CARE COORDINATION PROTOCOL
DHR CHILD CARE DIVISION/EARLY HEAD START (EHS) GRANT

The role of the Care Coordinator is to:

- Assist the family with establishing a medical home for the child, if needed.
- Educate the parent about the importance of keeping scheduled appointments with the child's assigned PMP. Assist the parent with scheduling the child's EPSDT screening and "Well Child" visits. Assess to determine if there are barriers preventing the parent/child from keeping scheduled appointments with the assigned Primary Medical Provider (PMP) or dental provider. Educate and Link the family to support services.
- Monitor the child's compliance with attending scheduled "Well Child" appointments and EPSDT appointments with the assigned PMP.
- Assist the family with locating a dental home for the child and monitor the child's compliance with attending scheduled "appointments.
- Assess to determine if the child has any identified health problems, unidentified health concerns, or psychosocial issues that could possibly be affecting the child's attendance and performance in the EHS Program. Link the family to available community resources and support services that may help to alleviate the identified stressors, if needed.

Refer to the steps below when assigned an Early Head Start Referral through CCRS:

1. Enter the electronic referral form in ACORN within **10 calendar days of the referral date**. Select **DHR/EHS** Grant as the Referral type.
2. Contact the Health Coordinator at the child's local Head Start Program. If needed, coordinate with local EHS staff to obtain signatures from the child's caregiver on the required release forms.
3. Attempt to contact the child's parent/guardian within **10 calendar days** of receiving the referral. After making initial contact with the family, the Care Coordinator is to have at least **one phone contact or face-to-face contact** with the child's parent/guardian **per 90 calendar days.**
4. Obtain the parent/guardian signatures on the CHR-3 and CHR 6A.
5. Complete a Psychosocial Assessment within **30 calendar days** of making contact with the family.
6. As updates are made to the child's Psychosocial Assessment, submit a copy of the updated assessment via fax or email to Family Health Services Bureau.
7. Develop a Case Plan with the child's parent/guardian within **30 calendar days** of making contact with the family.

8. Update the Case Plan, as needed. At the minimum, review the Psychosocial Assessment and the Case Plan with the parent/guardian **6 calendar months** from the date of the initial case plan. Complete a new case plan each year.
9. Complete the **Report to Referring Provider** after a significant contact with the family and/ or the child's health provider.
10. CC should have at least one significant contact with the child's parent/guardian over a period of **90 calendar days**.
11. Ensure the child has a PMP.
12. Remind the child's parent/guardian about all EPSDT and well child appointments.
13. Follow up to ensure EPSDT and Well Child appointments are kept.
14. Ensure the child has a dental home.
15. Follow up to ensure dental appointments are kept.