

Health Home  
Care Management Agency

Patient Name  
Gender  
Date of Birth  
Medicaid ID  
Primary address  
address n/a

**DEMOGRAPHICS** [BACK TO TOP ?](#)

**BASIC DEMOGRAPHICS**

Social security number

Address\*

**Provide either a home or a cell phone number.**

Telephone (home)\*

Telephone (cell)\*

Email address

Best method of contact\*

Home Phone Cell Phone Mail Email Text Emergency Contact  
Home Visit

Ability to receive text messages\*

Yes No

**EMERGENCY CONTACT**

Name of contact\*

Relationship to member\*

Phone (home)\*

Phone (cell)

Address

**ADDITIONAL DEMOGRAPHICS**

Current self-identified gender\* Female Male TransFemale TransMale Genderqueer Non-binary Intersex Two Spirit Another Gender

How would you identify your sexual orientation?\* Straight/Heterosexual Questioning Declined Homosexual Gay Lesbian MSM Bisexual

Race\* American Indian / Alaska Native Asian Black Hawaiian / Pacific Islander Multi Race White Other..

If Other, specify\*

Ethnicity\* Hispanic/Latino Not Hispanic/Latino

Primary spoken language\* Arabic Chinese Creole Dutch English French German Greek Hebrew Hindi Italian Japanese Korean Polish Russian Spanish Urdu Vietnamese Yiddish Other..

If Other, specify\*

Secondary spoken language Arabic Chinese Creole Dutch English French Greek Hebrew Hindi Italian Japanese Korean Polish Russian Spanish Urdu Vietnamese Yiddish Other...

If Other, specify\*

Do you read English?\* Yes No

Do you read in another language?\* Yes No

Are there any cultural or religious preferences that will impact your Health Home participation or service delivery?\*

**ADDITIONAL DEMOGRAPHICS NOTES**

**MEDICAL BACK TO TOP ?**

**PRIMARY CARE PROVIDER - CURRENT PROVIDER**

Do you have a PCP? \* Yes No

Title Dr. Mr. Ms. Mrs. Prof.

First name

Last name

Credentials DDS DMD DO FNP LCSW LPN MD MPT MSW NP PA PC  
PhD RN

Specialty

Facility Name

Address

Phone

Email

Start date

Followup needed

Last visit date

Social Worker Info

If HIV+, is the provider an HIV PCP? Yes No

Next Scheduled PCP appt date

Can we help you schedule an appointment today? \* Yes No

PATIENT ASSESSMENT

If No PCP, then would you like assistance in connecting with a medical provider? \* Yes No

Notes

**DIAGNOSES**

Asthma Cancer Cardiovascular Disease COPD Diabetes Hepatitis/Cirrhosis HIV Hypertension Kidney Disease Obesity Smoking/Tobacco Use Substance Abuse Tuberculosis Schizophrenia Depression Anxiety Disorder PTSD Bipolar disorder Psychosis Other...

Other diagnosis

**DIAGNOSES FOLLOWUP**

Have you ever been tested for HIV? \* Yes No

If not, would they like to be tested? \* Yes No

If they would like to be tested, where was the member referred to? \*

Date test was performed \*

Results of the test \*

**HIV**

What is the member's HIV status? \* Positive Negative Patient doesn't know

If HIV+, date of last CD4 monitoring \*

Result \*

If HIV+, date of last viral load lab (every 3 months) \*

PATIENT ASSESSMENT

Result\*

**DIABETES**

Have you been diagnosed with diabetes?\*

Yes No Patient doesn't know

If yes, date of last HbA1c (yearly)\*

Result\*

If yes, date of last LDL (yearly)\*

Result\*

**HYPERTENSION**

Have you been diagnosed with high blood pressure (hypertension)?\*

Yes No Patient doesn't know

If yes, date of last blood pressure reading\*

If yes, last blood pressure result\*

If yes, do you have a blood pressure monitor at home?\*

Yes No

If yes, are you on ACE/ARB?\*

Yes No

If yes, date of last potassium lab (yearly)\*

Result\*

If yes, date of last GFR lab (yearly)\*

Result\*

**OBESITY**

Have you had a diagnosis related to weight gain or loss?\*

Yes No Patient doesn't know

Have you met with a nutritionist in

PATIENT ASSESSMENT

Yes No

**LAST BMI (FOR DIABETES, WEIGHT MANAGEMENT, HYPERTENSION)**

Last BMI Date

Last BMI result

**ALLERGIES**

Do you have any allergies? (If yes, list them in the categories below)\*

Yes No

Medications\*

Food\*

Environmental\*

**OTHER MEDICAL PROVIDER / SPECIALIST #1**

Do you have a Provider?

