Anthem

Enhanced Care Management comprehensive assessment

California | Anthem Blue Cross | Medi-Cal Managed Care

Background Information

This assessment is designed as a tool for you, as lead care manager, to assess a C/Y member's health needs and help the C/Y member participate in the Enhanced Care Management (ECM) benefit. Today and over the next one to three visits, you and the C/Y member will complete this assessment together and, from there, develop goals and next steps that support the C/Y member's overall health and wellness.

Indicate if you used any of the following recently completed assessments or tools to complete/inform this assessment. (The lead care manager should incorporate findings from all available assessments. Assessments do not replace this comprehensive assessment but should inform the development of the care plan.)

Assessment	Completed	No / N/A
☐ ACEs (If no ACEs completed, refer to PCP/SW for screening.)	☐ Yes. Date Completed:	☐ No ☐ N/A
☐ Needs Evaluation Tool*	☐ Yes. Date Completed:	☐ No ☐ N/A
☐ (Pregnant/Postpartum) CPSP Assessment	☐ Yes. Date Completed:	☐ No ☐ N/A
☐ (Justice Involved) Health Risk Assessment	☐ Yes. Date Completed:	☐ No ☐ N/A
☐ (Justice Involved) Re-entry Care Plan	☐ Yes. Date Completed:	☐ No ☐ N/A
☐ Other(s) (List with date completed.):		

Section 1. Demographics

Today's date:	Patient name:
Date of Birth:	Medi-Cal ID:
Pop of focus (as identified on the referral/authorization form): ☐ Experiencing homelessness ☐ Homeless families ☐ At risk for avoidable hospital or ED utilization ☐ Serious mental health and/or SUD needs ☐ Transitioning from incarceration ☐ Living in the community who are at risk for LTC institutionalization ☐ Nursing facility residents transitioning to the community ☐ Birth equity	
Is anyone else in the family enrolled in ECM? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer If yes, list family member name(s), relationship(s) to member, and their ECM provider(s):	

* The Needs Evaluation Tool is used by DMH.

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CABC-CD-053524-24 CABC-CD-069233-24 September 2024

<table>
<tr><td>Preferred name and/or pronouns:</td><td colspan="2">Gender identification:</td></tr>
<tr><td>Preferred written/spoken language:</td><td colspan="2">Interpreter needed: ☐ Yes ☐ No
Language:</td></tr>
<tr><td colspan="3">Nationality/tribe/ethnicity (select all that apply):
☐ Hispanic or Latino ☐ Asian ☐ Pacific Islander/Native Hawaiian ☐ White ☐ Black/African American
☐ American Indian/Alaskan Native ☐ Other</td></tr>
<tr><td>Where would you like to receive mail? (Include physical address and location type such as home, friend's house, or DPSS office.)</td><td>Home phone(s):</td><td>Cell phone(s):</td></tr>
<tr><td>Is in-person contact OK? ☐ Yes ☐ No
If no, what is your preferred method of contact? (Select all that apply.):
☐ Phone ☐ Email ☐ Text
Reminder: ECM preferred contact is in-person.</td><td colspan="2">Email address(es):</td></tr>
<tr><td colspan="3">Preferred location(s) of contact. (Are you comfortable meeting at your home? Where would you generally like to meet?):</td></tr>
<tr><td>Relationship status:
☐ Single ☐ Married ☐ Divorced
☐ Domestic partnership ☐ Widowed
☐ Other:
☐ Declined to answer</td><td colspan="2">Opt-in to ECM date: ___________
☐ Verbal ☐ Written
☐N/A — grandfathered from HHP/WPC</td></tr>
<tr><td>Is there a person or location that we can contact if we need to get in contact with you? (List relationship of person and contact info, or location address and description, such as shelter.)</td><td colspan="2">Veteran/discharged from the U.S. armed forces?
☐ Yes ☐ No ☐ Declined to answer</td></tr>
</table>

Section 2. Culture

Do you have any cultural, religious, and/or spiritual beliefs that are important to your family's health and wellness? ☐ Yes ☐ No ☐ Declined to answer If yes, describe:

Section 3. Physical health

In general, would you say your health is: ☐ Very good ☐ Good ☐ Poor ☐ Declined to answer Please give me more information about why you chose this rating:

