib   OZ  Right:   Pass   Refer  Identified Concerns)  in your home?  (see below)  Twice by Parent)   Fluctors Provider Name unt_	ndicators of H  %  Left:  Pas  Refer  oride Supples	Length: cm % ss Both:  Refer  ment   Fluori	Temp: Pulse    Head Circum   cm     Pass	nable to orm
Admitted to NICU: (Birth)  Yes No Allergies:  Vision Screening: Corre  FAMILY/SOCIAL HISTORY: (CORRENTAL CONCERNS: How a BLOOD LEAD LEVEL RECORAL HEALTH: White Spots of First Dental Appointment Correspond to Corr	Birth Weight:    Birth Weight:   Ib o     Sted:   Yes   No   Automated     Device       Current Concerns/ Follow-Up on Previously     Every concerns of the step o	Risk Ir  Yes  Weight: DZ   Ib   OZ  Right:   Pass   Refer  Identified Concerns)  in your home?  (see below)  Twice by Parent)   Fluctors Provider Name unt_	ndicators of H  %  Left:  Pas  Refer  oride Supples	Length: cm % ss Both:  Refer  ment   Fluori	Temp: Pulse    Head Circum   cm     Pass	nable to orm
☐ Yes ☐ No Allergies:  Vision Screening: Corre  FAMILY/SOCIAL HISTORY: (0)  PARENTAL CONCERNS: How a  BLOOD LEAD LEVEL REC  ORAL HEALTH: White Spots of First Dental Appointment ☐ Co  NUTRITIONAL SCREENING: ☐ Adequate Weight Gain ☐ Solid  DEVELOPMENTAL SURVEILLE	Birth Weight:    Ib o	☐ Yes  Weight:  ID OZ  Right: ☐ Pass ☐ Refer  Identified Concerns)  in your home?  (see below)  Twice by Parent) ☐ Flucture: Provider Name  unt	%  Left: □ Pas □ Refer  oride Supples	Length: cm % ss Both:  Refer  ment   Fluori	Head Circum cm Pass Ut Perf	nable to orm
Allergies:  Vision Screening: Corre  FAMILY/SOCIAL HISTORY: (CONTENT OF THE PROPERTY OF THE PR	lb o  ted: □ Yes □ No Automated Device □  current Concerns/ Follow-Up on Previously e you feeling about baby? Do you feel safe:  DUIRED Teeth: □ Yes □ No □ Daily Brushing (* mpleted □ Scheduled Dental Hom Breastfeeding □ Whole Milk Amou	Weight:    DZ	%  Left:  Pas Refer  oride Supples	cm % s Both:  Refer  ment  Fluori	em Pass UI Perf	% nable to form
Vision Screening: Corre  FAMILY/SOCIAL HISTORY: (0)  PARENTAL CONCERNS: How a  BLOOD LEAD LEVEL REC  ORAL HEALTH: White Spots of First Dental Appointment  Concerns:  NUTRITIONAL SCREENING:  Adequate Weight Gain  Solid  DEVELOPMENTAL SURVEILLE	lb o  ted: □ Yes □ No Automated Device □  current Concerns/ Follow-Up on Previously e you feeling about baby? Do you feel safe:  DUIRED Teeth: □ Yes □ No □ Daily Brushing (* mpleted □ Scheduled Dental Hom Breastfeeding □ Whole Milk Amou	Right:  Pass Refer  Identified Concerns) in your home?  (see below) Twice by Parent)  Pluce: Provider Name unt	Left:   Pas   Refer	cm % s Both:  Refer  ment  Fluori	em Pass UI Perf	% nable to form
FAMILY/SOCIAL HISTORY: (COMPARENTAL CONCERNS: How a BLOOD LEAD LEVEL RECOUNTY OF THE PROPERTY	Device □  Current Concerns/ Follow-Up on Previously  e you feeling about baby? Do you feel safe a  DUIRED  Teeth: □ Yes □ No □ Daily Brushing (*)  mpleted □ Scheduled Dental Hom  Breastfeeding □ Whole Milk Amou	Right: □ Pass □ Refer  Identified Concerns) in your home?  (see below) Twice by Parent) □ Flucture: Provider Name unt	Left:   Pas   Refer	Both: Daries Refer	Pass UI Perf	PCP
PARENTAL CONCERNS: How a  BLOOD LEAD LEVEL REC  ORAL HEALTH: White Spots of First Dental Appointment  Concerns  NUTRITIONAL SCREENING: Adequate Weight Gain  Solid  DEVELOPMENTAL SURVEILLE	e you feeling about baby? Do you feel safe a <b>QUIRED</b> Teeth: □ Yes □ No □ Daily Brushing (*)  mpleted □ Scheduled Dental Hom  Breastfeeding □ Whole Milk Amou	in your home?  (see below)  Twice by Parent) □ Flucture: Provider Name	☐ Milk Intak	te/Weaning	=	
BLOOD LEAD LEVEL RECORAL HEALTH: White Spots of First Dental Appointment   Conversely Co	UIRED  Teeth: □Yes □No □ Daily Brushing ( mpleted □ Scheduled Dental Hom  Breastfeeding □ Whole Milk Amou	(see below) Twice by Parent) □ Fluctie: Provider Name unt	☐ Milk Intak	te/Weaning	=	
ORAL HEALTH: White Spots of First Dental Appointment  Consumption	Teeth: \( \text{Yes} \( \text{No} \) \( \text{Daily Brushing (} \) mpleted \( \text{Scheduled} \) Dental Hom Breastfeeding \( \text{Whole Milk Amountains} \)	Twice by Parent) □ Flucture: Provider Name	☐ Milk Intak	te/Weaning	=	
First Dental Appointment   Control Con	mpleted $\square$ Scheduled Dental Hom Breastfeeding $\square$ Whole Milk Amou	ne: Provider Name unt	☐ Milk Intak	te/Weaning	=	
Adequate Weight Gain □ Soli  DEVELOPMENTAL SURVEILLE				_		
DEVELOPMENTAL SURVEILLA	le·					
	•12•		Soda	☐ Juice ☐ Sup	pplements	
☐ Plays: Hides Object/Pushes  ANTICIPATORY GUIDANCE P  ☐ Car/Car Seat Safety(Rear-Fa	equests   Looks for Hidden Object  Ball Back and Forth   Other  EOVIDED:   Emergency/911  cing)   Passive Smoke   Safe	ts  Extends Arm/Le	eg for Dressi  Drowning Proofing	ng □Poin revention Sun Safety	ts to Objects  Choking Pr  Discipline	evention
	ay ☐ Ignore Tantrums/Give Attention  I (OBSERVED BY CLINICIAN/PARENT REPO				Positivaly to C	hild
				-	•	
•		ny//mxious with bu	angers	1 unu unis 🗆 🕻		
		y)	WNL	Abnormal (	see notes belo	w)
Skin/Hair/Nails		Lungs	,,,_,			,
Eyes/Vision		Abdomen				
Ear		Genitourinary				
Mouth/Throat/Teeth		Extremities				
Nose/Head/Neck		Spine				
Hoont		Neurological				
Heart						
ASSESSMENT/PLAN/FOL	LOW-UP:					
ASSESSMENT/PLAN/FOL  LABS ORDERED:   Blood L	LOW-UP:  ead Testing			red, If not Done a	t 9 Months) 🗆 TI	3 Skin
ASSESSMENT/PLAN/FOL  LABS ORDERED:   Blood L Test (If at Ri  IMMUNIZATIONS   HepA ORDERED:   Had Chic   Given at	ead Testing	□ DTaP □ Hib □	□ IPV □ Po	CV □ Influ	enza	
ASSESSMENT/PLAN/FOL  LABS ORDERED:   Blood L Test (If at Ri  IMMUNIZATIONS   HepA ORDERED:   Had Chie   Given at   Shot Recc REFERRALS:   ALTCS	ead Testing	□ DTaP □ Hib □ □ Delayed □ Defe ortance of Immunization DDD □ Dental □ Ear	IPV Perred Reasons Discussed	CV   Influon:  Parent Refurt   OT   P1	enza usal Form Comp Γ □ Speech □	oleted WIC
COMPREHENSIVE PHYS  Skin/Hair/Nails  Eyes/Vision  Ear  Mouth/Throat/Teeth	ary Caregiver Over All Others   CAL EXAM:  NL Abnormal (see notes below	Lungs Abdomen Genitourinary Extremities	WNL		Other see notes belo	