Yes No

Title

Dr. Mr. Ms. Mrs. Prof.

First name

Last name

Credentials

DDS DMD DO FNP LCSW LPN MD MPT MSW NP PA PC  
PhD RN

Specialty

Facility Name

Address

Phone

Followup needed

PATIENT ASSESSMENT

Last visit date

**OTHER MEDICAL PROVIDER / SPECIALIST #2**

Do you have a Provider? Yes No

Title Dr. Mr. Ms. Mrs. Prof.

First name

Last name

Credentials

DDS DMD DO FNP LCSW LPN MD MPT MSW NP PA PC  
PhD RN

Specialty

Facility Name

Address

Phone

Followup needed

Last visit date

**OTHER MEDICAL PROVIDER / SPECIALIST #3**

Do you have a Provider? Yes No

Title Dr. Mr. Ms. Mrs. Prof.

First name

Last name

Credentials

DDS DMD DO FNP LCSW LPN MD MPT MSW NP PA PC  
PhD RN

Specialty

PATIENT ASSESSMENT

Facility Name

Address

Phone

Followup needed

Last visit date

**DISCLOSURE ISSUES**

Do you have any disclosure concerns? \*

Yes No

If Yes, explain \*

**EMERGENCY ROOM VISITS**

How many times in the last year have you visited the ER? \*

Zero Once Two to nine times Ten to twenty times  
More than twenty times

If you have visited the ER, reason \*

Cardiovascular related Respiratory related HIV related  
Diabetes related Hepatitis related Obesity related Accident related  
Cancer related TB related Kidney disease related  
Substance abuse related Mental health related Other..

If Other, specify \*

Name of most recent ER \*

**HOSPITALIZATIONS**

In past 12 months, have you stayed overnight as a patient in a hospital? \*

Yes No

If hospitalized in past 12 months, date of hospitalization(s) \*

If hospitalized in past 12 months, name(s) of hospitals \*

If hospitalized in past 12 months, how long? \*

Overnight 1-3 days 3-5 days  
5-10 days Greater than 10 days

PATIENT ASSESSMENT

If hospitalized in past 12 months, reason \*

- Cardiovascular related
- Respiratory related
- HIV related
- Diabetes related
- Hepatitis related
- Obesity related
- Accident related
- Cancer related
- TB related
- Kidney disease related
- Substance abuse related
- Mental health related
- Other...

If Other, specify \*

**MEDICATIONS**

Are you prescribed any medications right now? \* Yes No

Name *	Dosage	Reason	Start	End	Active

**MEDICATION ISSUES OR CONCERNS**

Medication issues or concerns? \* Yes No

If yes, reason \*  
No pharmacy   Forgot   Side effects   No access to RX Medications  
Number of pills   Mental health issues   Substance use issues  
Out of medications

Are you out of medications? \* Yes No

Would you like to talk to someone about your treatment or how to take your medications? \* Yes No

**MEDICATION ADHERENCE QUESTIONNAIRE**

How often do you feel that you have difficulty taking your prescribed medications on time? By on time, I mean no more than two hours before or two hours after the time your doctor told you to take it. \*

- (1) All of the time
- (2) Most of the time
- (3) Rarely
- (4) Never
- (5) N/A

On average, how many days PER WEEK would you say that you missed at least one dose of your prescribed medications? \*

PATIENT ASSESSMENT

- (1) Every day
- (2) 4 to 6 days per week
- (3) 2 to 3 days per week
- (4) Once a week
- (5) Less than once a week
- (6) Never
- (7) N/A

When was the last time you missed at least one dosage of your prescribed medications? \*

- (1) Within the past week
- (2) 1 to 2 weeks ago
- (3) 3 to 4 weeks ago
- (4) 1 to 3 months ago
- (5) 3 or more months ago
- (6) Never
- (7) N/A

Score \*

**PHARMACY**

Pharmacy name \*

Pharmacy phone \*

**HEALTH SCREENING**

Do you have a DNR? \*

Yes No

Do you have a healthcare proxy? \*

Yes No

If you have a healthcare proxy, Name \*

If you have a healthcare proxy, Contact Telephone \*

Are you in pain today? \*

Yes No

If yes, level of pain between 1 and 10 (10 being the highest) \*

Are you interested in being vaccinated against HPV? (For ages 26 or less)

Yes No N/A

**PRENATAL PROVIDER**

Do you have a OB? \* Yes No

Title

PATIENT ASSESSMENT

Dr. Mr. Ms. Mrs. Prof.

