



## **Olympic Connect**

### **Connect2 Coordinator Guide**

Welcome!

Thank you for being an Olympic Connect Care Coordination Partner! We are grateful to work alongside you to better serve community members with unmet social needs. Together we will create a more coordinated system of social care. This workbook serves as a quick reference guide for using our client management system, Connect2 Coordinator.

Olympic Connect is an exciting new service of Olympic Community of Health (OCH). Olympic Connect is a Community Care Hub of Washington, a statewide network. A Community Care Hub is a community-centered entity that:

- Strengthens the regional network of partners.
- Coordinates between healthcare and service providers.
- Connects regional resources and tracks health outcomes for healthier individuals, families, and communities.

OCH serves as the Community Care Hub for the Olympic region, and our hub is named Olympic Connect. Olympic Connect strengthens the social care delivery system across Clallam, Jefferson and Kitsap counties by matching the available resources with people who are ready to access them.

Anybody who lives and seeks care in the Olympic region can access Olympic Connect at no direct cost. Olympic Connect is committed to ensuring confidential, positive, strengths-based support through trusted helpers, like you, who live and work in our local communities, possess deep local knowledge and cultural context, and who have valuable lived experience.

We are excited to partner with you to foster a region of healthy people and thriving communities!

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## Adding a New Client

*(This task is typically completed by OCH)*

The screenshot shows the Connect2 Coordinator interface. On the left, the 'CLIENTS' tab is selected, and the 'ALL' filter is chosen. The 'Add Client' form is open, displaying fields for First Name, Last Name, Date of Birth, Gender, and others. The 'ADD CLIENT +' button is highlighted in the bottom right corner of the client list.

To add a new client to C2C:

1. Select the **CLIENTS** tab on the left side navigation pane
2. Select **ALL**

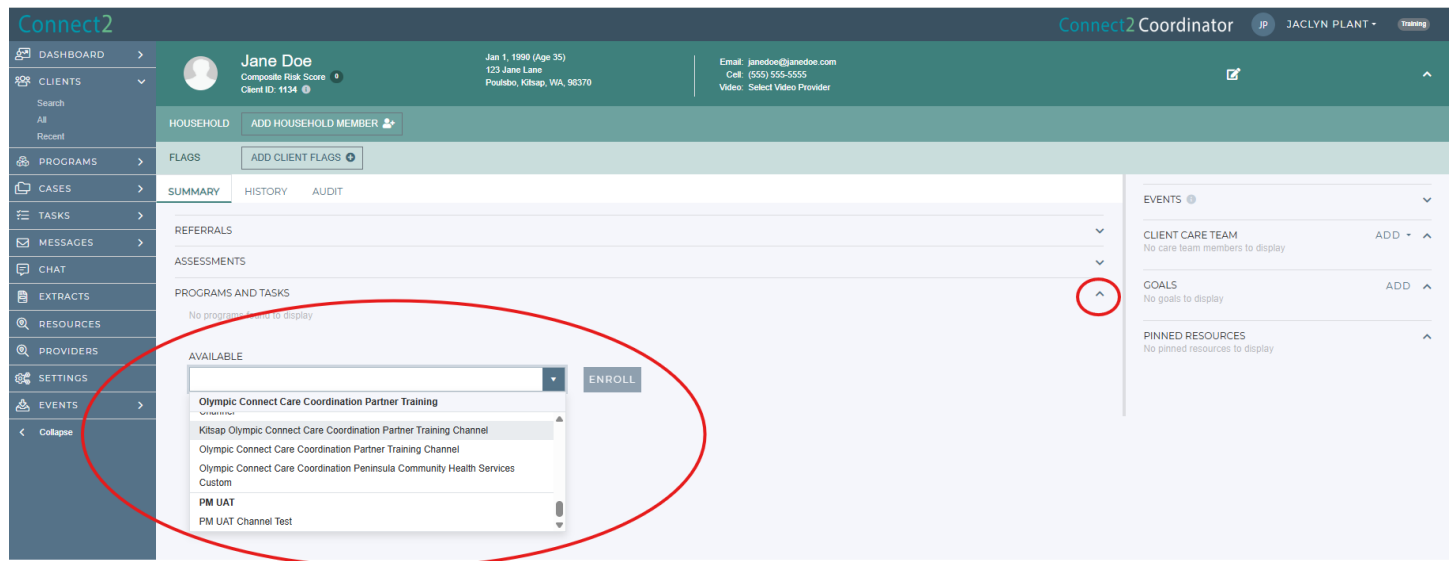
*(Before adding your new client, be sure to conduct a quick search to ensure they don't already have an existing profile)*

3. Select **ADD CLIENT** in the lower left-hand corner
4. When adding a new client, the only required fields are FIRST NAME, LAST NAME, and DATE OF BIRTH
5. Navigate through the additional tabs to document any other client information
6. When you are finished, select **SAVE**

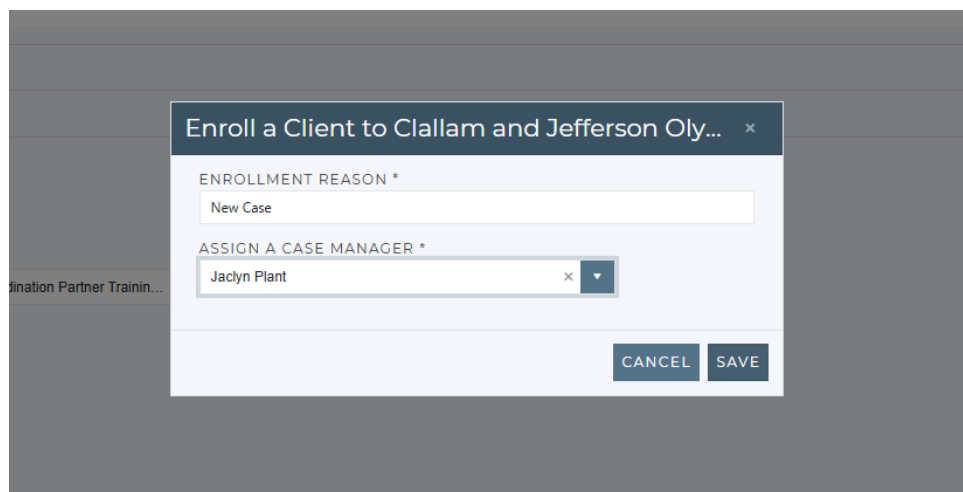
You can now navigate to the new client profile to continue working with your client or enroll them in a program channel.

# Enrolling a New Client to a Program Channel

(This task is typically completed by OCH)



From the client's profile view, expand the PROGRAMS AND TASKS section and select the appropriate channel from the AVAILABLE dropdown menu. Select **ENROLL**.



Input the Enrollment Reason (typically "New Case") and assign to the appropriate Case Manager. Select **SAVE**.

The client now is enrolled in a program channel with a new open case.