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Effective Dates: 03/01/19, 05/07/19



### POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

#### 15 MONTHS OLD - AHCCCS EPSDT TRACKING FORM

				I					1			
Date Las	st Name	1		First Name	1	A	HCCCS	ID#		DOB	Age	
Primary Care Pro	ovider	]	PCP ph. #	Health Plan	<u> </u>	Accompar	nied By (I	Name)		Rela	tionship	
Admitted to NIC	U: (Birth)	Current N	Medications/Vit	amins/Herbal Supplem	ents:	Risk Indi	cators of I	learing I	Loss:	Temp:	Pulse:	Resp:
	0					☐ Yes		No				
Allergies:						Weight:		Le	ngth:	Hea	d Circum	ference:
					lb	oz	%	cr	n '	<b>%</b>	cm	%
Vision Screening:	Con	rrected:	□ Yes □ No	Automated Device □	Right	t: □ Pass er	Left: □ □ Refe		Both: □ Ref	□ Pass er	□ Un Perfe	able to orm
FAMILY/SOCIAL	HISTORY	(Current	Concerns/ Follo	ow-Up on Previously Ide	ntified C	oncerns)	•	'				<u> </u>
PARENTAL CONC	ERNS: Ho	ow are you	feeling about cl	nild? Do you feel safe in	your hon	ne?						
VERBAL LEAD RI	SK ASSES	SSMENT:	Child At Ris	$k \square Yes \square No$ (If $Yes$ , $A$	ppropria	te Action to I	Follow)					
ORAL HEALTH: \	White Spo	ots on Te	eth: 🗆 Yes 🗆 N	No □ Daily Brush	ning (Tv	vice Daily by	(Parent)	$\Box F$	luoride	Supplem	ent	
☐ Fluoride Varnish	by PCP	(Once Eve	ry 6 Months) F	irst Dental Appoints	ment 🗆	Completed	□ Schedı	ıled De	ental Ho	ne Provid	ler:	
NUTRITIONAL SC	REENING	: 🗆 Feed	ls Self 🗆 Bre	astfeeding   Whole	Milk 🗆	Nutritiona	ally Balaı	nced Die	et 🗆 Jun	k Food [	□ Soda/Ju	ice
□ Solids □ Activit	y 🗆 Supp	plements				Overweig	ht 🗆 Un	derweig	ght 🗆 O	bservatio	on 🗆 Refe	rral
DEVELOPMENTAL	L SURVEI	LLANCE	: Says 3-6	words 🗆 Says No 🗆 V	Wide R	ange of En	notions	Repea	ats Wor	ls from (	Conversat	ion
☐ Uses Utensils ☐	Understai	nds Simp	ole Command	ls $\square$ Climbs Stairs $\square$	Walkin	g Duts O	bjects In	Out of C	Contain	er 🗆 Oth	er	
ANTICIPATORY G				<i>C</i> ,	Gun Sa	•	Drownin	_			king Prevo	
	•	_		at Home/Child-Pro	_		•			_	ndepende	
				e Limit Setting/Redi		•	Reading	/Parent	Asks C	hild "W	hat's that'	?
				ity to Scribble/Explo	_							
				NICIAN/PARENT REPORT		Family Ac			-		•	
				f-Calming  Frustrat			-		□ Com	municati	on/Langu	iage
	-			rs 🗆 Begins to Have 1	Demme	Preferen	ces $\square$ Ot	ner:				
COMPREHENS		WNL		(see notes below)			W	NT /	1 hnorn	aal (saa	notes bel	ow)
Skin/Hair/Nails		WINL	Abilorillai	(see notes below)	Lung	·c	**1	NL E	ADHOTH	iai (see	notes bei	OW)
Eyes/Vision/Red	Reflex				Abdo							
Ear	rterren				_	tourinary						
Mouth/Throat/Tee	eth				_	mities						
Nose/Head/Neck					Spine	2						
Heart						ological						
ASSESSMENT/P	LAN/FO	LLOW-	·UP:									
I ADS ODDEDED	□ Blood	T boo I I	Footing (Child	At Risk/Not already Doi	a a at 12 N	(Iontha)	Finger	tick (De	anlt.	) $\Box$ $V_{0}$	nous	
LABS ORDERED.			_	ther		nonuis) $\Box$	Tillgers	tick (Re	suit:	_) 🗆 🗸 C	nous	
IMMUNIZATIONE				R		TI:h				fluonzo		
IMMUNIZATIONS ORDERED:					DTaP			□ PC v		nuenza		
OKDERED.	□ Flau C	ancken p	ox ⊔oine v's Visit □	r Parent Refused	Delave	l □Def	erred 1	Reason:				
				red in ASIIS  Import							orm Comr	oleted
REFERRALS:				ZEIP CRS DD								
				al 🗆 Behavioral 🗆								<u> </u>
PROVIDER'S			-									
SIGNATURE:				NPI:			_ Date:					