First name

Last name

Credentials

DDS DMD DO FNP LCSW LPN MD MPT MSW NP PA PC  
PhD RN

Specialty

Facility Name

Address

Phone

Last visit date

Notes

**PRENATAL CARE**

Are you pregnant?\*

Yes No Patient doesn't know

If you are pregnant, Estimated Due Date\*

If you are pregnant, are you enrolled in prenatal care?\*

Yes No

If you are pregnant, Next Prenatal Clinic Visit\*

**MAMMOGRAM**

Have you had a mammogram? (should be conducted yearly for women ages 40-75)\*

Yes No

If you have had a mammogram, Last Mammogram

PATIENT ASSESSMENT

If you have had a mammogram, was last mammogram within 1 year?

Yes No

Results

Hospital/Clinic Name

Address

Phone Number

**PAP SMEAR**

Have you had a pap smear? \*

Yes No

If you have had a pap smear, Last Pap/Cervical Cancer Screening \*

Results \*

If you have had a pap smear, was your last pap within 1 year? \*

Yes No

GYN Provider/Clinic Name \*

Address \*

Phone Number \*

**COLONOSCOPY**

If over 50, have you had a colonoscopy in the past 10 years? \*

Yes No

Date \*

Result \*

Colonoscopy hospital/clinic name \*

Address \*

PATIENT ASSESSMENT

Phone Number\*

**EYE CARE**

Do you have a Optometrist?\*

Yes No

Title

Dr. Mr. Ms. Mrs. Prof.

First name

Last name

Credentials

DDS DMD DO FNP LCSW LPN MD MPT MSW NP PA PC  
PhD RN

Specialty

Facility Name

Address

Phone

Have you visited this provider in the last year?

Notes

**DENTAL CARE**

Do you have a Dentist?\*

Yes No

Title

Dr. Mr. Ms. Mrs. Prof.

First name

Last name

Credentials

DDS DMD DO FNP LCSW LPN MD MPT MSW NP PA PC  
PhD RN

PATIENT ASSESSMENT

Specialty	<input type="text"/>
Facility Name	<input type="text"/>
Address	<input type="text"/>
Phone	<input type="text"/>
	<input type="checkbox"/> Have you visited this provider in the last year?
Notes	<input type="text"/>

**PHYSICAL REHAB**

Do you have a Physical Rehab Provider?*	Yes No
Title	Dr. Mr. Ms. Mrs. Prof.
First name	<input type="text"/>
Last name	<input type="text"/>
Credentials	DDS DMD DO FNP LCSW LPN MD MPT MSW NP PA PC PhD RN
Facility Name	<input type="text"/>
Address	<input type="text"/>
Phone	<input type="text"/>
	<input type="checkbox"/> Have you visited this provider in the last year?
Notes	<input type="text"/>

**PODIATRY (IF MEMBER STATED THEY ARE HIV+ OR HAVE DIABETES)**

Do you have a Podiatrist?\* Yes No

Title Dr. Mr. Ms. Mrs. Prof.

First name

Last name

Credentials DDS DMD DO FNP LCSW LPN MD MPT MSW NP PA PC  
PhD RN

Specialty

Facility Name

Address

Phone

Have you visited this provider in the last year?

