MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SHOW ME HEALTHY WOMEN (SMHW)

P.O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

CLIENT / PATIENT NAVIGATION

ENROLLMENT SITE / SATELLITE (NAME AND ADDRESS)	NAVIGATOR NAME / DATE

A. PERSONAL DATA

NAME (LAST, FIRST, MIDDLE INITIAL)	PARTICIPANT ID	ID TYPE (CHOOSE ONE)
		Choose an item.

DATE OF BIRTH (MM/DD/YYYY)	CLIENT REFUSES NAVIGATION SERVICES	CLIENT (CHOOSE ONE)
	☐ Yes ☐ No	☐ Moved away ☐ Deceased ☐ Unable to locate ☐ Lost to follow-up

B. CLIENT ASSESSMENT

ASSESSMENT TYPE (CHOOSE ONE)	DATE OF ASSESSMENT (MM/DD/YYYY)
Choose an item.	
TYPE OF CONTACT DURING ASSESSMENT (CHOOSE ONE) Choose an item.	LENGTH OF ASSESSMENT (CHOOSE ONE) Choose an item.
TYPE OF NAVIGATION COMPLETED (CHOOSE ONE) Choose an item.	SERVICES NEEDED (CHOOSE ONE) Choose an item.

BARRIERS

SYSTEM BARRIERS (CHOOSE ALL THAT APPLY)

- ☐ Healthcare provider is >50 miles
- ☐ Housing issue / homeless
- ☐ Lacks capacity to enroll in a health insurance plan
- ☐ No healthcare provider
- ☐ No phone / invalid phone number
- ☐ Provider unable to bill insurance
- ☐ Transportation schedule is inconvenient
- ☐ Unable to schedule an appointment
- ☐ Unable to take off work
- ☐ Other ______________________________

FINANCIAL BARRIERS (CHOOSE ALL THAT APPLY)

- ☐ Has dependents / is a caregiver
- ☐ Insurance has high deductible
- ☐ Lack of / cannot afford transportation
- ☐ No health Insurance plan
- ☐ Underinsured
- ☐ Other ______________________________

PSYCHOSOCIAL BARRIERS (CHOOSE ALL THAT APPLY)

- ☐ Cultural / faith-based concerns
- ☐ Education level
- ☐ Education required on cancer
- ☐ Education required on lifestyle changes
- ☐ Education required on refusing services / care / treatment
- ☐ Education required on screening / diagnostics
- ☐ Education required on self-care vs. medical care
- ☐ Fear / denial
- ☐ Has concerns about health
- ☐ Other ______________________________

COMMUNICATION BARRIERS (CHOOSE ALL THAT APPLY)

- ☐ Confused / overwhelmed
- ☐ Cultural concerns
- ☐ Does not understand (health literacy)
- ☐ Needs interpreter
- ☐ Unable to read
- ☐ Other ______________________________

ACTION PLAN

COUNSELING / COMMUNICATION / EDUCATION (CHOOSE ALL THAT APPLY)

- ☐ Advocated on client's behalf (specify)______________________________
- ☐ Counseled regarding (specify) ______________________________
- ☐ Discussed client concerns
- ☐ Discussed diagnostic plan options
- ☐ Discussed options of available services
- ☐ Discussed treatment plan options
- ☐ Educated client on available resources
- ☐ Educated client with "teach-back" method on (specify)______________________________
- ☐ Notified Regional Program Coordinator (RPC) for assistance
- ☐ Provided interpreter services (specify language) ______________________________
- ☐ Provided culturally appropriate brochure / information
- ☐ Provided educational level appropriate brochure / information
- ☐ Provided literacy level appropriate brochure / information
- ☐ Other ______________________________

REFERRALS / APPOINTMENTS (CHOOSE ALL THAT APPLY)

- ☐ Referred to SMHW Provider (specify)______________________________
- ☐ Referred to breast and/or cervical care provider (specify) ______________________________
- ☐ Referred to other health care services (specify) ______________________________
- ☐ Referred to Breast and Cervical Cancer Treatment (BCCT) Program
- ☐ Referred to transportation resources
- ☐ Scheduled appointment for screening services
- ☐ Scheduled appointment for diagnostic services
- ☐ Scheduled appointment for transportation services
- ☐ Referred to legal services
- ☐ Referred to local agency for assistance (specify) ______________________________
- ☐ Other ______________________________

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SERVICES ENROLLMENT (CHOOSE ALL THAT APPLY)

- ☐ Enrolled for Navigation Services only
- ☐ Enrolled in SMHW Program
- ☐ Facilitated enrollment in BCCT Program
- ☐ Facilitated enrollment in health insurance plan
- ☐ Facilitated enrollment in Medicare / Medicaid
- ☐ Other ____________________

DATE ACTION(S) COMPLETED (MM/DD/YYYY)	SERVICES IMPLEMENTATION PLAN (CHOOSE ONE)	SERVICES INITIATED DATE (MM/DD/YYYY)
	Choose an item.	

DATE NAVIGATION COMPLETED (MM/DD/YYYY)	SMHW ELIGIBLE
	☐ Yes ☐ No

C. CLIENT MANAGEMENT

DATE NEXT NAVIGATION VISIT OR CALL PLANNED (MM/DD/YYYY)

CLIENT NOTIFIED OF ABNORMAL RESULTS (CHOOSE ONE)	CLIENT TRACKING METHOD (CHOOSE ONE)
Choose an item.	Choose an item.
DATE NAVIGATION / MANAGEMENT TERMINATED (MM/DD/YYYY)	REASON FOR TERMINATION (CHOOSE ONE)
	Choose an item.

D. COMMENTS

BARRIERS / ACTION PLAN / MANAGEMENT / NAVIGATION NOTES

E. FINAL OUTCOMES

FINAL OUTCOMES (CHOOSE ALL THAT APPLY)

- ☐ Diagnostic work-up planned
- ☐ Diagnostic work-up completed
- ☐ Enrolled in BCCT Program
- ☐ Enrolled in a health insurance plan
- ☐ Enrolled in Medicare / Medicaid
- ☐ Improved client adherence
- ☐ Improved client satisfaction
- ☐ Improved timeliness of care
- ☐ Provided case management
- ☐ Received a treatment plan
- ☐ Reduced care fragmentation
- ☐ Screening completed – breast
- ☐ Screening completed – cervical
- ☐ Treatment initiated – cancer
- ☐ Treatment completed – released by MD
- ☐ Other ____________________