## Client Assigned

### New Case

When a new client/case has been assigned to you, you will see it by selecting the **CASES** tab on the left side navigation pane and selecting **MY OPEN CASES**

Connect2 Coordinator JP JACLYN PLANT Training

Cases > My Open Cases 7

ADVANCED OFF SEARCH ON CASE OR ID

Client	Channel	Program	Case Manager	Referred To	Referral From	Workflow Status	Date Opened	Last Activity	Case ID	Case Status	Priority
Jane Doe	Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel	Olympic Connect Care Coordination Partner Training	Jaclyn Plant				8/13/2025 11:14 AM	8/13/2025 11:14 AM	3416	Open	N
OCHUPLeslie OCHUPJones	Default Referrals	Facilitated Partner Referrals Demo	Jaclyn Plant	North Olympic Healthcare Network	Olympic Community of Health	New	6/24/2025 2:32 PM	6/24/2025 2:32 PM	3031	Open	N
OCHUPLeslie OCHUPJones	Default Referrals	Facilitated Partner Referrals Demo	Jaclyn Plant	Olympic Community Action Programs	Olympic Community of Health	New	6/24/2025 2:29 PM	6/24/2025 2:29 PM	3030	Open	N
OCHUPLeslie OCHUPJones	Default Referrals	Facilitated Partner Referrals Demo	Jaclyn Plant	Sequim Food Bank	Olympic Community of Health	New	6/24/2025 2:29 PM	6/24/2025 2:29 PM	3029	Open	N
OCHUPMaria OCHUPRodriguez	Olympic Connect Care Coordination Partner Training Channel	Olympic Connect Care Coordination Partner Training	Jaclyn Plant				6/19/2025 1:59 PM	6/19/2025 1:59 PM	2999	Open	N
OCHUPMaria OCHUPRodriguez	Default Referrals	Facilitated Partner Referrals Demo	Jaclyn Plant	Boys & Girls Clubs of South Puget Sound	Olympic Community of Health	New	6/18/2025 2:53 PM	6/18/2025 2:53 PM	2996	Open	N
OCHUPMaria OCHUPRodriguez	Default Referrals	Facilitated Partner Referrals Demo	Jaclyn Plant	Kitsap Community Resources	Olympic Community of Health	New	6/18/2025 2:52 PM	6/18/2025 2:52 PM	2995	Open	N

### Contact Referring Provider

When a referring provider has requested to be contacted once the client has been enrolled, a task will be added to the case to ensure this is completed.

Connect2 Coordinator JP JACLYN PLANT Training

Jane Doe Composite Risk Score Client ID: 1134

CONTACT REFERRING PROVIDER

Case ID: 3416  
Task Priority: Medium  
Created On: Aug 13, 2025 (Today)  
Task Due: Aug 27, 2025 (in 14 Days)  
Assigned to: Jaclyn Plant

TASK SUMMARY / REASON  
Provider has indicated on the intake form that they would like to be notified when Jane Doe has been connected to an Olympic Connect Care Coordinator. Dr. Frankenstein can be reached by phone at (555)123-4567 or by email at frank@frankensteinmd.com. Contacting the referring provider helps ensure that no one falls through the cracks by confirming that connections to services are successfully made.

SUPPORTING DOCUMENTATION  
No documents found  
View Details

CLIENT CARE TEAM  
Frank Frankenstein Primary care (MD, DO, NP, PA) | PCHS  
Lucy Van Pelt Behavioral health provider | Kitsap Mental Health

**COMPLETE** this task once you've "closed the loop" with the referring provider included in the task details. (You may also find information on the referring provider in the **CLIENT CARE TEAM**).

## Intake Notes

To view the initial notes captured upon the client's enrollment, from the client's profile view, select the **HISTORY** tab and then the **NOTES** tab.

The screenshot shows the Connect2 interface for a client named Jane Doe. The left sidebar contains navigation options: DASHBOARD, CLIENTS, PROGRAMS, CASES, TASKS, MESSAGES, and CHAT. The main content area displays the client's profile information, including name, age, address, and contact details. Below this, there are tabs for SUMMARY, HISTORY, and AUDIT. The HISTORY tab is selected, and within it, the NOTES tab is highlighted. A table lists the notes, with the first entry titled 'Intake Notes' and a description: 'Client was referred by PCP Frank Frankenstein, MD, of PCHS via the online intake f...'. A red circle highlights this text.

Click on the preview text in the **Notes** section to view the entire note.

## Health-Related Social Needs (HRSN) Assessment

To view any HRSN assessments, expand the **ASSESSMENTS** section in the client's profile/case. Be sure to look at the date of the assessment to confirm that it's recent.

The screenshot shows the Connect2 interface for a client named Jane Doe. The left sidebar contains navigation options: DASHBOARD, CLIENTS, PROGRAMS, CASES, TASKS, MESSAGES, and CHAT. The main content area displays the client's profile information, including name, age, address, and contact details. Below this, there are tabs for SUMMARY, NOTES, CONTACTS, APPOINTMENTS, EVENTS, and EXTENSIONS. The SUMMARY tab is selected, and within it, the ASSESSMENTS section is expanded. A table lists the assessments, with the first entry titled 'OCH HRSN Assessment' and a date of '8/13/2025 1:13 PM'. A red circle highlights this entry.

## Care Team

Members of the client's Care Team (providers the client is working with) will be included in the CLIENT CARE TEAM section of the client's profile/case.

The screenshot displays a client profile for Jane Doe. The header includes her name, composite risk score, and contact information. Below the header, there are tabs for various case aspects like Transportation, Mobility, Food access, etc. The main content area is divided into sections: SUMMARY, TASKS, REFERRALS, and ASSESSMENTS. The TASKS section shows a table of tasks assigned to Jaclyn Plant and Lauryn Garrett. The CLIENT CARE TEAM section, highlighted with a red box, lists two members: Frank Frankenstein (Primary care) and Lucy Van Pelt (Behavioral health provider). Each member has an edit icon (pencil) next to their name. The right sidebar shows CASE HISTORY and PINNED RESOURCES.

**Client Profile: Jane Doe**  
Composite Risk Score: 8  
Client ID: 1134

**Case Information:**  
Jan 1, 1990 (Age 35)  
123 Jane Lane  
Poulsbo, Kitsap, WA, 98370  
Email: janedoe@janedoe.com  
Cell: (555) 555-5555  
Video: Select Video Provider

**Flags:** Transportation, Mobility/activities of daily living, Food access, Eldercare/disability care, Personal/household items, ADD CASE FLAGS

**SUMMARY**  
Ciallam and Jefferson Olympic Connect Care Coordination Partner Training Channel  
Case Manager: Jaclyn Plant  
Case ID: 3416  
Case Status: Open  
Priority: Normal  
Workflow Status: None  
Sensitivity: None

**TASKS**  
VIEW: List Card Show in Timeline Open

Task	Assigned to	Opened on	Due Date	Event	Priority
Contact referring provider	Jaclyn Plant	8/13/2025 1:05 PM	8/27/2025		M
Review case and assign to appropriate case manager	Lauryn Garrett	8/13/2025 11:15 AM	8/15/2025		M

**REFERRALS**

**ASSESSMENTS**

Method	Name	Type	Version	Entity	Modified By	Modified On	Actions
Others	OCH HRSN Assessment	SDoH	1.2	Advocate/Agency	Jaclyn Plant	8/13/2025 1:13 PM	

**CLIENT CARE TEAM**  
ADD

- Frank Frankenstein  
Primary care (MD, DO, NP, PA) | PCHS
- Lucy Van Pelt  
Behavioral health provider | Kitsap Mental Health

**PINNED RESOURCES**  
No pinned resources to display

To view additional details or edit, select the edit icon on the appropriate Care Team member.



## Outreach, Introductions and Engagement

Once the case has been assigned to a Case Manager, the first task to appear is “Outreach, Program Introduction, & Consent for Services”.