Compared to one (1) year ago, is your health: ☐ Much better ☐ Somewhat better ☐ About the same ☐ Somewhat worse ☐ Much worse now than one (1) year ago ☐ Declined to answer Comments about why you chose this rating?
How many times have you been to the emergency room in the past 6 months? ☐ None ☐ 1 time ☐ 2 times ☐ 3 times or more ☐ Don't remember/Unsure ☐ Declined to answer Comments:
How many times have you been a patient in the hospital in the past 6 months? ☐ None ☐ 1 time ☐ 2 times ☐ 3 times or more ☐ Don't remember/Unsure ☐ Declined to answer Comments:
In the last 12 months, how many times have you been in a nursing home, rehab, and/or recuperative care? ☐ None ☐ 1 time ☐ 2 or more times ☐ Declined to answer Comments (including which setting(s)):
Do you know who your regularly assigned health care providers are? Yes ☐ No Provider name(s)/clinic(s)/phone #(s): If yes, when was the last time you saw your regular doctor? ☐ Less than 3 months ago ☐ Less than 6 months ago ☐ 6-12 months ago ☐ More than 1 year ago ☐ Unsure Do you have a provider for women's health? ☐ Yes ☐ No ☐ N/A Provider name/clinic/phone number:
Have you had a dental visit in the past 12 months? ☐ Yes ☐ No ☐ Unsure ☐ Declined to answer Dentist's name/phone number:
Do you have any problems eating (for example, appetite, chewing, or swallowing)? Comments:
Have you been told by a doctor or a medical provider that you have any medical conditions? ☐ Yes ☐ No If yes, please include the date(s), estimated, of diagnosis(es): **If yes, please check all that apply:** ☐ Arthritis/chronic pain ☐ Asthma (difficulty breathing) ☐Ankle/leg swelling ☐ Alzheimer's/dementia/memory loss ☐ Cancer ☐ COPD/emphysema/bronchitis (breathing problems) ☐ Congestive Heart Failure ☐ Circulation problems ☐ Diabetes, Type 1 ☐ Diabetes, Type 2 ☐ Pre-Diabetes ☐ Heart problems (heart attack, chest pain) ☐ HIV/AIDS ☐ Hepatitis (liver problems) ☐ High cholesterol ☐ Hypertension (high blood pressure) ☐ Kidney disease ☐Osteoporosis ☐ Parkinson's

☐ Physical disability/para/quadriplegic/amputation ☐Recent fracture

☐ Seizure(s) ☐ Sickle Cell Disease ☐ Transplant: ☐ History of TB ☐ Urinary problems

☐ Other conditions not listed above (including a wound that needs care):

Do you have trouble with your vision? ☐ Yes ☐ No
If yes, describe:

If you have diabetes, have you had a diabetic eye exam done in the last year? ☐ Yes ☐ No ☐ N/A

Do you have trouble with your hearing? ☐ Yes ☐ No
If yes, describe:

Preventative Care

Have you had any of the following vaccines?

COVID 19 ☐ Yes (date if known): _________ ☐ No ☐ Unsure

Flu ☐ Yes (date if known): _________ ☐No ☐ Unsure

Tetanus ☐ Yes (date if known): _________ ☐ No ☐ Unsure

Pneumonia ☐ Yes (date if known): _________ ☐ No ☐ Unsure

Shingles ☐ Yes (date if known): _________ ☐ No ☐ Unsure

Other (list with dates, if known):

Do you have any questions or need support getting your vaccinations?

Have you had the following screenings/tests?

☐ Colonoscopy (5 yrs) ☐ Mammogram (2 yrs) ☐ Pap smear (3-5 yrs) ☐ Bone density

☐ Blood sugar (HbA1C, 12 mos) ☐ Kidney function, date: ☐ Eye exam, date:

Section 4. Medications

Please tell me what medications (including birth control, over-the-counter medications, vitamins, etc.) you are currently taking. If more space is needed, include information on the back of this assessment or available blank space. Additionally, if actual medication names and doses are unknown, attempt to capture general information as you are able (such as medication for diabetes or high blood pressure.

Medication name	How often (frequency)	How administered (route)	Dosage

☐ Please attach list for additional medications.