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Effective Dates: 03/01/19, 05/07/19



### POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

#### 18 MONTHS OLD - AHCCCS EPSDT TRACKING FORM

						1						I
Date Las	st Name			First Name		<u></u>	AHCCC	S ID#		DO	B Ag	ge
Primary Care Pro			P ph. #	Health Plan			ompanie	-			Relationship	þ
Admitted to NICU		Current M	edications/Vit	tamins/Herbal Supplem	ents:	Risk Indie				Temp	: Pulse:	Resp:
	No					∫ Ye	es	] No				
Allergies:						Weight:		Lo	ength:	H	Iead Circum	ference:
			-		lb	OZ	%	c	m	<b>%</b>	cm	%
Vision Screening:	Cor	rrected: [	□ Yes □ No	Automated Device □	Right	:: □ Pass er	Left: □ □ Refe		Both	: □ Pas fer	ss □ Uı Perf	nable to orm
FAMILY/SOCIAL I	<b>HISTORY</b>	: (Current C	Concerns/ Follo	ow-Up on Previously Ide	ntified C	oncerns)			•			-
PARENTAL CONC	ERNS: Ho	ow are you fo	eeling about ba	aby? Do you feel safe in y	our hon	e?						
DEVELOPMENTAI						AT 🗆 PED						
VERBAL LEAD RIS	SK ASSES	SSMENT: (	Child At Ris	$\operatorname{sk} \square \operatorname{Yes} \square \operatorname{No} (\operatorname{If} \operatorname{Yes}, A)$	Appropria	te Action to	Follow)					
ORAL HEALTH: V ☐ Fluoride Varnish				No □ Daily Brush First Dental Appoints	_				luoride ental He			
NUTRITIONAL SC	REENING	:     Feeds	Self □ Bre	astfeeding   Whole I	Milk 🗆	Nutritiona	ıllv Bala	nced D	iet □ Jι	ınk Foo	od 🗆 Soda/J	uice
											ation   Ref	
				up 🗆 Walks 🗆 Says		Words 🗆	Says "N	o" 🗆 Na	ame Oı	ne Picti	ure/2 Colors	8
				nows Animal Sound								
☐ Sibling Interaction	fety (Rea on □I	r-Facing)	☐ Safety at /Limits ☐	mergency/911		Sun Safe	ty 🗆 Hel	lmet Us	e $\square$ Ne	ver Lea	Choking Prave Toddler of Emotion	Alone
☐ Appropriate Bond	ding/Resp	onsive to l	Needs  Sel	NICIAN/PARENT REPORT f-Calming ☐ Frustrat iant Behavior/Offer (	ion/Hit	ing/Biting	/Impulse	Contro	-		•	
COMPREHENS	IVE PHY	YSICAL	EXAM:									
		WNL		l (see notes below)			W	NL .	Abnor	mal (se	ee notes be	low)
Skin/Hair/Nails				,	Lung	S				,		
Eyes/Vision/Red	Reflex				Abdo							
Ear					Geni	tourinary						
Mouth/Throat/Te					Extre	mities						
Nose/Head/Neck					Spin							
Heart					Neur	ological						
ASSESSMENT/P	LAN/F(	<u>DLLOW-</u>	·UP:									
LABS ORDERED:		l Lead Te kin Test (I	_	At Risk/Not already Dor Other	ne at 12 N	(Ionths)	☐ Finge	rStick (	Result:	)	□ Venous	
IMMUNIZATIONS ORDERED:	☐ Had c	☐ Hepl hicken po at Today' lecord Upd	ox Oth 's Visit	IR	Delaye	d □Def	ferred	Reason	ı:	Influen Refusal		oleted
REFERRALS:		CS   Aud	liology   A	zEIP  CRS  DD Behavioral  C	$D \square D$							
PROVIDER'S SIGNATURE:				NPI:			Date:_					

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Effective Dates: 03/01/19, 05/07/19



### POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

#### 24 MONTHS OLD - AHCCCS EPSDT TRACKING FORM

						1					
Date Last	Name		First Name			AHCO	CCS ID #		DOB	Age	
Primary Care P	rovider	PCP ph. #	Health Plar	<b>.</b>	Accom	nanied l	By (Name	<i>y</i> )	Rela	tionship	
						-	of Hearing				D
Admitted to NICU	` ′	it Medications/ vi	itamins/Herbal Supplen	nents:		İ	or Hearing	Loss:	Temp:	Pulse:	Resp:
Allergies:			Weight:		☐ Ye Leng			ircumfer	ence.	BMI	•
Anergies.			_		Leng		Ticau C	ii cuiiiici			
-				<b>%</b>	cm	%		cm	%	kg/m <sup>2</sup>	%
Vision Screening:	Corrected	d: □ Yes □ No	Automated Device □		ght: □ Pa Refer	ss   Left □ Re	: □ Pass efer	Both: □ Refe	□ Pass er	□ Una Perfor	
FAMILY/SOCIAL F	ISTODY (Curr	ent Concerns/ Foll	I low-Up on Previously Ide	antifia	d Concerns	\					
FAMIL 1/SOCIAL I	LISTORY. (Curr	ent Concerns/ Fon	low-up on Previously Id	enume	d Concerns,	)					
PARENTAL CONCE	RNS. How are v	you feeling about h	oaby? Do you feel safe in	vour	home?						
T ARENTAL CONCI	TIOW are y	ou reening about t	aby: Do you leef safe in	your	nome:						
DEVELOPMENTAL	SCREENING T	COOL COMPLE	TED:   ASQ	¬ M(	CHAT 🗆 l	PFDS					
			TED. LASQ	1010	JIIAI 🗆 I	LDS					
BLOOD LEAD L											
ORAL HEALTH:			•		-	•			Fluoride	Suppleme	nt
First Dental A	Appointment [	$\square$ Completed $\square$	Scheduled De	ntal I	Home: Pro	vider Nar	ne				
NUTRITIONAL SCI	REENING:	Feeds Self	☐ Nutritionally Bala	nced	Diet	☐ Junk F	ood	□Soda/Jι	iice		
☐ Activity ☐ Supple	ements			$\Box$ O	verweight	□Undei	weight [	Observa	ation 🗆 R	eferral	
DEVELOPMENTAL	SURVEILLAN	CE:   Kicks a	Ball Stacks 5-	6 Blo	ocks [] 50	Word Vo	cabulary	□Walks	Upstairs	/Runs Wel	1
			ows Two Step Comn				,		1		
			nergency/911 $\square$ G				ng Prever	ntion	Choking	g Prevention	on .
			afety at Home/Child								
	•	-	tion/Praise  Provid		_		•		•		
			□ Read to Child □								
			NICIAN/PARENT REPORT	_		iustment/	Parent Re	enonde P	ocitively t	o Child	
			lf-Calming  Frustra					-	-		re.
			ndependence 🗆 Play							ni/Languas	;c
COMPREHENSIV			naepenaenee = 1 iay	5 7 110	ongside i	ccis = O					
COMI REHENSIV	WNL		l (see notes below)				WNL	Ahnonn	nol (coo r	otes belo	***)
Skin/Hair/Nails	WINL	Abhorma	(see notes below)	T,	ungs		WINL	ADHOTI	nai (see i	iotes pero	w <i>)</i>
Eyes/Vision/Red R	efley				bdomen						
Ear	CHCX			_	enitourina	rv					
Mouth/Throat/Teet	h			_	xtremities	,	+				
Nose/Head/Neck				_	oine						
Heart					eurologic	al					
ASSESSMENT/PL	AN/FOLLO	W-UP:		1 -			<u> </u>				
110020011121(1711	III WI GELEG	<u>,, c1,</u>									
LABS ORDERED:	□ Blood Lead	l Testing □ Fi	ingerStick (Result	) [	Venous □	TB Skin	Test (If at	Risk) 🗆 (	Other		
	☐ HepA ☐ H		IR				V DPCV				
		en Pox $\square$ Othe		DTai		)   IP	v 🗆 PC v	III	fluenza		
OKDERED.				Dela		Deferred	Dancor				
	☐ Given at To	•			•				Pofusal Es	rm Comel	otad
REFERRALS:			$\begin{array}{c} \text{red in ASIIS}  \square \text{ Impor} \\ \text{zEIP}  \square \text{ CRS}  \square \text{ DDD} \end{array}$								icu
REFERRALS.			ZEIP   CRS   DDD   Behavioral   Ot		emai 🗆 Ea	шу пеаа	Statt 🗆 C	,ı 🗆 P I	_ speecn	□ WIC	
PROVIDER'S	Specialist.	Developmentar	_ Denavioral _ Of	.1161							
PROVIDER'S SIGNATURE:			NIDI.			D-4					
SIGNATUKE:			NPI:			Date	·				