The screenshot shows the 'Outreach, Program Introduction, & Consent for Services' task window for Jane Doe (Case ID: 3416). The window displays three outcome options: 'CONTACTED - ENROLLED IN PROGRAM' (green), 'CONTACTED - DECLINES PARTICIPATION' (orange), and 'NOT CONTACTED/VOICEMAIL' (red). The task summary includes details such as Case ID, Task Priority (Medium), Created On (Aug 13, 2025), Task Due (Aug 14, 2025), and Assigned to (Jaclyn Plant). The supporting documentation section indicates 'No documents found'. The window also shows a history of tasks and a client care team.

There are three outcome options for this task:

**COMPLETE:** Closes the task and initiates the next step in the process.

**CONTACTED – DECLINES PARTICIPATION:** Closes the task and initiates the discharge process.

**NOT CONTACTED/VOICEMAIL:** Closes the task and initiates outreach follow-up tasks.

## Updating Client Profile

To update the client’s profile, select the Edit icon in the top right corner.

The screenshot shows the 'Edit Client' form for Jane Doe (Case ID: 3416). The form is divided into several tabs: CLIENT, CONTACT, ADDRESSES, HOUSEHOLD, INSURANCE, DEMOGRAPHICS, CONSENTS, IDENTIFIERS, EXTENSIONS, and OTHER CONTACTS. The CLIENT tab is active, showing fields for First Name, Last Name, Middle Name, Preferred Name, Pronouns, Date of Birth, Gender, Administrative Gender, Spoken Languages, Written Languages, Reading Languages, Video Provider, English Proficiency, Interpreter Need, and Interpreter Need (Other). The form also includes a 'CANCEL' button and a 'SAVE' button. A red circle highlights the 'Edit' icon in the top right corner of the client profile header.

Although only a few profile fields are required, aim to have information entered for all fields with a star. If a client doesn't share the relevant information, use the "Declined to Answer" drop-down option when available.

*Updating clients' profiles ensures we have the most accurate information and helps support data for future services and funding.*

## Client

Edit Client

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICSSENTSIDENTIFIERSEXTENSIONSOTHER CONTACTS

OTHER NAMES

FIRST NAME \*  
Jane

LAST NAME \*  
Doe

MIDDLE NAME

PREFERRED NAME

PRONOUNS  
She/her

PRONOUNS (OTHER)

DATE OF BIRTH \*  
1/1/1990

GENDER

ADMINISTRATIVE GENDER

SPOKEN LANGUAGES  
English

WRITTEN LANGUAGES

READING LANGUAGES

VIDEO PROVIDER

ENGLISH PROFICIENCY

INTERPRETER NEED

INTERPRETER NEED (OTHER)

\* Required fields

CANCELSAVE

## Contact

Edit Client

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICSSENTSIDENTIFIERSEXTENSIONSOTHER CONTACTS

OTHER NAMES

HOME PHONE  
( ) \_ - \_

CELL PHONE  
(555) 555-5555

WORK  
( ) \_ - \_

EXT

OTHER  
( ) \_ - \_

EMAIL \*  
janedoe@janedoe.com

PREFERRED CONTACT METHODS  
Email

NOTIFICATION LANGUAGE  
English

NOTIFICATION  
Email

\* Required fields

CANCELSAVE

## Addresses

Edit Client

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICS

CONSENTSIDENTIFIERSEXTENSIONSOTHER CONTACTS

OTHER NAMES

NEW ADDRESS +

PRIMARY

TYPE \*

ADDRESS LINE 1

ADDRESS LINE 2

CITY

COUNTY \*

STATE OR PROVINCE \*

ZIP/POSTAL CODE

COUNTRY

\* Required fields

CANCEL

SAVE

When working with an unhoused client (or an unknown address), you can enter the TYPE, CITY, COUNTY, and STATE only.

## Household

Edit Client

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICS

CONSENTSIDENTIFIERSEXTENSIONSOTHER CONTACTS

OTHER NAMES

HOUSEHOLD SIZE

DEPENDENTS

FAMILY INCOME

POVERTY LEVEL (FPL)

LIVES ALONE

PRIMARY CAREGIVER

TOTAL ADULTS

19-55 YEARS OLD

>55 YEARS OLD

TOTAL CHILDREN

0-5 YEARS OLD

6-11 YEARS OLD

12-18 YEARS OLD

CANCEL

SAVE

## Insurance

Edit Client

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICS

OTHER NAMES

NEW INSURANCE +

INSURER \*  
★ Medicaid/Apple Health/CHIP- Molina

START DATE  
month/day/year

END DATE  
month/day/year

INSURED FIRST NAME  
★

INSURED LAST NAME  
★

INSURER PHONE  
() \_-\_\_

INSURER WEBSITE

MEMBER ID  
★

PLAN  
★

GROUP ID

EXTERNAL ID

POLICY HOLDER

EMPLOYER

INSURANCE CARD

SELECT CARD

\* Required fields

CANCELSAVE

## Demographics

Edit Client

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICS

OTHER NAMES

RACE/ETHNICITIES  
★ Declined to answer

RACE DETAIL

VETERAN STATUS  
★ No

SEXUAL ORIENTATION

EMPLOYMENT STATUS  
★ Unemployed

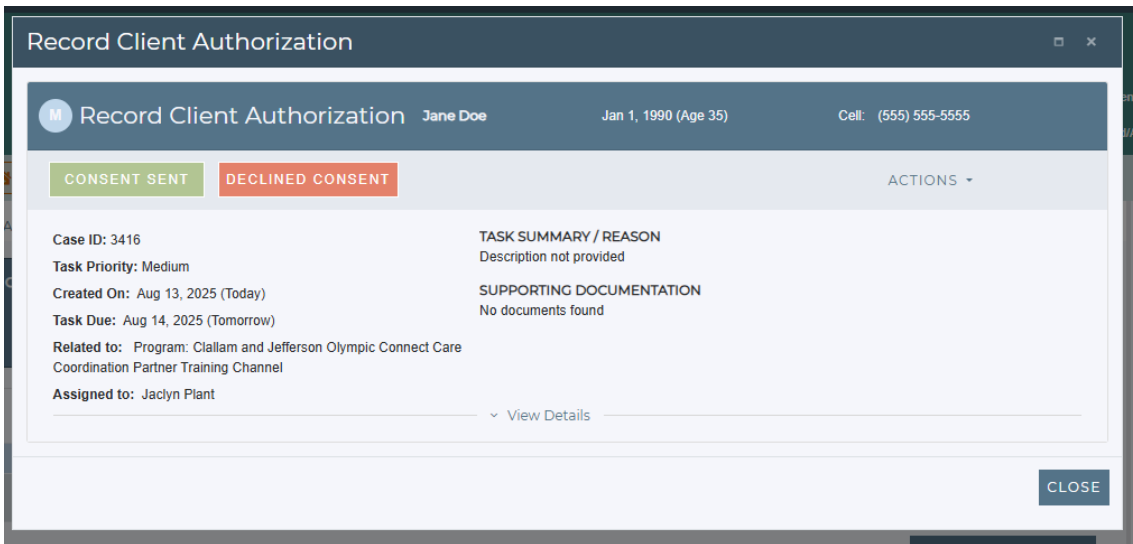
HOUSING  
★ Permanent housing (rental, owner, subsidized, s...