Are you having any trouble getting or filling your medications? ☐ Yes ☐ No If yes, comments:
People sometimes miss taking their medications. Thinking over the past week, were there any days you did not take your medications as prescribed? ☐ Yes ☐ No If yes, please describe what gets in the way:
Do you need help taking your medicines? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer

Section 5. Activities of daily living (ADLs)

Do you need help with any of these actions?	
Taking a bath or shower: ☐ Yes ☐ No Comments:	Going up stairs: ☐ Yes ☐ No Comments:
Eating: ☐ Yes ☐ No Comments:	Getting Dressed: ☐ Yes ☐ No Comments:
Brushing teeth, brushing hair, shaving: ☐ Yes ☐ No Comments:	Making meals or cooking: ☐ Yes ☐ No Comments:
Getting out of a bed or a chair: ☐ Yes ☐ No Comments:	Shopping and getting food: ☐ Yes ☐ No Comments:
Using the toilet: ☐ Yes ☐ No Comments:	Walking: ☐ Yes ☐ No Comments:
Washing dishes or clothes: ☐ Yes ☐ No Comments:	Writing checks or keeping track of money: ☐ Yes ☐ No Comments:
Getting a ride to the doctor or to see your friends: ☐ Yes ☐ No Comments:	Doing house or yard work: ☐ Yes ☐ No Comments:

Do you need help with any of these actions?	
Going out to visit family or friends: ☐ Yes ☐ No Comments:	Using the phone: ☐ Yes ☐ No Comments:
Keeping track of appointments: ☐ Yes ☐ No Comments:	
If yes, are you getting all the help you need with these actions? ☐ Yes ☐ No Comments:	
Have you fallen the last month? ☐ Yes ☐ No Are you afraid of falling? ☐ Yes ☐ No Comments:	
Do friends or family members express concerns about your ability to care for yourself? ☐ Yes* ☐ No Comments: *If yes, ***consult with clinical consultant and supervisor.***	

Do you use or need any of the following? (Select all that apply.):			
☐ Glasses ☐ Use ☐ Need	☐ Cane ☐ Use ☐ Need	☐ Walker ☐ Use ☐ Need	☐ Hearing device ☐ Use ☐ Need
☐ TTY (visual support) ☐ Use ☐ Need	☐ Crutches ☐ Use ☐ Need	☐ Grab bars ☐ Use ☐ Need	☐ Raised toilet seat/chair ☐ Use ☐ Need
☐ Feeding tube ☐ Use ☐ Need	☐ Wheelchair ☐ Use ☐ Need	☐ Food supplements ☐ Use ☐ Need	☐ Hospital bed ☐ Use ☐ Need
☐ Oxygen ☐ Use ☐ Need	☐ Ostomy supplies ☐ Use ☐ Need	☐ CPAP/BiPAP ☐ Use ☐ Need	☐ Diabetes supplies ☐ Use☐ Need
☐ Large print ☐ Use ☐ Need	☐ Sideboard ☐ Use ☐ Need	☐ Urinary catheter ☐ Use ☐ Need	☐ IV infusions for meds ☐ Use ☐ Need
☐ Incontinence supplies ☐ Use ☐ Need	☐ Trach/suction supplies ☐ Use ☐ Need	☐ Lift device (for transferring) ☐ Use ☐ Need	☐ Other ☐ Use ☐ Need
Comments:			

Section 6. Pain management

Do you experience pain? ☐ Yes ☐ No ☐ Declined to answer If yes, answer below.
During the past week, how much did pain interfere with your normal activities (including work outside the home and/or housework)? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐ Declined to answer

Section 7. Pregnancy/postpartum

☐ N/A for Section 7, Pregnancy/postpartum (for example, not of child-bearing age). Continue to Section 8.