Notes

**VACCINATIONS**

Hepatitis Status\* Positive Negative Unknown

If Positive, type\* Hepatitis A Hepatitis B Hepatitis C Unknown

Have you received two HEP A and three HEP B vaccines?\* Yes No

If No, are you interested in getting vaccinated?\* Yes No

Have you been vaccinated for the seasonal flu this year?\* Yes No

If Yes, Date\*

PATIENT ASSESSMENT

If No, are you interested in getting vaccinated?\* Yes No

Have you received the Pneumovax vaccination?\* Yes No

If Yes, Date\*

If No, are you interested in getting vaccinated?\* Yes No

**TUBERCULOSIS SCREENING (PPD)**

Date of last PPD\*

What is your PPD status?\* Positive Negative Unknown

If Positive, date of last chest X-ray\*

**KEEPING APPOINTMENTS / ADDITIONAL CONCERNS**

Are you consistent in keeping your medical appointments?\* Yes No

Do you have any additional medical concerns you'd like to speak to your doctor about?\* Yes No

If Yes, explain\*

**ADDITIONAL MEDICAL NOTES**

**MENTAL HEALTH BACK TO TOP ?**

**MENTAL HEALTH PROVIDER - CURRENT PROVIDER**

Do you have a Provider?\* Yes No

Type of Provider Individual therapy Group therapy Psychiatrist

Title Dr. Mr. Ms. Mrs. Prof.

First name

Last name

Credentials DDS DMD DO FNP LCSW LPN MD MPT MSW NP PA PC PhD RN

Specialty

Facility Name

Address

Phone

Notes

**MENTAL HEALTH SCREENING**

Are you currently receiving mental health treatment or counseling?\* Yes No

If Yes, does member keep mental health appointments consistently?\* Yes No

If member does not keep mental health appointments, what are the reasons or barriers?\*  
 Lack of transportation  
 Untreated Mental Health Issues  
 Untreated Substance Abuse Issues  
 Forgets about appointments

PATIENT ASSESSMENT

If No, are you interested in receiving mental health treatment?\*

Yes No

Have you received mental health treatment or counseling in the past?\*

Yes No

If Yes, explain\*

Do you feel currently stable?\*

Yes No

If No, explain\*

**ADDITIONAL MENTAL HEALTH NOTES**

**PHQ-9** [BACK TO TOP ?](#)

**PHQ-9**

1. Little interest or pleasure in doing things \*  
 Not at all   Several days  
 More than half the days  
 Nearly every day

2. Feeling down, depressed or hopeless \*  
 Not at all   Several days  
 More than half the days  
 Nearly every day

**If you answered "Not at all" to questions 1 and 2, skip the following questions.**

3. Trouble falling/staying asleep, or sleeping too much \*  
 Not at all   Several days  
 More than half the days  
 Nearly every day

4. Feeling tired or having little energy \*  
 Not at all   Several days  
 More than half the days  
 Nearly every day

5. Poor appetite or overeating \*  
 Not at all   Several days  
 More than half the days  
 Nearly every day

6. Feeling bad about yourself-or that you are a failure or  
 have let yourself or your family down \*  
 Not at all   Several days  
 More than half the days  
 Nearly every day

7. Trouble concentrating on things such as reading the  
 newspaper or watching television \*  
 Not at all   Several days  
 More than half the days  
 Nearly every day

8. Moving or speaking so slowly that other people could  
 have noticed. Or the opposite-being so fidgety or restless  
 that you have been moving around a lot more than usual \*  
 Not at all   Several days  
 More than half the days  
 Nearly every day

9. Thoughts that you would be better off dead, or of  
 hurting yourself in some way \*  
 Not at all   Several days  
 More than half the days  
 Nearly every day

10. If you checked off any problems, how difficult have  
 these problems made it for you to do your work take care  
 of things at home, or get along with other people? \*  
 Not difficult at all  
 Somewhat difficult   Very difficult  
 Extremely difficult

**ADDITIONAL PHQ-9 NOTES**

**SUBSTANCE USE** [BACK TO TOP ?](#)

**SUBSTANCE USE HISTORY**

Have you used any of the following substances? **If “No” is selected on the first column, disregard the following columns.**

Substance	Have you ever used?*	In the past 3 months?*	How often (past 3 months)?*
Tobacco*	Yes No Declined to answer	Yes No Declined to answer	Never Monthly or less Two to four times a month Two to three times a week Four or more times a week
Alcohol*	Yes No Declined to answer	Yes No Declined to answer	Never Monthly or less Two to four times a month Two to three times a week Four or more times a week
Marijuana*	Yes No Declined to answer	Yes No Declined to answer	Never Monthly or less Two to four times a month Two to three times a week Four or more times a week
Cocaine*	Yes No Declined to answer	Yes No Declined to answer	Never Monthly or less Two to four times a month Two to three times a week Four or more times a week