EDUCATION LEVEL  
★ Associate's or technical degree complete

\* Required fields

CANCELSAVE

## Record Consent and Authorization



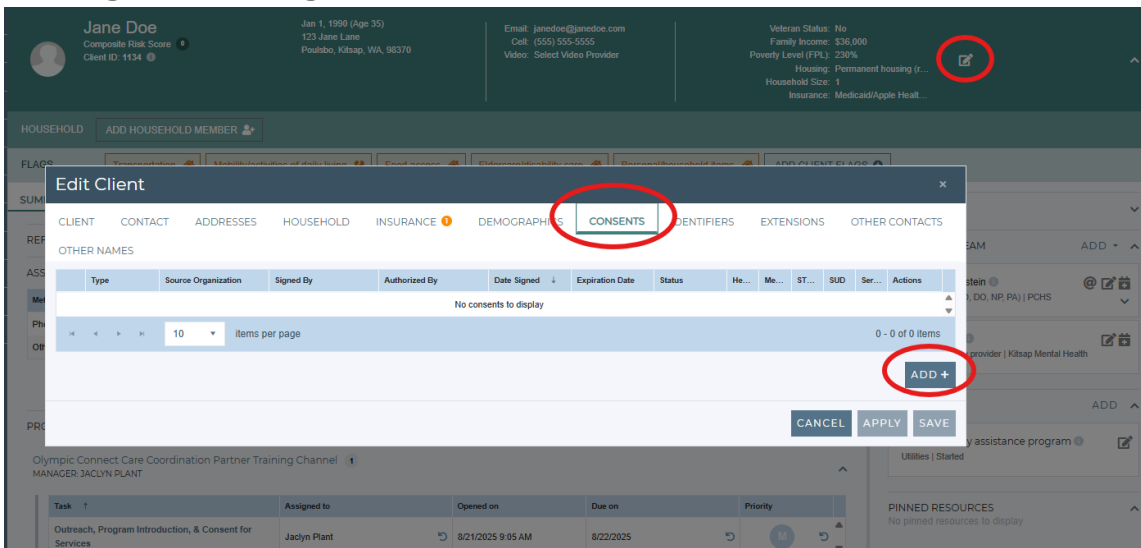
The form is titled "Record Client Authorization" and is for Jane Doe, born Jan 1, 1990 (Age 35), with cell number (555) 555-5555. It features two main outcome buttons: "CONSENT SENT" (green) and "DECLINED CONSENT" (red). The form displays task details for Case ID 3416, with a medium priority, created on Aug 13, 2025, and due on Aug 14, 2025. It also shows related information such as the program (Clallam and Jefferson Olympic Connect Care), the assigned person (Jaclyn Plant), and a "View Details" link. A "CLOSE" button is located at the bottom right.

There are two outcome options for this task:

**CONSENT SENT:** Closes the task and initiates the next step in the process

**DECLINED CONSENT:** Closes the task and initiates the next step in the process

## Sending or Recording a Consent



The screenshot shows the "Edit Client" modal for Jane Doe, with the "CONSENTS" tab selected. The modal has tabs for CLIENT, CONTACT, ADDRESSES, HOUSEHOLD, INSURANCE, DEMOGRAPHICS, CONSENTS, IDENTIFIERS, EXTENSIONS, and OTHER CONTACTS. The "CONSENTS" tab is currently active, showing a table with columns: Type, Source Organization, Signed By, Authorized By, Date Signed, Expiration Date, Status, He..., Me..., ST..., SUD, Ser..., and Actions. The table is empty, displaying "No consents to display" and "0 - 0 of 0 items". A red circle highlights the "ADD +" button at the bottom right of the table. Another red circle highlights the "Edit" icon (a pencil) in the top right corner of the main client profile area.

- 1) Select the Edit icon at the top right
- 2) Select the **CONSENTS** tab
- 3) select **ADD+**

## Sending Consent Electronically

**Edit Client**

CLIENT CONTACT ADDRESSES HOUSEHOLD INSURANCE 1 DEMOGRAPHICS **CONSENTS** IDENTIFIERS EXTENSIONS OTHER CONTACTS

OTHER NAMES

Type	Source Organization	Signed By	Authorized By	Date Signed	Expiration Date	Status	He...	Me...	ST...	SUC
Olympic Community of Health	Olympic...	Self	Jane Doe	8/21/...	8/28/...					

No consents to display

0 - 0 of 0 items

**ADD +**

**CANCEL APPLY SAVE**

MANAGER: JACLYN PLANT

To send an electronic consent:

- 1) Under 'Type' select 'OCH Written Consent and Authorization'
- 2) Under 'Signed by' select 'Self' if the client is signing. Use one of the other options depending on the circumstance.
- 3) Under 'Date Signed' select today's date (the date you are sending the authorization).
- 4) Under 'Expiration Date', change the date to be 7-days from today's date.
- 5) When the above fields have been completed, click the green check mark in the 'Actions' column and hit **APPLY**.
- 6) Click the gray arrow in the first column next to the saved consent.
- 7) Select **SEND CONSENT LINK** to email or text the form to the client.

## Uploading a PDF copy of client consent

Edit Client

CLIENT
CONTACT
ADDRESSES
HOUSEHOLD
INSURANCE
DEMOGRAPHICS
CONSENTS
IDENTIFIERS
EXTENSIONS
OTHER NAMES

	Type	Source Organization	Signed By	Authorized By	Date Signed	Expiration Date	Status	He...	Mo...	ST...	SUD	Se...	Actions
	PDF Consent	Olympic Community of Health	Self	Product Test Product Test	7/8/2025	7/8/2027	730 Days						

Name
Attachment Type
Date
Actions

No attachments to display

SEND CONSENT LINK
SEND CAPTURE LINK
ADD ATTACHMENT +

1
10
items per page
1 - 1 of 1 items

REVOKE CONSENTS
REVOKE ALL
ADD +

CANCEL
SAVE

If you had a form signed in-person and need to upload a pdf:

- 1) Under 'Type' select 'PDF Consent'
- 2) Under 'Signed by' select 'Self' if the client is signing. Use one of the other options depending on the circumstance.
- 3) Under 'Date Signed' select today's date (the date you are sending the authorization).
- 4) Under 'Expiration Date', it will populate to two years from the 'Date Signed' date.
- 5) Select the appropriate checkboxes to indicate the data the client has authorized to share on their signed paper copy of the consent.
- 6) When the above fields have been completed, click the green check mark in the 'Actions' column and hit **APPLY**.
- 7) Click the gray arrow in the first column next to the saved consent.
- 8) Select **ADD ATTACHMENT** to open your file explorer and select the PDF consent to upload.
- 9) Select **SAVE**

Product Test Product Test

Jan 1, 2021 (Age 24)
111 1st Street  
Snohomish, WA, 98292

No contact info  
Video: Select Video Provider

When the client's consent has been successfully recorded, you will see green bars next to the edit client profile icon to indicate that a written consent and authorization has been recorded. Red bars indicate that the consent and authorization on file has expired.

# Update Social and Health Needs Assessment

Update Social and Health Needs Assessment

M

Update Social and Health Needs Assessment

Jane Doe

Jan 1, 1990 (Age 35)

Cell: (555) 555-5555

START ASSESSMENT

SKIP - ASSESSMENT ON FILE

ACTIONS ▾

Case ID: 3416

Task Priority: Medium

Created On: Aug 13, 2025 (Yesterday)

Task Due: Aug 14, 2025 (Today)

Related to: Program: Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel

Assigned to: Jaclyn Plant

TASK SUMMARY / REASON

Complete the HRSN assessment with the client. This does not need to be completed in one sitting, you may save it and come back to it.

Be sure to verify any needs that are already "flagged" in the client profile. Client profile flags will be added automatically as you complete the assessment with your client. Be sure to update the flag priority level to reflect the priority level of your client's needs, and continue to update the priority level of the flags as you work with your client to address needs.