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Effective Dates: 03/01/19, 05/07/19



### POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

#### 3 YEARS OLD - AHCCCS EPSDT TRACKING FORM

				1									
Date Las	ast Name First Name AHCCCS ID# DOB Age										Age		
Primary Care Pr	ovider	P(	CP ph. #	Hea	alth Plan	1	Accomp	anied	By (Name)		Relation	ship	
Current Medication									d Pressure:	Temp:	Pulse:		Resp:
Current Medication	is/ v italii	iiis/iici bai	Supplen	icits.				Dioc	d I ressure.	Temp.	1 uisc.		Resp.
Allergies:						Weigl	ıt:		Hei	ght:		BMI:	
						lb/kg		%	cm	%	kg/ı	m <sup>2</sup>	%
Vision Screening	: Co □ N	rrected: [ No	□Yes	<b>Device</b> □ C	hart 🗆	Right: □ Refer	Pass □	Left	: 🗆 Pass 🗆 1	Refer	] Both Refe		Pass □
Hearing Screening	g: Rig	ght □ Pass	□ Refer	Left □ Pas	ss 🗆 Refe	er 🗆 Un	able to Pe	rform	Age Ap	propriate	Speech:	□ <b>Y</b>	es □ No
FAMILY/SOCIAL	HISTOR	Y: (Current	Concerns	Follow-Up on	Previous	ly Identified	Concerns)		-				
PARENTAL CONC													
VERBAL LEAD R	ISK ASS	ESSMENT:	Child A	t Risk □ Yes	s □ No (If	f Yes, Appro	priate Acti	on to F	ollow)				
		_		Yes □ No □	-	_		-	-	☐ Fluorid			
Last Dental Appo	intment	·		Future Der	ntal App	ointment	Schedul			ne: Provide	Name		
NUTRITIONAL SO			lutritiona	llyBalanced					da/Juice	□Supplem			
☐ Activity/Family									☐ Observat				
<b>DEVELOPMENTA</b> ☐ Names Self & C									-			's Ger	ıder
ANTICIPATORY (				☐ Emergenc								rever	ition
☐ Car /Car Seat S☐ Supervise Outd	•		-	•			_	-					
☐ Provide Opportu☐ Encourage Lite								depen	dently/Be A	vailable if C	hild Seeks	You	Out
SOCIAL-EMOTIO	NAL HE	ALTH (OBS	SERVED BY	CLINICIAN/PA	ARENT RE	CPORT):	Family A	djustn	nent/Parent	Responds Po	sitively to	Chile	d
☐ Manage Anger				Frustration/F									
☐ Objects to Majo	or Chang	e in Routi	ne 🗆 Sh	ows Interest	in Othe	r Children	☐ Kind	to An	imals 🗆 Ot	her			
COMPREHENSI	VE PH	YSICAL	EXAM:										
		WNL	Abnor	mal (see no	tes belo	w)			WNL	Abnorma	l (see not	es bel	low)
Skin/Hair/Nails		1				Lur							
Eyes/Vision							lomen						
Ear	.1						itourina	ry					
Mouth/Throat/Te	eth						remities						
Nose/Head/Neck						Spi		.1					
Heart ASSESSMENT/P	T A NI/E4		I ID			INE	ırologica	ii					
LABS ORDERED:													
IMMUNIZATIONS				IMR UVa							za 🗌 Ha	d Chi	cken Pox
ORDERED:				☐ Parent F					ed Reason				
<b>D</b>				Entered in AS									
REFERRALS				gy   ACC clopmental					ad Start	□ OT □	PT 🗆 S	Speech	1
PROVIDER'S	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Pecianst.	_ Beve	pmomui									
SIGNATURE:					NPI:			D	ate:				