Section 7 questions
Are you currently pregnant? ☐ Yes ☐ No ☐ Declined to answer Comments: Have you given birth in the last 12 months? (Includes live or still birth delivery; miscarriage [SAB, spontaneous abortion]; or an abortion induced for medical reasons [TAB, therapeutic abortion]) ☐ Yes ☐ No ☐ Declined to answer Comments: Are you planning to become pregnant? ☐ Yes ☐ No ☐ Unsure ☐ Declined to answer Comments:
If yes to currently pregnant, the following questions must be completed. ☐ N/A
How many months pregnant are you? ______ ☐ Unsure ☐ Declined to answer
Due date: _________ ☐Unsure ☐ Declined to answer
Have you been told you are carrying more than one baby? ☐ No ☐ Yes: _____ ☐ Unsure ☐ Declined to answer
Do you have the following plans for pregnancy and labor and delivery? **Birth plan:** ☐ Have ☐ Don't have, but want ☐ Don't have and don't want **Delivery wishes:** ☐ Vaginal ☐ Natural (unmedicated/no epidural) ☐ C-section ☐ Vaginal birth after C-section (VBAC) **Delivery location:** ________________________ **Birthing classes:** ☐ Have ☐ Don't have, but want ☐ Don't have and don't want **Labor support person(s) (including doulas):** ☐ Have ☐ Don't have, but want ☐ Don't have and don't want List: ______________________________________ **Going into labor:** When to call someone and/or go to your birthing location: ☐ I know what to do ☐ I need help with this **Goals/plan for transportation to hospital:** ☐ Have ☐ Don't have, but want ☐ Don't have and don't want **Childcare goal/plans for other kids:** ☐ Have ☐ Don't have, but want ☐ Don't have and don't want ☐ N/A **Breastfeeding plans:** ☐ Have ☐ Don't have, but want ☐ Don't have and don't want Comments:
If yes to having given birth in the last 12 months, the following questions must be completed. ☐ N/A *Birth* includes live or stillbirth delivery, miscarriage (SAB, spontaneous abortion), or an abortion induced for medical reasons (TAB, therapeutic abortion).
Did you have any issues with delivery? ☐ Yes ☐ No ☐ Declined to answer Comments:

Does your baby (babies) have any special healthcare needs?
☐ Yes* ☐ No ☐ Unsure ☐ N/A (for example, stillbirth, SAB, TAB)
Comments:

Do you need any mental health support as a result of your birthing experience?
☐ Yes* ☐ No ☐ Declined to answer
Comments:

**Consider needed connections for baby, such as CCS, or ECM services.*

What are you enjoying most about your new baby?

What is most challenging?

☐ N/A ☐ Declined to answer

Are your family members adjusting to the baby? ☐ Yes ☐ No ☐N/A ☐Declined to answer
Comments:

Are you breastfeeding? ☐Yes ☐ No ☐ N/A ☐ Declined to answer
If no, would you like to, or do you plan to? ☐Yes ☐ No ☐ Unsure ☐ Declined to answer
If yes to either:
Do you feel like you need help with breastfeeding? ☐ Yes ☐ No ☐ Declined to answer
Do you need a breast pump? ☐Yes ☐ No ☐ Declined to answer

Do you have any concerns about your baby's feeding (breastfeeding, bottle feeding)?
☐Yes ☐ No ☐ N/A ☐ Declined to answer
Comments:

If yes to either pregnant or having given birth in the last 12 months, complete below.
☐ N/A (for example, pregnancy resulted in stillbirth, SAB, or TAB; or only ask applicable questions)

When was your most recent prenatal or postpartum appointment? __________
☐ Unsure ☐ Declined to answer ☐ Have not gone to an appointment; comments:

When is your next prenatal or postpartum appointment: __________
☐ Unsure ☐ Declined to answer ☐ No appointment scheduled

Has the doctor told you that there are health issues that need follow-up? ☐ Yes ☐ No ☐ Unsure
If yes, do you need support in following up with those issues? ☐ Yes ☐ No ☐ Unsure
Comments:

<table>
<tr><td>Do you feel supported in your pregnancy/during your postpartum period?
☐ Yes ☐ No ☐ Unsure ☐ Declined to answer
Comments:

Based on response, consult with a clinical consultant and supervisor if needed for any follow-up support.</td></tr>
<tr><td>Are there people that smoke around you and/or your baby? ☐Yes ☐No ☐ Declined to answer
If yes, have you discussed this with your provider? ☐Yes ☐No ☐ Unsure ☐ Declined to answer</td></tr>
<tr><td>Do you need any of the following during your pregnancy or postpartum care (check all that apply):

☐ Education/resources on pregnancy/post-pregnancy (body changes, baby growth, postpartum discomforts, self-care after pregnancy, etc.)
☐ Education/resources on family planning/birth control
☐ Education/resources on infant health (nutrition, developmental milestones, safe sleeping)
☐ Education/resources on immunizations for self and baby
☐ Education/resources on parenting skills/parenting classes
☐ Essential baby supplies (crib, diapers, formula, bottles, breast pump, clothing, blankets, and other supplies)
☐ Car seat
☐ Finding childcare or assistance paying for childcare
☐ Other:

☐ Declined to answer</td></tr>
<tr><td>Do you have a doctor for your baby? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer
If yes, provider name/phone number:</td></tr>
<tr><td>When (day and/or month) did you most recently take your baby to the doctor?
Answer: ______________ ☐ Unsure ☐ N/A ☐ Declined to answer
Has the doctor told you that there are health issues with your baby that needs follow-up?
☐ Yes ☐ No ☐ Unsure
If yes, do you need support in following up with any those issues? ☐ Yes ☐ No ☐ Unsure</td></tr>
<tr><td>Do you have a dentist for your baby?
☐ Yes ☐ No ☐ N/A (no teeth present and less than 1 year of age) ☐Declined to answer
If yes, provider name/phone number:

Date of last visit (if known) or an approximate date: _________</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS) Screener</td></tr>
<tr><td>☐ Declined to complete (and reason, if provided):

Have member self-complete the screener online here. The member should complete the scale themselves unless they have limited English or difficulty reading.
Scoring:
• Score of 9 and above: Consult with clinical consultant and supervisor.
• Score of 13 and above: Consult with clinical consultant and supervisor and initiate referral for behavioral health.

Positive score (1, 2, or 3) on question 10: Immediate discussion required: consult with clinical consultant and supervisor and initiate referral for behavioral health.</td></tr>
</table>

Section 8. Behavioral health

Mental health history

Has a healthcare or mental health provider ever told you that you have a mental health diagnosis (including postpartum depression or postpartum anxiety)?

☐ Yes ☐ No ☐ Unsure ☐ Declined to answer

Comments:

If yes to above:

What diagnosis have you been given?

☐ Depression ☐ Bipolar Disorder ☐ Schizophrenia ☐ Anxiety ☐ PTSD ☐Declined to answer

☐ Other(s):

Comments:

If yes, have you had a psychiatric hospitalization? ☐ Yes ☐ No ☐ Unsure ☐ Declined to answer

If yes, list date(s), reason(s), outcome(s), location(s):

If yes, have you received outpatient treatment? ☐ Yes ☐ No ☐ Unsure ☐ Declined to answer

If yes, list date(s), reason(s), outcome(s), location(s):

If yes, have you received any other types of treatment? ☐ Yes ☐ No ☐ Unsure ☐ Declined to answer

If yes, describe:

Can you provide the contact information of your current or past mental health provider?

Name of provider:

Phone number:

Over the past month (30 days), how many days have you felt lonely? (Check one.)

☐ None — I never feel lonely ☐ Less than 5 days ☐ More than half the days (more than 15)

☐ Most days — I always feel lonely ☐ Declined to answer

Depression

The following are questions from the *Patient Health Questionnaire* (*PHQ*), questions 1, 2, and 9.

☐ Not completed because the EPDS was completed above.

Over the last two weeks, how often have you been bothered by any of the following?

- Little interest or pleasure in doing things?
  ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
- Feeling down, depressed, or hopeless?
  ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

- Thoughts that you would be better off dead or of hurting yourself?
  ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

If the answer is several days or more to any of these, consult with a clinical consultant and supervisor.

Anxiety
The following are questions from the *Generalized Anxiety Disorder 2-item* (*GAD-2*).

Over the last two weeks, how often have you been bothered by the following problems?

- Feeling nervous, anxious, or on edge?
  ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
- Not being able to stop or control worrying?
  ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

If the answer is several days or more to any of these, consult with a clinical consultant and supervisor.

Trauma and stressors
The following are questions from the *Generalized Anxiety Disorder 2-item* (*GAD-2*).

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic that leave an impact on our day-to-day life. Are you interested in getting support with this, such as referral to a mental health professional, support groups, and coping skills?
☐ Yes ☐ No ☐ Declined to answer
Comments:
.

Cognitive functioning

Have you had any changes in thinking, remembering, or making decisions? ☐ Yes ☐ No
Comments:

In the past month, have you felt worried, scared, or confused that something may be wrong with your mind or memory? ☐ Yes ☐ No
Comments:

Scoring: If the patient checks yes to either box, consult with the clinical consultant and supervisor.

Section 9. Substance abuse

☐ Member declined to complete.
Comments:

I have some questions about your experience with alcohol, nicotine products, marijuana, and other substances. Some of the substances we will talk about are prescribed by a doctor, but I will only be focusing on whether you have taken them for reasons other than prescribed or in doses other than prescribed.