PATIENT ASSESSMENT

Substance	Have you ever used?*	In the past 3 months?*	How often (past 3 months)?*
Crack*	Yes No Declined to answer	Yes No Declined to answer	Never Monthly or less Two to four times a month Two to three times a week Four or more times a week
Heroin*	Yes No Declined to answer	Yes No Declined to answer	Never Monthly or less Two to four times a month Two to three times a week Four or more times a week
PCP/Hallucinogens*	Yes No Declined to answer	Yes No Declined to answer	Never Monthly or less Two to four times a month Two to three times a week Four or more times a week
Crystal Meth*	Yes No Declined to answer	Yes No Declined to answer	Never Monthly or less Two to four times a month Two to three times a week Four or more times a week

PATIENT ASSESSMENT

Substance	Have you ever used?*	In the past 3 months?*	How often (past 3 months)?*
Rx pills (recreationally)*	Yes No Declined to answer	Yes No Declined to answer	Never Monthly or less Two to four times a month Two to three times a week Four or more times a week
Other: <input type="text"/>	Yes No Declined to answer	Yes No Declined to answer	Never Monthly or less Two to four times a month Two to three times a week Four or more times a week

**SUBSTANCE USE SCREENING**

Do you think you have a problem with alcohol or drugs?\*

Yes No

If Yes, modalities of use (specify substances and modes of administration)\*

If Yes, when, where, and in what situations are you most likely to use?\*

Are you interested in reducing or quitting your use?\*

Yes No

If Yes, which substance(s)?\*

**SUBSTANCE USE SERVICES - CURRENT PROVIDER**

Do you have a Provider?\*

Yes No

Title

Dr. Mr. Ms. Mrs. Prof.

PATIENT ASSESSMENT

First name	<input type="text"/>
Last name	<input type="text"/>
Credentials	DDS DMD DO FNP LCSW LPN MD MPT MSW NP PA PC PhD RN
Specialty	<input type="text"/>
Facility Name	<input type="text"/>
Address	<input type="text"/>
Phone	<input type="text"/>
Email	<input type="text"/>
Start date	<input type="text"/>
Notes	<input type="text"/>

**SUBSTANCE USE SERVICES**

Have you ever been in a treatment program? \* Yes No

If Yes, have you been in any of the following treatment programs? \*

Program	Currently	In the past
Harm reduction/Needle exchange	<input type="checkbox"/>	<input type="checkbox"/>
AA/NA/Self-Help Group	<input type="checkbox"/>	<input type="checkbox"/>
Recovery Readiness	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Substance Use	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT ASSESSMENT

Program	Currently	In the past
Outpatient Alcohol Program	<input type="checkbox"/>	<input type="checkbox"/>
Methadone Maintenance	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient Substance Use	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient Alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Detox	<input type="checkbox"/>	<input type="checkbox"/>

Are you interested in receiving any substance use services or treatment that you are not already receiving? \* Yes No

If Yes, what kind of services or treatment are you interested in? \*

- Harm reduction
- Inpatient rehab
- Outpatient rehab
- Detox

Other

**ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)**

Begin the AUDIT by saying “Now I am going to ask you some questions about your use of alcoholic beverages during this past year.” Explain what is meant by “alcoholic beverages” by using local examples of beer, wine, vodka, etc.

1. How often do you have a drink containing alcohol? \* Never [Skip Qs 2-8]  
Monthly or less  
Two to four times a month  
Two to three times a week  
Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking? \* 1 or 2 3 or 4 5 or 6 7 to 9  
10 or more

3. How often do you have 5 or more drinks on one occasion? \* Never Less than monthly Monthly  
Weekly Daily or almost daily

PATIENT ASSESSMENT

4. How often during the last year have you found that you were not able to stop drinking once you had started? *	Never Weekly	Less than monthly Daily or almost daily	Monthly
5. How often during the last year have you failed to do what was normally expected of you because of drinking? *	Never Weekly	Less than monthly Daily or almost daily	Monthly
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? *	Never Weekly	Less than monthly Daily or almost daily	Monthly
7. How often during the last year have you had a feeling of guilt or remorse after drinking? *	Never Weekly	Less than monthly Daily or almost daily	Monthly
8. How often during the last year have you been unable to remember what happened the night before because of your drinking? *	Never Weekly	Less than monthly Daily or almost daily	Monthly
9. Have you or someone else been injured because of your drinking? *	No Yes, during the last year	Yes, but not in the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? *	No Yes, during the last year	Yes, but not in the last year	