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### POLICY 430, ATTACHMENT E – AHCCCS EPSDT TRACKING FORMS

#### 4 YEARS OLD - AHCCCS EPSDT TRACKING FORM

Date Last	Name		Fir	st Name	9		A	HCCCS ID 7	#	DOB	Age
Drives and Come Dress	: a	CD b #	II.	aldh Dla		A		D (No)		Dalatianal	
Primary Care Prov		CP ph. #		alth Pla	n	Accomp		By (Name)	l m	Relationsl	
Current Medications	s/Vitamins/Herba	al Supplen	nents:				Bloo	d Pressure:	Temp:	Pulse:	Resp:
Allergies:					Weig	ht:		Heig	 tht:	I	BMI:
					lb / kg		%	cm	%	kg/m	2 %
Vision Screening:	Corrected:	□ Yes	Device □ C	hart □	Right: □ Refer	Pass □	Left:	□ Pass □ R	Refer		□ Pass □
Hearing Screening	Right  Pass	s □ Refer	Left □ Pas	ss 🗆 Ref	er Uu	able to Pe	rform	Age Ap	propriate S	peech:	□ Yes □ No
FAMILY/SOCIAL	HISTORY: (Curren	nt Concerns	/ Follow-Up on	Previous	sly Identified	Concerns)	)				
PARENTAL CONC	ERNS: How are yo	u feeling ab	out child? Do y	you feel s	afe in your h	ome?					
VERBAL LEAD RI	SK ASSESSMENT	:Child At	t Risk 🗆 Yes	□ No (Ar	opropriate Ac	tion to Foll	low)				
ORAL HEALTH:	White Spots on T	Teeth: □ Y	es 🗆 No	☐ Daily	Brushing	Twice D	aily by	Parent)	☐ Fluorid	e Supplem	ent
Last Dental Appoir	-		Future Denta	•	_			ntal Home: I			
NUTRITIONAL SC		Nutrition	allyBalance		□Junk			oda/Juice	□Supplem		
☐ Activity/Family								Observati			
DEVELOPMENTAL			-							s 4 Colors/3 Brushes Ov	
☐ Counts 1-7 Object☐ Asks/Answers - V		-									wn reem
ANTICIPATORY GU			Emergency/9		Gun Safet			g Prevention		king Preve	ntion
☐ Car/Car Seat Safe						-		-		_	
☐ Positive Discipli	•	-	ng/Preschool		□ School R		.y ⊔ sp	orts/Heimet	Ose 🗆 Good	i and Dad 1	ouches
☐ Allow Child to I			-				er				
SOCIAL-EMOTIONA	AL HEALTH (OBS	SERVED BY	Y CLINICIAN/	PARENT	Γ REPORT):	☐ Famil	y Adjus	stment/Parer	nt Responds	Positively	to Child
☐ Self-Calming ☐									-	-	
								Other			
COMPREHENSI											
C1: AI : AI :1	WNL	Abnor	mal (see no	tes belo				WNL	Abnormal	(see note	s below)
Skin/Hair/Nails Eyes/Vision					Lu						
•						domen					
Ear	41-					nitourina	•				
Mouth/Throat/Tee	uı					remities					
Nose/Head/Neck					Sp:		. 1	+			
Heart ASSESSMENT/PI	AN/EOLLOW	 			Ne	urologica	11				
ASSESSIVEN 1/F1	LAN/FULLOW	UF									
LABS ORDERED:	☐ Blood Lead	Testing (0	Child at Risk/No	ot Alread	y Done at 12/	24Months)	□ТВ	Skin Test (If	at Risk) $\square$ H	gb/Hct	Other
IMMUNIZATIONS	☐ HepA ☐ He	pB 🗆 N	IMR □ Va	ricella	□ DTaP	☐ Hib ☐	IPV	□ PCV □	Influenza	☐ Had C	hicken Pox
<b>ORDERED:</b>	☐ Given at Toda	ay's Visit	☐ Parent I	Refused	□Delay	ed □1	Deferre	ed Reason	:		
	☐ Shot Record U	pdated 🗆 l	Entered in AS	SIIS 🗆 In	mportance o	f Immuni	zations	Discussed [	Parent Refu	ısal Form (	Completed
REFERRALS:	□ ALTCS □	Audiolo	gy 🗆 CRS		DD 🗆 D	ental					
	Specialist:   I	Developm	ental  Be	haviora	I □ Other						
PROVIDER'S SIGNATURE:				NDI.			D	2424			
SIGNATUKE:				NPI:			Da	ate:			

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#### 5 YEARS OLD - AHCCCS EPSDT TRACKING FORM

Date La	ast Name F				First Name			AHCCCS I	<b>D</b> #	DO	OB Age		
Primary Care Prov	ider	PCP ph.	# 1	Haalth P	Health Plan Accor			d By (Name	,	Po	Relationship		
Current Medications				i i caitii i	lan	Accor		d Pressure:	_		Pulse:	Resp:	
	, , , , , , , , , , , , , , , , , , , ,	аг дарргог	iiciitis•				2100	a i ressure.	101	P-	1 disc.	itesp.	
Allergies:					Weight	:		Hei	ght:		BM	11:	
					lb/kg		%	cm		%	kg/m <sup>2</sup>	%	
Vision Screening:	g: Corrected:     Yes   Device   Chart   Right:   Pass   Left:   Pass   Refer   Both:   Pass   Refer   Refer											Pass □	
Hearing Screening:	Right □ Pas	s □ Refer	Left □ Pa	ss 🗆 Ref	er Unab	le to Per	form	Age Ap	propria	te Sp	eech:	Yes 🗆 No	
FAMILY/SOCIAL H	ISTORY: (Current	Concerns/	Follow-Up on	Previousl	y Identified Co	ncerns)							
PARENTAL CONCE	RNS: How do you	feel about y	our child? Do	you feel s	afe in your hor	ne?							
VERBAL LEAD RIS	K ASSESSMENT	: Child A	t Risk □ Yes	□ No (If	Yes, Appropria	te Action	to Follo	ow)					
	White Spots on '			` `					stance) [	□ Flu	oride Supp	lement	
Last Dental Appoin	-							ntal Home:					
NUTRITIONAL SCI	REENING: Nut	ritionally I	Balanced Die	t/5 Serv	ings Fruits &	Veggie	s 🗆 Jun	k Food □ So	oda/Juic	e 🗆 Sı	upplements		
	ctivity/Family E		•					nderweight			vation   Refe		
DEVELOPMENTAL													
☐ Counts to 10	□ Follows Sim				and Attends			utton & Zip		_		y	
☐ Goes to Bathroo ☐ Good Articulation	-		olds Pencil/C	uts wit⊓ Otl □		ЦС	oopera	ates More in	Group	Settii	ng		
☐ TV Screen Time ☐ School Readines  SOCIAL-EMOTION ☐ Self-Calming ☐ Tells Stories of Co	S Commun NAL HEALTH (C Wants to Plea	ication w BSERVED ase & Be	ith Teachers  BY CLINICIA  with Friends	Other  N/PARE  Show	r NT REPORT)	: □ Fam	nily Ad	justment/Pa	rent Re	spond			
COMPREHENSIV	E PHYSICAL	EXAM:											
	WNL	Abnor	mal (see no	tes bel				WNL	Abnor	rmal	(see notes	below)	
Skin/Hair/Nails		1			Lung								
Eyes/Vision Ear						omen tourina	rv.						
Mouth/Throat/Tee	th	1				emities	1 y						
Nose/Head/Neck				Spine									
Heart						ologica	ıl						
ASSESSMENT/PI	AN/FOLLOW	<u> </u>											
I ADS ODDEDED.	□ Plood I and	Testing	Cl-:14 -4 D:-1-/N	T-4 A1	I D4 12/2	4 <b>)</b>	\ ¬тр	Clain Toat	TC -4 D:-1-	\ \ \ \	[ab/Hat □ t	Other	
LABS ORDERED: IMMUNIZATIONS	☐ HepA ☐ H		MMR   MMR					IPV []					
ORDERED:	☐ Given at Too						Deferre			La	_ 11au CIIIC	VCII LOX	
	☐ Shot Record U	-			•					t Refi	ısal Form C	ompleted	
REFERRALS:			gy CRS						OT				
	WIC Specialist:	•											
PROVIDER'S SIGNATURE:				NPI:			D	ate:					