In the past 6 months, how often have you used the following:	Never	1-2 times	Monthly	Weekly	Daily
Alcohol					
Nicotine products (cigarettes, vaping, chewing tobacco)					

Using prescription drugs not as prescribed (circle any relevant): • Pain medicines • ADHD medicines • Sleeping pills • Other:					
Marijuana or products with THC					
Other substances. For example, cocaine, meth, heroin, hallucinogens, inhalants, designer drugs					

Have you ever felt you ought to cut down on your drinking or drug use?
☐ Yes ☐ No ☐ N/A ☐ Declined to answer
If yes, go to next question.

Would you like to talk with someone about your substance use, especially if you are thinking of quitting or cutting back? ☐ Yes ☐ No ☐ N/A ☐ Unsure ☐ Declined to answer

Are you currently or have you received treatment for substance use?
☐ Yes ☐ No ☐ N/A ☐ Unsure ☐ Declined to answer

If yes, can you describe the treatment you received (for example: residential treatment; outpatient treatment; or medication-assisted treatment such as Vivitrol, Suboxone, Naltrexone, Methadone, or Subutex):

Can you provide the contact information for where you are receiving or have received treatment?
Name of provider:
Phone number:
☐ Currently receiving treatment ☐ Previously received treatment

Please share any additional information about your past substance use (for example, longer than the past 6 months, family history):

Note: If any safety concerns for member or their family, consult with clinical consultant and supervisor.

Comments:

Section 10. Developmental factors

Ask the following question only if this information is not already available to the ECM provider team.

Question for patient *or* family/caregiver/case manager (depending on individual's ability to answer):
Has a healthcare provider ever told you or your family that when you were a child or adult that you had a developmental delay, disability or brain injury that impacted your ability to think clearly (for example, traumatic brain injury, autism spectrum disorder, ADHD, learning disability)?
☐ Yes ☐ No ☐ Unsure ☐ Declined to answer
Comments:

Section 11. Health literacy

I would like to ask you about how you think you are managing your health conditions.

- Do you need help filling out health forms? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer
- Do you need help answering questions during a doctor's visit?

  ☐ Yes ☐ No ☐ N/A ☐ Declined to answer

Section 12. Social Determinants of Health (SDoH)

Housing
What is your current housing condition? ☐ Stable and safe ☐ Motel ☐ Garage or portion of a living space ☐ Staying with friends ☐ Car ☐ Transitional housing ☐ Temporary shelter ☐ Frequent migration ☐ Other: ☐ Declined to answer Comments:
Are you worried about losing your housing? ☐ Yes ☐ No ☐ Declined to answer If yes, please explain:
What concerns you the most about your housing situation?
Is anyone currently helping you with your housing support (for example, Housing Navigator, case management, or tenants' rights)? ☐ Yes ☐ No ☐ N/A

Housing environment
Can you live safely and easily around your home? ☐ Yes ☐ No ☐ Declined to answer If no, does the place where you live have:

Good lighting ☐ Yes ☐ No	Good heating ☐ Yes ☐ No	Good cooling ☐ Yes ☐ No
Rails for any stairs/ramps ☐ Yes ☐ No	Hot water ☐ Yes ☐ No	Indoor toilet ☐ Yes ☐ No
A door to the outside that locks ☐ Yes ☐ No	Stairs to get into your home or stairs inside your home ☐Yes ☐No	Elevator ☐ Yes ☐ No
Space to use a wheelchair ☐ Yes ☐ No	Clear ways to exit your home ☐ Yes ☐ No	

Comments:

Safety
Do you feel physically and emotionally safe where you currently live? ☐ Yes ☐ No* If no, please describe: *If no, consult with clinical consultant and supervisor.*
Is anyone staying in your home without your permission? ☐ Yes* ☐ No If yes, please explain: *If yes, consult with clinical consultant and supervisor.*

Are you afraid of anyone or is anyone hurting you? ☐ Yes* ☐ No If yes, please explain: *If yes, consult with clinical consultant and supervisor.*
Is anyone using your money without your OK? ☐ Yes* ☐ No If yes, please explain: *If yes, consult with clinical consultant and supervisor.*
Food security
In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there was not enough money for food? ☐ Yes ☐ No ☐ Declined to answer
How often are you hungry or do not eat because there is not enough food in the house? ☐ Often ☐ Not often ☐N/A ☐ Declined to answer
Do you eat less than you feel you should because there is not enough food? ☐ Yes ☐ No ☐ Declined to answer
Comments:
Social connection/support
Who do you live with? ☐ Live alone ☐ Live with spouse or significant other. If checked, please list more information of relationship(s) and age(s): ☐ Live with children or other relatives or friends. If checked, please list more information of relationship(s) and age(s): ☐ Live with caregiver. If checked, please list more information of relationship(s) and age(s):

☐ Live with other residents in my facility/program.