ASSESSMENT

Olympic Connect HRSN Assessment - v1.1

SUPPORTING DOCUMENTATION

No documents found

▾ View Details

CLOSE

**START ASSESSMENT:** Opens a new HRSN assessment for the client.

**SKIP – ASSESSMENT ON FILE:** Closes the task.

Jane Doe

Composite Risk Score 0

Client ID: 1134

Jan 1, 1990 (Age 35)

123 Jane Lane

Poulsbo, Kitsap, WA, 98370

Email: janedoe@janedoe.com

Cell: (555) 555-5555

Video: Select Video Provider

Veteran Status: No

Family Income: \$36,000

Poverty Level (FPL): 230%

Housing: Permanent housing...

Household Size: 1

Insurance: Medicaid/Apple He...

HOUSEHOLD

ADD HOUSEHOLD MEMBER

FLAGS

Transportation

Mobility/activities of daily living

Food access

Eldercare/disability care

Personal/household items

ADD CLIENT FLAGS

SUMMARY

HISTORY

AUDIT

REFERRALS

ASSESSMENTS

Method	Name	Type	Version	Entity	Modified By	Modified On	Actions
Others	OCH HRSN Assessment	SDoH	1.2	Advocate/Agency	Jaclyn Plant	8/13/2025 1:13 PM	<div><div></div><div></div></div>

ADD ASSESSMENT +

PROGRAMS AND TASKS

EVENTS

CLIENT CARE TEAM

Frank Frankenstein

Primary care (MD, DO, NP, PA) | PCHS

Lucy Van Pelt

Behavioral health provider | Kitsap Mental Health

GOALS

Before completing this task, check to see if there is already a recent HRSN Assessment on file. If there is, you can view and edit that assessment by clicking the green edit icon.



## Complete Prime Age Employment Group (PAEG) Assessment

*(Clallam and Jefferson Counties only)*

Complete Prime Age Employment Group Assessment

M

Complete Prime Age Employment Group...

Jane Doe

Jan 1, 1990 (Age 35)

Cell: (555) 555-5555

COMPLETE

ACTIONS ▾

**Case:** Jane Doe - Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel

**Case ID:** 3416

**Task Priority:** Medium

**Created On:** Aug 14, 2025 (Today)

**Task Due:** Aug 15, 2025 (Tomorrow)

**Related to:** Program: Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel

**Assigned to:** Jaclyn Plant

**TASK SUMMARY / REASON**

Olympic connect clients who live in Clallam or Jefferson County that meet the definition for Prime Age Employment Group (PAEG) and who have employment-related goals may qualify for additional resources and services.

**ASSESSMENT**

OCH Prime Age Employment Group (PAEG) Assessment - v1.0

**SUPPORTING DOCUMENTATION**

No documents found

▾ View Details

CLOSE

Selecting **COMPLETE** will initiate the PAEG Assessment.

---

*This assessment is used to determine clients' eligibility for specific employment-related resources and services.  
(Applicable for Clallam and Jefferson counties only).*

---

# Set Goals

Set Goals

M Set Goals

Jane Doe

Jan 1, 1990 (Age 35)

Cell: (555) 555-5555

COMPLETE

LOST TO FOLLOW-UP

ACTIONS ▾

Case: Jane Doe - Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel

Case ID: 3416

Task Priority: Medium

Created On: Aug 13, 2025 (Yesterday)

Task Due: Aug 14, 2025 (Today)

Related to: Program: Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel

Assigned to: Jaclyn Plant

TASK SUMMARY / REASON

Based on the HRSN assessment, use the goals module in the right-hand side of the client profile to create 1-3 goals at a time that work towards meeting your client's needs. To access the goals module, you will need to navigate out of case view and into client profile view.

Choose a goal type and be sure to update progress status as you continue working with your client.

SUPPORTING DOCUMENTATION

No documents found

View Details

CLOSE

**COMPLETE:** Closes the task.

**LOST TO FOLLOW UP:** Initiates discharge process

The screenshot shows the 'Set Goals' interface. On the left, there's a sidebar with 'SUMMARY', 'HISTORY', and 'AUDIT' tabs. The main area displays a list of tasks. A modal window titled 'Add Goal' is open, showing fields for 'GOAL \*', 'TYPE OF GOAL \*', and 'PROGRESS \*'. The 'GOAL' field contains 'Enroll in utility assistance program'. The 'TYPE OF GOAL' dropdown is set to 'Utilities'. The 'PROGRESS' dropdown is set to 'Started'. The modal has 'CANCEL' and 'SAVE' buttons. On the right side of the screen, there's a 'GOALS' section with an 'ADD' button highlighted by a red box.

To add a goal:

1. From the client profile view, select **ADD** from the GOALS section on the right side of the screen.
2. **GOAL:** Use simple, descriptive language to name the goal
3. **TYPE OF GOAL:** Select the client's HRSN need that the goal addresses
4. **PROGRESS:** Update the goal progress accordingly

Started: When the goal is first identified

In Progress: When a goal is in progress

Paused: When a client is not actively working on a goal

Achieved: When the goal has been achieved

## Action Plan

The screenshot shows a client profile view with the **HISTORY** tab selected. An **Action Plan** modal is open, displaying a list of tasks: "1. Call Client on 8/14", "2. Complete update demographic information", and "3. Capture insurance information". The modal also shows the date "Aug 14, 2025, 12:00:35 PM" and the author "Yvonne Owyn". The "ADD +" button in the bottom right corner is circled.

### Creating an Action Plan

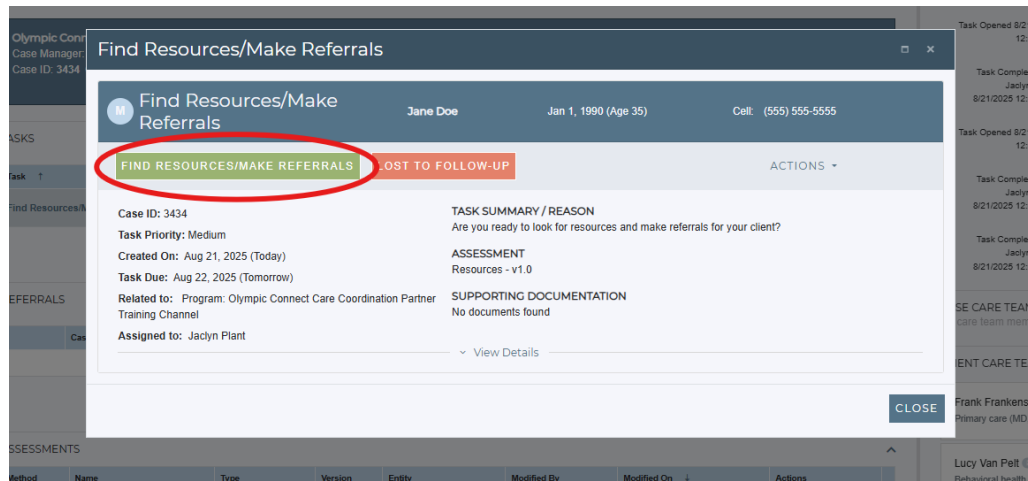
1. Select the **HISTORY** tab from the client profile view.
2. Select the **NOTES** tab.
3. Select **ADD+** in lower right corner.
4. After documenting header and notes in the body of the action plan, select **SAVE**.
5. If you need to make edits to the action plan, navigate back to the action plan note and click the green pencil icon. Please note: only the care coordinator who created the note can make edits.