**DRUG ABUSE SCREENING TEST (DAST)**

1. Have you used drugs other than those required for medical reasons? *	Yes	No
2. Do you abuse more than one drug at a time? *	Yes	No
3. Are you always able to stop using drugs when you want to? *	Yes	No
4. Have you had 'blackouts' or 'flashbacks' as a result of drug use? *	Yes	No
5. Do you ever feel bad or guilty about your drug use? *	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs? *	Yes	No
7. Have you neglected your family because of you use of drugs? *	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs? *	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? *	Yes	No

PATIENT ASSESSMENT

10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?\*

Yes No

**ADDITIONAL SUBSTANCE USE NOTES**

**HOUSING BACK TO TOP ?**

**HOUSING SCREENING**

What is your living situation today?\*

- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

Where do you currently live?\*

- Homeless/Location not meant for human Habitation (Car/Aband. Building etc.)
- Hotel/Motel (paid for w/o rental) Subsidy/Emergency shelter voucher
- Emergency Shelter (non SRO) Single room occupancy
- Supportive Housing Program Rental Staying with friends/family
- Foster home/group home Own Hospital/Institution/Facility Declined

Supportive Housing Program\*

Supportive Housing Case Manager\*

If Homeless, ZIP code you spend the most time\*

What date did you start living where you currently live?

Do you need help with housing?

Yes No

If Yes, what type of help?\*

Do you have any current housing issues?\*

Yes No

Doubled up in Unit\*

Yes No

Health/Safety Concerns\*

Yes No

Eviction/Pending Eviction\*

Yes No

Expanding household/Space Issue\*

Yes No

Conflict w/others in household\*

Yes No

PATIENT ASSESSMENT

Release from institutional setting\* Yes No

Other (specify)

Think about the place you live. Do you have problems with any of the following? Choose all that apply.\*

- Pests such as bugs, ants, or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above

**ADDITIONAL HOUSING NOTES**

**INCOME AND ENTITLEMENTS** [BACK TO TOP ?](#)

**INCOME AND ENTITLEMENTS**

Income per Month\*

Pay/Salary/Regular Employment\* Yes No

Unemployment benefits\* Yes No

Alimony/ child support payments\* Yes No

Veteran's benefits\* Yes No

Enhanced rent\* Yes No

If Yes, reason\* Section 8 HRA DHS Other...

If Other, specify\*

Energy assistance\* Yes No

Social Security\* Yes No

Medicaid/Medicare\* Yes No

HASA\* Yes No

Public Assistance\* Yes No

SSI\* Yes No

SSD\* Yes No

Food Stamps\* Yes No

TANF\* Yes No

Other entitlements

Has a PA/HASA worker?\* Yes No

PATIENT ASSESSMENT

PA/HASA Worker\*

PA/HASA Worker Telephone  
Number\*

PA/HASA Center\*

PA/HASA Supervisor Name

PA/HASA Supervisor Number

Is member currently in rental  
arrears?\*

Yes No

If Yes, rental arrears reason\*

If Yes, how much?\*

What are your total monthly  
expenses?\*

**Some people have made the following statements about their food situation. Please answer whether the following two statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.**

Within the past 12 months, you worried that your food would run out before you got money to buy more.\*

Often true Sometimes true Never true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.\*

Often true Sometimes true Never true

In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?\*

Yes No Already shut off

Does member have a representative payee?\*

Yes No

If Yes, Name\*

PATIENT ASSESSMENT

Are you interested in setting up direct-rent payments? \* Yes No

Do you need a fair hearing/appeal process for any denials of entitlements? \* Yes No

If Yes, Explain \*

Medicaid recertification date \*

Do you have any spenddowns? \* Yes No

If Yes, amount per month \*

**ADDITIONAL INCOME AND ENTITLEMENTS NOTES**

**FAMILY** [BACK TO TOP ?](#)

**HOUSEHOLD INFORMATION**

Number of members in household\*      1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Member of Household 1 Name

Member of Household 1 Age

Member of Household 1  
Relationship

Member of Household 2 Name

Member of Household 2 Age

Member of Household 2  
Relationship

Member of Household 3 Name

Member of Household 3 Age

Member of Household 3  
Relationship

Member of Household 4 Name

Member of Household 4 Age

Member of Household 4  
Relationship

Member of Household 5 Name

Member of Household 5 Age

Member of Household 5  
Relationship

**CHILDREN**

Do you have any children? \* Yes No

If Yes, how many children? \* 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Have you ever had an ACS Case? \* Yes No