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#### 6 YEARS OLD - AHCCCS EPSDT TRACKING FORM

Date I	4 N			First Name			AHCCCS	ID# D	OB A		
	Last Name				riist Name				OB Age		
Primary Care Pro	vider	P	CP ph. #	Health Plan		Accomp	oanied By (Nan	ne) I	Relationship		
Current Medication	ns/Vitami	ins/Herbal S	upplements:			Bl	lood Pressure:	Temp:	Pulse:	Resp:	
Allergies:					Weight:		Heig	ht:	BM	I:	
G					lb/kg	%	cm	%	kg/m <sup>2</sup>	%	
Vision Screening: Record Abnormal Re Below	. 14	orrected: Yes 🗆 No	Right:  □ Pass □		eft: Pass □ Re	efer	Both: □ Pas	s □ Refer	☐ Unable to Perform		
Audiometry:	Within I	Normal Limi	ts Abnorm	al	Age A	Approp	riate Speech:	☐ Yes		$\square$ No	
FAMILY/SOCIAL F			_	-							
VERBAL LEAD RI	SK ASSE	SSMENT: Cl	nild At Risk 🗆 Y	es 🗆 No (If Yes	, Appropriate	Action to	o Follow)				
ORAL HEALTH: W	/hite Spot	s on Teeth:	Yes □ No □ Twice	Daily Brushin	g/Flossing (	with Pare	ent Assistance)	Sealants 🗆 <b>Fl</b>	uoride Suppl	ement	
Last Dental Appoi	intment:_		Future De	ental Appoint	ment Sche	duled	Dental Hor	ne: Provider	Name		
NUTRITIONAL SCI			•	et/5 Servings I							
		mily Exercis		(			Underweight		tion  Referra		
<b>DEVELOPMENTAI</b> ☐ Follows Simple			_					ice $\square$ Readi	ng at Grade I	_evel	
ANTICIPATORY G								□ Chol	ing Preventio		
☐ Car /Car Seat Sa☐ TV Screen Time☐ Daily Reading☐  SOCIAL-EMOTION	afety (Bo e  Positi Other _	oster Seat) ive Discipli	☐ Safety at Hone/Redirect ☐ Pr	ome   Surrovide Opport	n Safety unities for	☐ Spor Social	tt/Helmet Use Interaction	□ Bullying □ Age App	☐ Street safe propriate Chor	ty res	
☐ Frustration/Impu ☐ Is Liked by Othe	ulse Cont	rol Com	munication/Lang	guage	Friends 🗆 I	Plays W	ell with Others	-	Feels Capable		
<u>COMPREHENSI</u>	IVE PH										
		WNL	Abnormal (see 1	notes below)			WNL	Abnorma	(see notes b	elow)	
Skin/Hair/Nails					Lungs						
Eyes/Vision Ear					Abdom						
Mouth/Throat/Te	eth				Genitor Extrem						
Nose/Head/Neck					Spine	itics					
Heart	•				Neurological						
ASSESSMENT/P	LAN/F(	DLLOW U	P			<u> </u>					
				/Not Already Do	ne at 12/24 M	onths)	TB Skin Test	(If at Risk) 🗆 I	Hgb/Hct □ O		
LABS ORDERED:				,					8	ther	
LABS ORDERED: IMMUNIZATIONS ORDERED:	☐ Hep. ☐ Give	A ☐ HepB n at Today's Record Upda			Delayed	□De	ferred Reason	on:	☐ Had Chic	ken Pox	
IMMUNIZATIONS	☐ Hep. ☐ Give ☐ Shot ☐ ALT	n at Today's Record Upda 'CS	s Visit □ Pare	nt Refused  ASIIS Impor	□ Delayed tance of Im □ DDD	□De munizati □	ferred Reasons Discussed	on:		ken Pox	

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### **FORMS**

#### 7-8 YEARS OLD - AHCCCS EPSDT TRACKING FORM

Date La	st Name		1	First Name	rst Name			AHCC	) #	DOB A				
Primary Care Provi	ider		PCP ph. #	Health Pla	n	Acco	Accompanied By (Name)					ationship		
Current Medications	Ticarin Tia		Acco		lood Pressui		Tem		Pulse:	_	Resp:			
current ivicultations,	v italiilis/	TICI Dai	Supplements.				D	1000 1 1 63501		TCIII	,.	i disc.		Resp.
Allergies:					Weight:	ı.		Не	eight:			BI	MI:	
					lb / kg		%	cm		%	% kg/m <sup>2</sup>		;	%
Vision Chart Exam:	Right	t	Left		Both			Corrected [	Yes	es □ No □ Unable			to Perform	
Audiometry:	Within No	rmal Lii	nits ]	Abnormal	Age	Appr	opr	riate Speech		□Yes				□No
FAMILY/SOCIAL H	ISTORY:	(Current	Concerns/ Follow-Up	on Previously l	Identified Co	ncerns)	)							
PARENTAL CONCE	ERNS: How	do you	feel about your child?	Do you feel safe	e in your hon	ne?								
ORAL HEALTH: W													emei	ıt
Last Dental Appoir														
NUTRITIONAL SCR														
☐ Supplements														al
<b>DEVELOPMENTAL</b> ☐ Discuss Body Ch							evel	I □ School I	Perfo	rmance	□ IE -	P/504 Pl	an	
ANTICIPATORY GU	JIDANCE ]	Provi	DED: ☐ Emerger	ncy/911 🗆 🔾	Gun Safety	□Dr	owi	ning Preven	tion	□ Chok	ing P	revention	n	
☐ Car /Car Seat Saf	ety (Boos	ter Seat	i) 🗆 Safety at Hom	ne 🗆 Sun Safe	ety 🗆 Sport	/Bike	Не	lmet Use	Bull	ying/Fi	ghtin	ıg		
$\square$ Street Safety $\square$	Smoke-F	ree Env	vironment $\Box$ Po	sitive Discip	line □R	eading	g	Other						
SOCIAL-EMOTION  ☐ Frustration /Impu										sponds rage Ind		•	Chile	d
☐ Praise Strengths						j					- F			
COMPREHENSIV			EXAM:											
	V	VNL	Abnormal (see	notes below	)			WNL	A	bnorm	al (s	see notes	belo	w)
Skin/Hair/Nails					Lungs	,								
Eyes/Vision					Abdo	men								
Ear					Genite		-							
Mouth/Throat/Teet	th				Extre	nities								
Nose/Head/Neck					Spine									
Heart					Neuro	logica	al							
ASSESSMENT/PL	AN/FOL	LOW	<u>UP</u>											
LABS ORDERED:	□ TD CL	.i T	to de la Dista Dis	/II-4	41									
			t (If at Risk) $\Box$ Hgb/		ther		_				_			
IMMUNIZATIONS			pB								n Po	x $\square$ Oth	er_	
ORDERED:			•	ent Refused	□Delaye					:				
D			pdated  Entered is											
REFERRALS:			☐ Audiology	CRS		ט		Dental		ОТ		□ PT	П	Speech
Drovines to	Special	ıst:	Developmental	Behavioral	□ Other									
PROVIDER'S				MDI				D .						
SIGNATURE:				_ NPI:				_ Date:						



