	ashington State epartment of Social Health Services	Health Act	tion Plan Washington State Health Care Autho	rity	ENT'S FIRST NAME	CLIENT	I'S LAST NAM	ИЕ	MALE FEMALE UN		R DATE O	F BIRTH	PROVIDER ONE CLIENT ID	
71111 &	Health Services	(HA		HEA	LTH HOME LEAD O	RGANIZATION					HH LEA	D ORGAI	NIZATION PHONE	
DATE OF H	AP: BEGIN	END	DATE OPTED IN	CAR	CARE COORDINATION ORGANIZATION CARE COORDINAT				DINATOR'S NAME		CARE C	OORDIN	ATOR'S PHONE	
Benef		out 🗌 Mov	ve to a county that does not ha longer eligible	ve Health Home services				choice to change	ANSFER OF THE HAP ce to change CCO or Lead Organization nanged (change to/from FFS or MCO)					
	RODUCTION													
CLIENT'S L	ONG TERM GOA				DIAGNOSIS (PEF				PERTINENT TO HAP	RTINENT TO HAP)				
	Initial / Anr	ual HAP Requi	ired Screenings		Four Month	Update Requir	red Screer	nings	s Eight Month Update Required Screenings					
SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN	SCREEN	DATE	SCORE / LEVE	IF N	OT COMPLETE EXPLAIN	^{E,} SCREEN	DATE	SCORE / I	EVEL	IF NOT COMPLETE, EXPLAIN	
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ADDITIONA	L COMMENTS	·		ADDITION	IAL COMMENTS				ADDITIONA	L COMMENTS	·			

Health Action I Bepartment of Social & Health Services	Plan Health Care Authority	CLIENT'S FIRST NAME	CLIENT'S LAST NAI	ME MALE	FEMALE UNKNOV		DATE OF BIRTH PROVIDER ONE CLIENT ID
AIIII & Health Services (HAP)		HEALTH HOME LEAD ORGA	NIZATION				HH LEAD ORGANIZATION PHONE
DATE OF HAP: BEGIN END	DATE OPTED IN	CARE COORDINATION ORG	GANIZATION	CARE COORDINATO	OR'S NAME		CARE COORDINATOR'S PHONE
Initial / Annual HAP		Four		Eight Month Update			
Short Term Goal: Goal Start Date: Goal End Outcome: Completed No longer pertinent – life of Revised Client request to discontine	Date: Go ou r health change	ort Term Goal: Short Term Goal: aal Start Date: Goal End Date: itcome: Outcome: Completed No longer pertinent – life or health change Revised Client request to discontinue			e:	Goal End Date: er pertinent – life or health change equest to discontinue	
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Washington S Department o & Health Serv	of Social Heal	th Action F	Plan Washington State Health Care Authori		FIRST NAME	CLIENT'S LAST NA	ME MALE			DATE OF BIRTH	PROVIDER ONE CLIENT ID	
& Health Serv	vices	(HAP)		HEALTH	HOME LEAD ORGA	NIZATION				HH LEAD ORGAN	ZATION PHONE	
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	Initial /	Annual HAP			Four Month Update				Eight Month Update			
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Health Action Department of Social & Health Services (HAP)		CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE	FEMALE UNKNOWN OT		
AIII & Health Services (HAP)		HEALTH HOME LEAD ORGA	NIZATION			HH LEAD ORGANIZATION PHONE	
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Department of Social	Action Plan Washington State Health Care Authority			FEMALE UNKNOWN OTHER	DATE OF BIRTH PROVIDER ONE CLIENT ID	
& Health Services	(HAP)	HEALTH HOME LEAD ORGA	NIZATION		HH LEAD ORGANIZATION PHONE	
DATE OF HAP: BEGIN END	DATE OPTED IN	CARE COORDINATION ORG	ANIZATION CARE COORDINAT	OR'S NAME	CARE COORDINATOR'S PHONE	
Initial / An	inual HAP	Four	Month Update	Eight Month Update		
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	Action Plan Washington State Health Care Authority	CLIENT'S FIRST NAME		FEMALE UNKNOWN OTHER	DATE OF BIRTH PROVIDER ONE CLIENT ID		
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	ction Plan Washington State Health Care Authority	CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE FEMALE UNKNOWN OTH			
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Initial / Annua	al HAP	Four	Month Update		Eight Month Update		
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