☐ Declined to answer

Do you have any children not already listed above? If so, include ages:

How often do you see or talk to people that you care about and feel close to? (For example, talking to friends on the phone, visiting friends or family, going to church or club meetings.)

☐ Less than once a week ☐ 1 or 2 times a week ☐ 3 to 5 times a week ☐ 5 or more times a week

☐ Declined to answer

Are you caring for anyone and/or any pets? ☐ Yes ☐ No

If yes, describe:

Family member/individual supports (including caregiver resources and involvement)

Do you have family members, friends, or others willing to help you when you need it?

☐ Yes ☐ No ☐ Declined to answer

Comments:

Do you have a caregiver assisting you? ☐ Yes ☐ No ☐ Declined to answer

If yes, name and contact info (phone/email):

Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No ☐ N/A

If yes, please explain:

Do you have an in-home supportive services (IHSS) worker? ☐ Yes ☐ No ☐ Declined to answer

If yes, how many IHSS hours are you receiving? _____

Name of IHSS worker:

Contact phone number:

Comments:

Section 13. Benefits and other services

Funding/benefit source/services:

☐ WIC (list site): ___________________ ☐ CalFresh benefits (SNAP) ☐ TANF recipient

☐ SSI recipient ☐ SSDI recipient

☐ SSA (retirement) recipient ☐ Other retirement income ☐ Employed ☐ VA benefits ☐ General relief

☐ CalWorks ☐ Home Visiting Program (list): ___________________

☐ Others:

☐ None

Do you sometimes run out of money to pay for food, rent, bills and medicine?

☐ Yes ☐ No ☐ Declined to answer

What is your current work situation? ☐ Declined to answer ☐ Part-time ☐ Full-time ☐ Student ☐ Retired
☐ Other:

Unpredictable (such as day labor)? ☐ Yes ☐ No

Are there any concerns or challenges with your job?
☐ Yes ☐ No ☐ Declined to answer
If yes, describe:

Are you receiving any services from any of the programs below?:
☐ Long-term care and support (SNF, rehab center) ☐ Family PACT ☐ Community-based adult services
☐ Veterans Administration ☐ Palliative care programs ☐ Regional center
☐ California Children's Services
☐ Other:

☐ None

Section 14. Legal involvement

In the past 12 months, have you been involved with the following:
☐ Court-ordered services ☐ On probation ☐ On parole ☐ Re-entry program ☐ DUI/restricted license
☐ Adult Protective Services (APS) ☐ Child Protective Services (CPS) ☐ Community legal services ☐ None
☐ Declined to answer ☐ Other (list):
Comments:

Contact information as applicable (name, number, organization):

In the past year, have you spent more than two (2) nights in a row in a jail, prison, detention center, or juvenile correctional facility? ☐ Yes* ☐ No ☐ Declined to answer

If yes, say, "I would like to coordinate with anyone you are working with related to your stay in _____ so we can work together to support you and your goals. May I contact that person with you?"

Have you ever associated with members of a gang or been involved in one?
☐ Yes ☐ No ☐ Declined to answer

If yes, what is your current status?

Section 15. Advance care planning

Life planning is an important aspect to one's holistic health and planning needs.

Do you have a life-planning document or advance directive in place? ☐ Yes ☐ No ☐ Declined to answer

Do you have an authorized representative to speak on your behalf about issues?
☐ Yes ☐ No ☐ Declined to answer
Name and relationship:

Do you want information on these topics? ☐ Yes ☐ No ☐ Declined to Answer

Section 16. Member priorities

What concerns you most about your physical or mental health?
What is one thing you would like to do right now to improve your health (such as cutting back on caffeinated or sugary drinks?) (*Note: Provide easy, harm-reduction examples.*)
What would you like to achieve from our work and time together?
From our meeting today, what comes to mind as your top two or three goals for your health, wellness, and social and/or living situation for the next three to six months? 1. 2. 3.

Narrative summary

Include **primary needs** identified from assessment:	
Next steps	**Person responsible**
1.	
2.	
3.	
Next appointment/location:	

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.