#### 9-12 YEARS OLD - AHCCCS EPSDT TRACKING FORM

1 1		<i>)</i> -1	12 TEARS OLD	Ancces		INA		711	1	ı		ı	
Date	Last Name	1		First Name			AHCCCS	CCS ID # DOB			Age		
Primary Care Pro	ovider		PCP ph. #	Health Plan		comr	panied By (Nan	D <sub>4</sub>	elationship				
Current Medicati				ircaith i ian		_	Blood Pressure: Temp: Pulse:						
Current Medicati	ons/ vitamins/	iici ba	Supplements.			D;	lood 1 ressure.		ciiip.	1 uisc.	ı, ı,	esp:	
Allergies:				We	ight:		Heigh	ıt:		B	MI:		
				lb/		%	cm		%	kg/m²	2	%	
Vision Chart Exa											e to Perform		
Audiometry:	☐Within No	rmal Li	imits	ıl 🏻 🗆 🗆	ble to per	form	Menses:	M	enarche		LMP	-	
•			Concerns/ Follow-Up on				□Yes □No						
PARENTAL CON	CERNS: How o	lo you fe	eel about your child? Do	you feel safe in y	our home?	•							
HEALTH RISK AS	SESSMENT:	Early	Adolescent GAPS (I	Beginning at 10	Years) $\square$	Other	r						
Last Dental Appo	intment:		h:  \[ Yes \] No \[ Da \]  \[ Future Dental \]	Appointment S	cheduled		Dental Home:	Provid	er Name	<u> </u>			
			onally Balanced Diet	_			-						
			Activity/Family Exe					-					
			School Attendance	-		evel	□ Discuss B	ody Cł	nanges	☐ Dating			
			Well in School $\Box$ C  Emergency/9							g Prevent			
☐ Safety Rules w ☐ Depression/An ☐ After-School A	with Adults exiety	Sex Sobaccervision Observision teraction		Monitor TV/0x Drugs/Inhala pals/Activities	Computer .nts Other _	Time	sks of Tattoos/	usal Sl Pierci	cills [	☐ Sun Safe ☐ Self-Con	ntrol		
COMIREMENS			Abnormal (see no	tes below)			WNL	Ahn	ormal (	see notes	helov	v)	
Skin/Hair/Nails		. 12	TIDITOTINAT (See III)	,	Lungs		7,112	11011	OI III (	(See Hotes	DCIOT	• )	
Eyes/Vision					Abdomer	ı							
Ear					Genitouri Tanner Sta	•							
Mouth/Throat/Te	eeth				Extremiti								
Nose/Head/Neck	[				Spine								
Heart					Neurolog	ical							
ASSESSMENT/I	PLAN/FOLI	OW U	<u>J<b>P</b></u>										
LABS ORDERED:	□ TB Skin	Test (	If at Risk) $\Box$ Hgb/	Hct □ Other									
	Tdap (11 - □ Varice □ Given at	- <b>12 Ye</b> lla □' Today	ars Only) □ Meningo Td □ IPV 's Visit □ Parent F lated □ Entered in AS	coccal (11 – 12 Influenza Refused De	Years Onl a □ Had elayed	Chicl	ken Pox □ C ferred Reaso	other n:					
REFERRALS:	□ ALTCS	$\Box P$	Audiology 🗆 C	CRS DD		Denta				□ PT		peech	
PROVIDER'S	Specialist:	Deve	elopmental   Behav										
SIGNATURE:				NPI:			_ Date:						

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#### 13-17 YEARS OLD - AHCCCS EPSDT TRACKING FORM