The screenshot shows the **Create Action Plan** form. The form displays client information: **OCHE Maria OCH Rodriguez**, Jan 1, 1989 (Age 36), Female, Home: 1111111111, Cell: (360) 316-6928. The form has two tabs: **COMPLETE** (selected) and **LOST TO FOLLOW-UP**. The **COMPLETE** tab shows a task summary: "Case: OCHHub - Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel", "Case ID: 3323", "Task Priority: Medium", "Created On: Aug 14, 2025 (Today)", "Task Due: Aug 17, 2025 (In 3 Days)", and "Assigned to: Yvonne Owyn". The **TASK SUMMARY / REASON** section contains instructions on setting SMART goals. The **SUPPORTING DOCUMENTATION** section shows "No documents found".

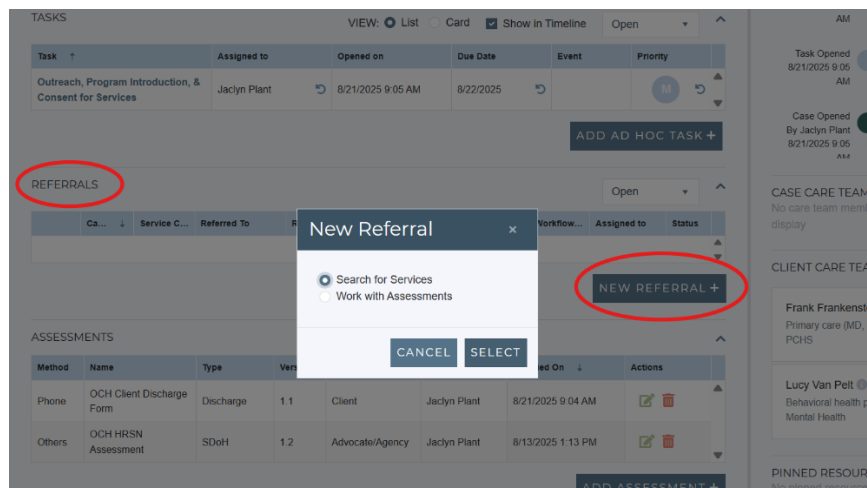
### Completing Action Plan Task

1. Navigate back to **SUMMARY** tab in the client profile view.
2. Locate "Create Action Plan" task.
3. Select either **COMPLETE** (closes the task) or **LOST TO FOLLOW UP** (initiates discharge process).

## Resources and Referrals



Resources can be shared with your client in by clicking the **FIND RESOURCES/MAKE REFERRALS** button in the “Find Resources” task. You can also add resources by following the instructions below.



### Recording Resources/Referrals

1. Navigate to the REFERRALS section in the client case and select **NEW REFERRAL +**.
2. A pop-up window will appear, select **Search for Services** and hit **SELECT**.
3. This will open the resource directory. Use the following methods to navigate the resource directory:
  - a. Under SUBMITTING ORGANIZATION, select Olympic Community of Health from the dropdown menu. **(Note: This is a shared resource directory, so this step is vital to ensure you're only accessing resources that have been vetted by OCH).**
  - b. Deselect the check box to the right of HOW FAR AWAY WOULD YOU LIKE TO SEARCH?
  - c. Search for resources by SERVICE NAME, ORGANIZATION, or SERVICE CATEGORIES.

d. If you are unable to find the resource you are looking for, let us know by submitting a Suggest a Resource Form.

**New Referral**

SERVICES SEARCH

FILTER NAME  
Type or select from the dropdown

SERVICE NAME

ORGANIZATIONS

CITIES SERVED

LANGUAGES

HOW FAR AWAY WOULD YOU LIKE TO SEARCH? ...

SERVICE CATEGORIES  
Dental

SUBMITTING ORGANIZATION  
Olympic Community of Health

COUNTIES SERVED

TARGETED DEMOGRAPHICS / AGES SERVED

ZIP CODES SERVED

SAVE FILTER

- To record the referral to a resource, select both check boxes to **SELECT REFERRAL** and **CONSENT TO REFER**, and scroll down to select the **SEND REFERRALS** button.

PRINT (1) EMAIL (1) PIN (1)

Select R...	Consent...	Service Name	Organization	Service Type	Service Categ...	Languages	Enhanced Service...	Distance
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Dentistry	Jamestown Family Health Clinic	Health Care	Dental	English		26.11 Miles
<input type="checkbox"/>	<input type="checkbox"/>	Dentistry	North Olympic Healthcare Network	Health Care	Dental	English		44.16 Miles
<input type="checkbox"/>	<input type="checkbox"/>	Free Dental Clinic	Olympic Peninsula Community Clinic	Health Care	Dental	English		44.29 Miles

10 items per page 1 - 3 of 3 items

☐ SEND A COPY OF THIS REFERRAL TO THE CLIENT

CANCEL SEND REFERRALS (1)

- A pop-up window will appear to confirm the referral and let you know if the organization providing the service is set up to receive referrals electronically. Select **YES**.

**Confirm Referral(s) Submission**

Are you sure you want to send these selected referrals from Olympic Community of Health?

Only include personal identifiable information (PII), protected health information (PHI), or other sensitive information if it is necessary to provide services to the Client.

Referring To	Service Category	Referral Comments
Mobile Services at Peninsula Community Health Services	Primary Care	

\* THESE SERVICE PROVIDERS DO NOT HAVE A CONTACT EMAIL SETUP IN THEIR PROFILE. PLEASE CONTACT THEM DIRECTLY BY PHONE TO INITIATE THE REFERRAL.

NO YES

*Capturing referrals accurately within C2C supports data for future services and funding.*

## Updating the Status of a Referral

Once the referral has been recorded it will appear in the referrals section.

1. In the referrals section of the client profile, select the gray arrow to complete the 2 tasks associated with the referral to update the status.
2. Open the task and select whether the resource is **CARE COORDINATOR MANAGED**, **CLIENT MANAGED**, or **CLIENT DECLINED**.

Contact Peninsula Community Health Services

M

Contact Peninsula Community Health...

OCHMaria OCHRodriguez

Jan 1, 1989 (Age 36)  
Female

Home: 1111111111

Cell: (360) 316-6928

CARE COORDINATOR MANAGED

CLIENT MANAGED

CLIENT DECLINED

ACTIONS ▾

Case ID: 3421

Referred Service: Mobile Services

Service Type: Health Care

Service Category: Primary Care

From: Yvonne Owyen - Olympic Community of Health  
 yvonne@olympicch.org  
 (360) 302-0007

To: Peninsula Community Health Services

Task Priority: Medium

Created On: Aug 14, 2025 (Today)

TASK SUMMARY / REASON

Care Coordinator Managed - Care Coordinator will make the direct connection between the resource and the client. Requires written consent/authorization

Client Managed Care Coordinator sends the resource listing to the client, and the client has decided to connect with the resource directly, without the Care Coordinator directly involved. Can be done with verbal consent

Client Declined - Client no longer wants or needs the referral to the resource

SUPPORTING DOCUMENTATION

No documents found

3. In the next referral task, select whether the referral was **SUCCESSFUL** or **UNSUCCESSFUL** and complete the Record a Contact window.

Care Coordinator Managed Referral to Resource Peninsula Community ...

M

Care Coordinator Managed Referral to Resource...