If Yes, reason for case \* Abuse Medical Neglect Educational Neglect Neglect  
Lack of Supervision Substance Abuse

Is the case currently open? \* Yes No

Name of ACS Worker \*

ACS Worker Telephone \*

Do you have children with any medical issues? \* Yes No

If Yes, specify \*

Do you have any children with mental health/behavioral issues? \* Yes No

If Yes, specify \*

**SUPPORT SYSTEM**

Do you have someone to talk to about your needs/emotions? \* Yes No

If Yes, specify \*

Do you have any religious affiliations? \* Yes No

**ADDITIONAL FAMILY NOTES**

**LEGAL BACK TO TOP ?**

**CRIMINAL JUSTICE STATUS**

Have you ever been incarcerated? \* Yes No

If Yes, where?

If Yes, when?

Length of incarceration

Nature of incarceration

NYS ID number

Are you currently on parole/  
probation? \* Yes No

PO name

PO telephone number

Until when?

**CITIZENSHIP STATUS**

What is your current citizenship status? \* US Citizen Permanent Resident Student Visa Asylum Refugee Undocumented Declined to Answer

If not US citizen, what is your country of citizenship?

**LEGAL NEEDS**

Are you in need of assistance with creating a will? \* Yes No In Place

Are you in need of assistance with creating a living will? \* Yes No In Place

Are you in need of assistance with Yes No In Place

PATIENT ASSESSMENT

Are you in need of assistance with your immigration status? \* Yes No In Place

Are you in need of assistance with a standby guardianship? \* Yes No In Place

Are you in need of assistance to make a plan to stay permanently? \* Yes No In Place

Is there another type of legal assistance you need? \* Yes No In Place

If Yes, what is this type of assistance? \*

**ADDITIONAL LEGAL NOTES**

**ACTIVITIES OF DAILY LIVING** [BACK TO TOP ?](#)

**ACTIVITIES OF DAILY LIVING**

Are you currently receiving home care? \* Yes No

If currently receiving home care, name of agency

If currently receiving home care, agency phone

If currently receiving home care, how often?

If currently receiving home care, are you satisfied with the services you are receiving? Yes No

Do you need assistance with bathing? \* No assistance needed  
Some assistance needed  
Full assistance needed

Do you need assistance with toileting? \* No assistance needed  
Some assistance needed  
Full assistance needed

Do you need assistance with taking medications? \* No assistance needed  
Some assistance needed  
Full assistance needed

Do you need assistance with meal preparation? \* No assistance needed  
Some assistance needed  
Full assistance needed

Do you need assistance with housekeeping? \* No assistance needed  
Some assistance needed  
Full assistance needed

Do you need assistance with shopping/errands? \* No assistance needed  
Some assistance needed  
Full assistance needed

Do you need any of the following assistive equipment? \* None Yes, Walker Yes, Cane  
Yes, Wheelchair Yes, Hospital Bed  
Other...

If Other, specify \*

PATIENT ASSESSMENT

Do you need assistance with transportation? \*

No assistance needed  
Yes, Reduced Fare MetroCard  
Yes, Access-a-ride Other...

If Other, specify \*

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? \*

Yes No

**ADDITIONAL ADL NOTES**

**EDUCATION** [BACK TO TOP ?](#)

**EDUCATION**

Highest level of education completed:\*

None Eighth grade or less Some high school  
High school Diploma/GED Some college  
Bachelor's degree/technical degree Post graduate

Is member interested in any educational opportunities?\*

Yes No

If Yes, specify

GED Certificate courses Adult education College degree - AA  
College degree - BS/BA College degree - Graduate

How do you like to learn new information?\*

Seeing it Hearing it Reading it Doing a task Other..