										l	I		
Date	La	nst Name			First Name	1		AHCCCS	ID#	DOB		Age	
Primary	rimary Care Provider		PCP	oh. #	Health Plan	A	ccomp	anied By (Nan	ne)	Rela	tionship	)	
		s/Vitamins/H						ood Pressure:	Ten		Pulse:		esp:
Allergies	:				W	eight:		Heigl	nt:		BN	ИI	
					lb	/ kg	%	cm	9/	ó	kg/m <sup>2</sup>		%
Vision Cl	hart Exam	Right		Left	Both			Corrected	Yes □ No	)	Unable	to Perf	form
Audiome	etry: 🗆 🗆 🛚	ithin Normal I	imits	□Abnormal	□Unal	ole to perfo	rm	Menses:	Mena	rche:		LMP:	:
FAMILY/	SOCIAL H	ISTORY: (Cur	ent Concern	ns/ Follow-Up or	n Previously Iden	ified Conce	rns)	□ Yes □No					
PARENTA	AL CONCE	RNS: How are y	ou feeling a	bout your teenag	ger? Do you feel s	afe in your h	ome?						
HEALTH	RISK ASSI	ESSMENT:   H	EADDSS	□ GAPS □ O	ther								
	EALTH: W	hite Spots on T			Daily Brushin Appointment			ng □ <b>Flu</b> ental Home: Pr	oride Su ovider Na		ent		
NUTRITI	ONAL SCR	EENING: 🗆 Nu	ritionally	Balanced Die	t 🗆 5 Servings	of Fruits &	v Vegg	gies 🗆 Junk Foo	od 🗆 Soda	ı/ Energ	gy Drink	S	
				-			_	Underweight 🗆	Observat	ion 🗆 R	Referral		
DEVELO	PMENTAL S	SURVEILLANC	E: □Sc	hool Attendan	nce □ Readi	ng at Grade	e Level	□ Dating	$\square$ Sex	uality/0	Orientatio	on	
☐ Risk-T	Taking $\square$	Other											
ANTICIPA	ATORY GU	IDANCE PROV	IDED:	Emergency/91	11 □ Violen	ce Preventi	on/Gu	n Safety/Bullyi	ng 🗆 Dro	wning	y/Sun Sa	fety	
					ts/Injury preve				_		priate Lii		
	Orientatio	-				-	-	Planning Servi					
		-	-		Tattoos/Pierci	-	Educat	tional Goals/Ac	ctivities	□ Jo	b/Caree	: Plann	ing
	•				upervision   O								
		•				-	mfortal	ble Body Imag	e $\square$ Ment	al Heal	lth Conc	erns	
		ss 🗆 Depressi			Making $\Box$	Other							
COMP	KEHENSI	VE PHYSIC			- 4 ll)			XX/NIT	A 1	1 (	4	1 1	
Skin/Ha	ir/Noils	WNI	Abn	ormal (see no	otes below)	Lungs		WNL	Abnorr	nai (se	e notes	below	)
Eyes/Vis						Abdome	n						
Ear	31011					Genitour	rinary						
) / /1 //T	D1 //D	.1				Tanner St	-						
	<u>Γhroat/Tee</u> ead/Neck	tn				Extremit Spine	ies						
Heart	eau/INECK					Neurolog	gical						
	SMFNT/P	LAN/FOLL	)W IIP			Ticurorog	Sicui						
ABBLBB	51V1121V171	LANTOLL	<del>)                                    </del>										
T 0													
	RDERED:				t □ Lipid Prof								
	ZATIONS	$\square$ HepA $\square$ M			HepB   Tdap		nza	☐ Meningoco	occal 🗆	HPV 🗆	IPV	□ To	1
ORDER	RED:	☐ Had Chicke		Other									
		☐ Given at To				Delayed		ferred Reaso		D C 1	F 6		
Decemb	AT C.							ons Discussed					
REFERR	ALS:	☐ ALTCS	☐ Audio		CRS □ D avioral □ Oth		Denta	ıl 🗆 PT	□ OB/0	JIN	□ОТ	⊔ S	Speech
PROVIDE	D'S	specialist:	Developi	nemai 🗆 Ben	avioiai 🗆 Uth	C1							
SIGNATU					NPI:			Date:					
	_				T 4T T.								_

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#### 18-21 YEARS OLD - AHCCCS EPSDT TRACKING FORM

							1				
Date L	ast Name		First Name		AHCCCS	ID#	DOB	Age			
Duimour Come Duor		DCD wh #	Hoolth Dlon	Accommo	nied Dr. (Nom	a) I	Relationship				
Primary Care Prov		<del>_</del>	Health Plan		nied By (Namod Pressure:	Temp:	Pulse:	Resp:			
Current Medication	us/ vitaiiiiis/iici b	ai Supplements.		DIO	ou i iessuie.	Temp.	i disc.	Kesp.			
Allergies:			Weight:		Heigl	nt:	BN	MI			
ē			lb / kg	%	cm	%	kg/m <sup>2</sup>	%			
Vision Chart Exam	: Right	Left	Both		Corrected□	Yes□No	☐ Unable to				
Audiometry:	☐Within Normal	Limits	Unable to pe	rform	Menses:	Menar	che:	LMP:			
FAMILY/SOCIAL I	HISTORY/CONCI	ERNS: (Current Concerns			<b>Yes</b> □No						
Identified Concerns)		(									
HEALTH RISK ASS	ESSMENT: HE	ADDSS □GAPS	□ Other								
ORAL HEALTH: W	hite Spots on Tee	eth:   Yes   No	☐ Daily Brushing 2x 1	Daily/Floss	ng □ Fl	uoride Supp	lement				
		□ Future Denta									
NUTRITIONAL SCR	<b>EENING:</b> □ Nutriti	ionally Balanced Diet	☐ 5 Servings of Fruits	& Veggies	☐ Junk Food	□Soda	/Energy Drii	nks			
☐ Supplements		Activity/Exercise (1	hr/day) □ Ove	weight 🗆 U	Jnderweight [	Observation	n 🗆 Referral				
DEVELOPMENTAL	SURVEILLANCE:	☐ Abstract Thinkin	g School Atte	endance	☐ Sexuality	/Orientation					
☐ Physical Growth	and Developmen	t 🗆 Other		_							
ANTICIPATORY GU	JIDANCE PROVIDI	ED: Emergency/91	1 □ Violence Pro	evention/Gu	ın Safety	□ Drowning	/Sun Safety				
☐ Car/Seat Belt/Dr		•	Sports/Injury Prevent			_	e Appropriat				
			Availability of Family	_							
	-	/Inhalants □ Risks o	of Tattoos/Piercing	□Educat	ion Goals/Acti	vities 🗆 J	Job/Career Pl	anning			
☐ Parenting Advice											
		ERVED BY CLINICIAN/									
	_	e/Complex Relationsl	nips   Depression/An	xiety/Sieep	Issues   Mood	1 Changes L	Other				
COMPREHENS	WNL		otog bolow)		WNL	Ahnaumal	l (ann matag	holow)			
Skin/Hair/Nails	WNL	Abnormal (see no	Lung	9	WINL	Abhorma	l (see notes	below)			
Eyes/Vision			Abdo								
Ear				ourinary							
Dui				r Stage							
Mouth/Throat/Tee	eth			mities							
Nose/Head/Neck			Spine								
Heart			Neur	ological							
ASSESSMENT/F	PLAN/FOLLOV	<u>V UP</u>									
LABS ORDERED:	☐ TB Skin Test	(If at Risk) ☐ Hgb/Hct	☐ Lipid Profile ☐ O	her							
IMMUNIZATIONS	☐ HepA ☐ MM		HepB □ Tdap □ Inf		☐ Meningoco	ccal □ HD	V   IDV	□ Td			
ORDERED:	☐ Had Chicken I		перв паар пп	iuciiza	_ Mennigoco	ccai 🗆 IIF	V LIFV	⊔ Iu			
ORDERED.	☐ Given at Toda		ed Delayed 🗆	 Deferred	Reason:						
		pdated/Entered in ASI	•			Refusal Fo	rm Complete	ed ed			
REFERRALS:		Audiology   CF		Dental		OB/GYN		☐ Speech			
		evelopmental   Beh						- F			
PROVIDER'S		*						-			
SIGNATURE:			NPI:	]	Date:						

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