OCHMaria OCHRodriguez

Jan 1, 1989 (Age 36)  
Female

Home: 1111111111

Cell: (360) 316-6928

CONNECTED

UNSUCCESSFUL

ACTIONS ▾

Case ID: 3421

Referred Service: Mobile Services

Service Type: Health Care

Service Category: Primary Care

From: Yvonne Owyen - Olympic Community of Health  
 yvonne@olympicch.org  
 (360) 302-0007

To: Peninsula Community Health Services

Task Priority: Medium

Created On: Aug 14, 2025 (Today)

TASK SUMMARY / REASON

- Connected - Resource accepted the client and the client either has an appointment, got services, or is on a waitlist.
- Unsuccessful - Referral not completed. Reasons include the referral being declined, resource exhausted, unreachable, no show etc.
- Selecting Connected or Unsuccessful should close the task and prompt the Care Coordinator to record a contact.

SUPPORTING DOCUMENTATION

No documents found

## Progress Updates

Progress Update

M

Progress Update

OCHMaria OCHRodriguez

Jan 1, 1989 (Age 36)  
Female

Home: 1111111111  
Cell: (360) 316-6928

COMPLETE

LOST TO FOLLOW-UP

ACTIONS ▾

Case: OCHHub - Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel

Case ID: 3323

Task Priority: Medium

Created On: Aug 14, 2025 (Today)

Task Due: Aug 28, 2025 (In 14 Days)

Assigned to: Yvonne Owyan

TASK SUMMARY / REASON

Follow-up with your client in 1-2 weeks to see if they had any success with the referrals you made. You may ask your client directly or reach out to the organization you referred them to. If your client was not successful, problem solve accordingly.

Be sure to also follow-up on your clients goals.

Is continued follow-up needed?

SUPPORTING DOCUMENTATION

No documents found

▾ View Details

1. Visit action plan to update any progress notes for the client.
2. Once the action plan has been updated, select **COMPLETE** (Closes the task) or **LOST TO FOLLOW UP** (Initiates discharge process).
3. If **COMPLETE** is selected, "Schedule Progress Update" will populate as the next task.

Schedule Progress Update?

M

Schedule Progress Update?

OCHMaria OCHRodriguez

Jan 1, 1989 (Age 36)  
Female

Home: 1111111111  
Cell: (360) 316-6928

YES

FIND ADDITIONAL RESOURCES/MAKE REFERRALS

NO

ACTIONS ▾

Case: OCHHub - Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel

Case ID: 3323

Task Priority: Medium

Created On: Aug 14, 2025 (Today)

Task Due: Aug 15, 2025 (Tomorrow)

Assigned to: Yvonne Owyan

TASK SUMMARY / REASON

Does your client need further follow-up on the status of their current referral(s) or to support carrying out their goal(s)? If yes, then schedule a progress update for 1-2 weeks from now.

If no, does your client need new resources/referrals, or are they ready to discharge?

SUPPORTING DOCUMENTATION

No documents found

▾ View Details

CLOSE

**COMPLETE:** Cycles back to progress update

**FIND ADDITIONAL RESOURCES/MAKE REFERRALS:** Allows you find additional resources. In addition, it will cycle back to progress update

**NO:** Initiates discharge process

# **Olympic Connect: Discharge and Case Review Checklist**

## **Discharge Checklist (Care Coordinator):**

- ☐ All recorded referrals are closed.
- ☐ All goals are marked as either “achieved” or “ongoing”.
- ☐ All case flags are updated. Remember, do not delete case flags – flags that are no longer a need or that have been achieved should be marked as “no alarm.”
- ☐ All action plans are updated.
- ☐ There is sufficient documentation for your supervisor to review the case. You may consider adding a note summarizing the reason for case closure.

## **Case Review (Program Lead/Direct Supervisor):**

- ☐ Confirm discharge reason and review discharge form.
- ☐ If client “lost to follow up”, confirm at least 3 outreach attempts were made.
- ☐ Complete a brief review of the case documentation to ensure fidelity to the 6-step workflow:
  - An assessment is documented.
  - Goals were set and are marked as either “achieved” or “ongoing” upon discharge. Goals follow a SMART goal framework.
  - Action plans were set and updated.
  - Case flags are updated to reflect goals and action plan status.
  - Referrals are recorded and all listed referrals are closed.

If you have questions or need technical assistance, please email the OCH Team at:  
[Connect@OlympicCH.org](mailto:Connect@OlympicCH.org).



## Ready for Discharge

The screenshot shows a modal window titled "Ready for Discharge?" for a client named Jaclyn Test, born Jan 1, 2000 (Age 25). The modal has two main buttons: "YES" (green) and "NO" (orange). Below these buttons, there is a section for task details and a "TASK SUMMARY / REASON" section. The task details include: Case: Jaclyn Test - Olympic Connect Care Coordination Peninsula Community Health Services Custom, Case ID: 3087, Task Priority: Medium, Created On: Jul 9, 2025 (Today), Task Due: Jul 10, 2025 (Tomorrow), Related to: Program: Olympic Connect Care Coordination Peninsula Community Health Services Custom, and Assigned to: Jaclyn Plant. The "TASK SUMMARY / REASON" section contains the text: "Is your client ready to be discharged because they have received the services they needed, met their goals, or otherwise no longer need support?". Below this is a "SUPPORTING DOCUMENTATION" section with the text: "No documents found". At the bottom right of the modal is a "CLOSE" button.

**YES:** Closes the task and initiates the next step in the discharge process

**LOST TO FOLLOW-UP:** Closes the task and goes back to previous 'Check on overall case status' task

## Completing Discharge Form

The screenshot shows a modal window titled "Complete Discharge Form" for the same client, Jaclyn Test. The modal has a prominent orange button labeled "START DISCHARGE FORM". Below this button, there is a section for task details and a "TASK SUMMARY / REASON" section. The task details include: Case: Jaclyn Test - Olympic Connect Care Coordination Peninsula Community Health Services Custom, Case ID: 3087, Task Priority: Medium, Created On: Jul 9, 2025 (Today), Task Due: Jul 10, 2025 (Tomorrow), Related to: Program: Olympic Connect Care Coordination Peninsula Community Health Services Custom, and Assigned to: Jaclyn Plant. The "TASK SUMMARY / REASON" section contains the text: "When the client is ready for discharge ask the client experience questions and complete the discharge form.". Below this is an "ASSESSMENT" section with the text: "OCH Client Discharge Form - v1.1". At the bottom right of the modal is a "CLOSE" button.

Selecting **START DISCHARGE FORM** will open the client's Discharge Assessment page

**Add Assessment**

**CONTACT** **ASSESSMENT**

ASSESSOR: Jaclyn Plant

ASSESSMENT DATE \*: 7/9/2025

ASSESSMENT \*: OCH Client Discharge Form - v1.1

ENTITY \*: Client

METHOD \*: Phone

COMMENTS

☐ ADD FLAG

\* Required fields

Complete the **CONTACT** tab as applicable, and then select the **ASSESSMENT** tab.

**Add Assessment**

**CONTACT** **ASSESSMENT**

1. Reason for Case Closure \*

2. Was a warm hand-off completed to connect the client to ongoing care coordination or case management support? (select one) \*

3. For this portion of the discharge form, refer to the social needs you have worked with your client to address. Use the drop down menus in each section to select which needs you were able to help your client meet, those that are still in progress, and those that have not been met.

Please select the client's social needs that have been met:

Please select the client's social needs that are still in progress:

Select the client's social needs that remain unmet:

4. For this portion of the discharge form, refer to the health needs you have worked with your client to address. Use the drop down menus in each section to select which needs you were able to help your client meet, those that are still in progress, and those that have not been met.

Please select the client's health needs that have been met:

Please select the client's health needs that are still in progress:

Please select the client's health needs that remain unmet:

**Client Experience Questions**

5. Overall, do you feel like your needs were met through this program?

☐ Yes

☐ No

☐ N/A

CANCEL **COMPLETE TASK**

When you have completed the assessment, select **COMPLETE TASK** to close out the task and save the assessment.