If Other, specify\*

Are there any physical/sensory barriers to learning?\*

- No barriers
- Blindness or difficulty seeing
- Deafness or difficulty hearing
- Unable to understand
- Unable to read
- Learning disability
- Developmental disability
- Other disability

If other disability, specify\*

Will member benefit from health literacy education regarding any of the following?\*

- Medication adherence
- Medical health

PATIENT ASSESSMENT

Mental health

Substance abuse

None of the above

**ADDITIONAL EDUCATION NOTES**

**EMPLOYMENT** [BACK TO TOP ?](#)

**EMPLOYMENT**

Current employment status\*      Employed full-time    Employed part-time  
Unpaid volunteer/peer work    Unemployed    Out of work force  
Declined

Are you interested in finding a      Yes    No  
job?\*

If Yes, what resources do you need?\*

- Employment agency referral
- Job readiness training
- Occupational training

Other

**ADDITIONAL EMPLOYMENT NOTES**

**RISK ASSESSMENT BACK TO TOP ?**

**SEXUAL HEALTH**

How often do you use condoms for vaginal/anal sex (in the past 12 months)?\* Always Mostly Sometimes Never N/A (denies vaginal or anal sex)

If answer to the above is anything OTHER THAN always, what are the barriers to condom use?\* Allergy Doesn't like the feeling Limited/No access Substance Use Partner declined Not sexually active

Has the member had a syphilis screening?\* Yes No

If Yes, Last Annual Syphilis Screening\*

Result\*

If screened, were you also treated for syphilis?\* Yes No

If Yes, when?\*

Has the member had an anal pap?\*

Yes No

If Yes, Last Anal Pap\*

Result\*

**DOMESTIC VIOLENCE**

**Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.**

How often does anyone, including family and friends, physically hurt you?\* Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)

How often does anyone, including family and friends, insult or talk down to you?\* Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)

How often does anyone, including Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)

## PATIENT ASSESSMENT

How often does anyone, including family and friends, scream or curse at you?\*

Never (1) Rarely (2) Sometimes (3) Fairly often (4) Frequently (5)

Do you feel like you are in a relationship in which you are being controlled?\*

Yes No

If Yes, explain\*

**A score of 11 or more on the domestic violence questions indicates the person might not be safe. Attempt to engage the member around safety planning.**

Provide a safety plan for the member.\*

## SUICIDE ASSESSMENT

Have you ever had thoughts of committing suicide?\*

No Past Present

If Past, explain/date of last ideation\*

If Present, do you have a plan?\*

Yes No

If you have a plan, explain\*

Have you ever attempted suicide?\*

Yes No Declined

If Yes, when (dates)\*

If Yes, please describe the method\*

If Yes, please describe the events that led up to attempt\*

## VIOLENCE ASSESSMENT

Do you have a history of violence?\*

No Past History (Explain) Present (Explain)

If Past History or Present, Explain\*

## HOMICIDE ASSESSMENT

PATIENT ASSESSMENT

Have you ever had thoughts of committing homicide (homicidal ideations)?\*

No Past Ideation Current Ideation

If PAST, Explain\*

Date of last ideation\*

If CURRENT, Explain\*

**SELF-NEGLECT**

Are there any signs of self-neglect?\*

- Poor nutrition
- Poor hygiene
- Safety issues
- Med/Treat Refusal
- Other

If Other, specify\*

- None of the above

**ADDITIONAL RISK ASSESSMENT NOTES**

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**DISASTER PLAN** [BACK TO TOP ?](#)

**DISASTER PLAN**

**HCBS** [BACK TO TOP ?](#)

**HCBS**

Has the member been assessed for HCBS? \*

Yes No Patient is not in a HARP

If they have been assessed, is the member utilizing HCBS? \*

Yes No The assessment determined they were not eligible

If they are not currently engaged in HCBS, please outline the next steps to engage the member in HCBS: \*

If they have not been assessed yet, please outline a plan for them to be assessed: \*

**SUMMARY** [BACK TO TOP ?](#)

**OUTREACH PLAN**

Describe plans for outreach and engagement activities that will support engagement and continuity of care.\*

**STRENGTHS, PREFERENCES, BARRIERS**

Member's strengths:\*

Member's treatment preferences:\*

Barriers to care that may impact ability to achieve goals:\*

Strategies to overcome barriers:\*

**SUMMARY NOTES**

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**COMPLETE ASSESSMENT** [BACK TO TOP ?](#)

**MARK AS DONE**

Clicking "Mark as Done" will check to ensure that all required questions have been answered. The assessment can then be approved by a supervisor and/or completed and locked.

**SUPERVISOR APPROVAL**

As the supervisor, clicking "Approve" indicates that I have reviewed and approved this assessment.