## Review Case for Discharge

**Review Case for Discharge** JP

**M** **Review Case for Discharge** **Jaclyn Test** **Jan 1, 2000 (Age 25)**

**COMPLETE** **ACTIONS ▾**

**Case:** Jaclyn Test - Olympic Connect Care Coordination Peninsula Community Health Services Custom  
**Case ID:** 3087  
**Task Priority:** Medium  
**Created On:** Jul 9, 2025 (Today)  
**Task Due:** Jul 10, 2025 (Tomorrow)  
**Related to:** Program: Olympic Connect Care Coordination Peninsula Community Health Services Custom  
**Assigned to:** Miranda Burger

**TASK SUMMARY / REASON**  
Description not provided

**SUPPORTING DOCUMENTATION**  
No documents found

[View Details](#)

**CLOSE**

This is the last task that will appear, which will be assigned to the Program Lead, who will complete all case reviews.

## **Appendix: Recent Updates & Workflow Changes**

This appendix includes supplemental materials that reflect the most recent updates, process adjustments, and workflow improvements. These resources are provided to ensure teams have access to the most current guidance and tools.

Please review this section regularly, as updates may be added over time to support implementation and continuous improvement.

Updates in this section may include:

- New or revised workflows
- Policy or process changes
- Training materials or reference guides



July 2, 2025

**Subject: C2C Updates Effective July 1**

To improve data reporting accuracy, we've updated three parts of the C2C workflow **effective for all new clients enrolled after July 1st**. **Please share these changes with your Care Coordinator team.**

### 1. Initial Assessment

**Change:** OCH now completes the intake assessment. Care Coordinators should no longer create a new assessment but instead update the existing one.

#### Steps:

1. Check if an **OCH HRSN Assessment** exists in the in the Assessments section of the client's profile.
2. If so, on the 'Update Social and Health Needs Assessment' task, select '**Skip – Assessment on File**'.
3. Click the edit icon next to the **OCH HRSN Assessment** to update or add notes.

The screenshot displays the 'Update Social and Health Needs Assessment' task interface. At the top, there are tabs for 'FLAGS', 'SUMMARY', 'NOTES', and 'CONTACTS'. The 'SUMMARY' tab is active, showing client information: 'Test 20250630\_175132...', 'Composite Risk Score', and 'Client ID: 10787'. Below this, there are buttons for 'Employment or employee assistance', 'Primary care', 'Food access', 'Utilities', and 'ADD CASE FLAGS'. The main task area shows 'Update Social and Health Needs Assessment' with a 'START ASSESSMENT' button and a 'SKIP - ASSESSMENT ON FILE' button (highlighted with a red box). The task details include 'Case ID: 24002', 'Task Priority: Medium', 'Created On: Jun 30, 2025 (Today)', 'Task Due: Jul 1, 2025 (Tomorrow)', 'Related to: Program: Olympic Connect Care Channel', and 'Assigned to: Lauryn Garrett'. The 'TASK SUMMARY / REASON' section explains the purpose of the assessment. The 'ASSESSMENT' section indicates 'OCH HRSN Assessment - v1.0'. The 'SUPPORTING DOCUMENTATION' section shows 'No documents found'. At the bottom, the 'ASSESSMENTS' table lists the existing assessment: 'SMS', 'OCH HRSN Assessment', 'SDoH', '1.0', 'Client', 'Lauryn Garrett', '6/30/2025 3:42 PM'. A red box highlights the 'Edit' icon (pencil) next to this assessment, with a red arrow pointing to it from the 'SKIP - ASSESSMENT ON FILE' button.

Method	Name	Type	Version	Entity	Modified By	Modified On	Actions
SMS	OCH HRSN Assessment	SDoH	1.0	Client	Lauryn Garrett	6/30/2025 3:42 PM	



## 2. Prime Age Employment Group (PAEG) Assessment

**Change:** There is a new task and accompanying assessment with a total of 5 questions designed to proactively identify Olympic Connect clients that qualify as part of The Prime Age Employment Group (PAEG). Gathering this data is a funder requirement and will also be used to determine eligibility for upcoming programs created to remove barriers to gainful employment.

**While the programs are still under development, supports may include:**

- Tuition for short-term training
- Transportation
- Childcare
- Basic needs assistance

### Steps:

1. After completing the *Update Social and Health Need Assessment* task, you will see a **new 'Complete PAEG Assessment' task**.
2. Select the 'Complete PAEG Assessment' task and select 'Start Assessment'.
3. Ask and record responses to all 5 questions to determine program eligibility.
4. If the client answers 'YES' to all assessment questions, **a red 'PAEG' identifier flag will appear** in the client's flag section.
5. Submit the completed assessment as part of the client's workflow.

Olympic Connect Care Channel PAEG update

Case Manager: Lauryn Garrett

Case ID: 23721

Case Status: Open

Priority: Normal

Workflow Status: Client Consent and Authorization

Sensitivity: None

ACTIONS

TASKS

VIEW: ☒ List ☐ Card ☒ Show in Timeline Open

Task	Assigned to	Opened on	Due Date	Event	Priority
Complete Prime Age Employment Group Assessment	Lauryn Garrett	6/25/2025 8:34 PM	6/26/2025		M
Set Goals	Lauryn Garrett	6/25/2025 8:33 PM	6/26/2025		M
Written Consent and Authorization	Lauryn Garrett	6/25/2025 8:33 PM	7/2/2025		M

ADD AD HOC TASK +

REFERRALS

ASSESSMENTS

Method	Name	Type	Version	Entity	Modified By	Modified On	Actions
Phone	OCH HRSN Assessment	SDoH	1.0	Client	Lauryn Garrett	6/25/2025 8:32 PM	



### 3. Discharge Form

**Change:** The client experience questions have been updated and the form now includes dropdown menus to capture needs that have been met, needs still in progress, and unmet needs.

#### Steps:

1. Review the client's social and health needs identified on their **OCH HRSN Assessment**. These are the needs you will be updating as met, unmet, or in progress on the discharge form.
2. Open the 'Complete Discharge Form' task and select 'Start Discharge'.
3. Use dropdowns in questions 3 and 4 to **mark needs as met, in progress, or unmet**.
4. Ask the client the **client experience questions** and record feedback in the free text field.

1. Reason for Case Closure \*

Graduated - successfully completed program x

2. Was a warm hand-off completed to connect the client to ongoing care coordination or case management support? (select one) \*

☒ Yes  
☐ No

3. For this portion of the discharge form, refer to the social needs you have worked with your client to address. Use the drop down menus in each section to select which needs you were able to help your client meet, those that are still in progress, and those that have not been met.

Please select the client's social needs that have been met:

Education x Pet services x

Please select the client's social needs that are still in progress:

Childcare x

Select the client's social needs that remain unmet:

Financial assistance x

4. For this portion of the discharge form, refer to the health needs you have worked with your client to address. Use the drop down menus in each section to select which needs you were able to help your client meet, those that are still in progress, and those that have not been met.

Please select the client's health needs that have been met:

Dental x

Please select the client's health needs that are still in progress:

Health insurance x Medications x

Please select the client's health needs that remain unmet:

Specialty care x

**Client Experience Questions**

5. Overall, do you feel like your needs were met through this program?

☒ Yes  
☐ No

6. Overall, are you satisfied with the Olympic Connect program?

☒ Yes  
☐ No

7. Do you have anything else you'd like to share about your experience with our program?