# *Netsmart Adult Comprehensive Assessment*

# Core Demographics

|  |  |
| --- | --- |
|  First Name: |  |
|  Last Name: |  |
|  DOB: |  |
|  Primary CIN: |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 1

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 2

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip code

|  |  |
| --- | --- |
|  Phone Type: |  |
|  |  |
|  Phone Number: |  |

## ADDITIONAL DEMOGRAPHIC INFORMATION

1. What is the member’s ethnicity?

|  |  |
| --- | --- |
| *Hispanic or Latino* | *Not Hispanic or Latino* |

2. What is the member’s race?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Alaskan Native/American Indian* | *Asian* | *Black/African American* | *Caucasian* | *Native Hawaiian/Pacific Islander* | *Other* | *Unknown/Not Provided* |

3. What is the member’s primary language?

4. Can you read/write in your primary language?

|  |  |
| --- | --- |
| *Yes* | *No* |

5. Are you experiencing any language and cultural barriers in trying to get the care you need?

|  |  |
| --- | --- |
| *Yes* | *No* |

6. Is there another language spoken in the home?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

7. What is the member’s religion?

8. How does the member describe their gender?

9. What is the member’s sexual orientation?

10. Additional information regarding specific beliefs or customs that may impact the way your healthcare is delivered:

# **Social Determinants of** Health

All questions in this section are required, or conditionally required.

1. With reference to food security, are there concerns regarding the following? (Select all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Access to healthy food* | *Ability to afford adequate amount of food* | *Quality of diet* | *Access to meals* | *Availability of food resources/pantries* | *None* |

2. In the last 12 months, has your utility company shut off your service for not paying your bills?

|  |  |
| --- | --- |
| *Yes* | *No* |

3. Are you worried that in the next 2 months, you may not have stable housing?

|  |  |
| --- | --- |
| *Yes* | *No* |

3a. If yes, potential cause? (Select all that apply)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *Financial* | *Safety Transfer* | *Foster placement in jeopardy* | *Quality of housing* | *Environmental conditions* | *Crime/Risk of Violence* | *Legal involvement* | *Other* |

3b. If other, please specify:

4. Where do you live now?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Apartment* | *Foster Home* | *Group Home* | *Guested Homeless* | *Home-Family/Friend* | *Home - Own* | *Homeless-Shelter* | *Homeless-Street* | *Transitional Housing* | *Other* |

4a. If Other, please specify:

5. Have you ever been evicted or homeless in the past?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unwilling to Answer* |

6. How many times has the member moved in the last 6-12 months?

|  |  |  |
| --- | --- | --- |
| *0* | *1-3 times* | *4+ times* |

7. Do problems getting child care make it difficult for you to work or study?

|  |  |
| --- | --- |
| *Yes* | *No* |

8. In the last 12 months, have you needed to see a doctor, but could not because of cost?

|  |  |
| --- | --- |
| *Yes* | *No* |

9. In the last 12 months, have you ever had to go without health care because you didn’t have a way to get there?

|  |  |
| --- | --- |
| *Yes* | *No* |

10. Does the member have adequate access to transportation?

|  |  |  |  |
| --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Denies History* |

10a. If no, what transportation resources does the member need assistance accessing?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Subway/*Bus* | *Medicaid Transportation* | *Medical* | *Transportation* | *Private Vehicle* | *None*  |

11. What is the member’s primary mode(s) of transportation?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Subway/*Bus* | *Medicaid Transportation* | *Medical* | *Transportation* | *Private Vehicle* | *None*  |

12. Are any special transportation accommodations needed? If so, which?

|  |  |  |  |
| --- | --- | --- | --- |
| *Wheelchair accessible* | *Stretcher* | *1:1 Support* | *None* |

13. Do you ever need help reading or understanding materials that you get from your doctor or other health care providers?

|  |  |
| --- | --- |
| *Yes* | *No* |

14. Are you afraid you might be hurt by another person in your apartment building or house?

|  |  |
| --- | --- |
| *Yes* | *No* |

15. Are there any other situations at home that make it hard for you take care of yourself?

|  |  |
| --- | --- |
| *Yes* | *No* |

16. If yes, please specify:

# **Benefits**

All questions in this section are required, or conditionally required.

1. Does the member’s current household receive any of the following income sources? (Select all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *SSI/SSDI* | *Section 8* | *MRT Housing Subsidy* | *Child Support* | *Unemployment Insurance* |  |
| *WIC* | *SNAP* | *Foster Care Subsidy* | *Employment* | *None* |

2. Does the member’s current household need any of the following benefits/entitlements? (Select all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *SSI/SSDI* | *Section 8* | *MRT Housing Subsidy* | *Child Support* | *Unemployment Insurance* |  |
| *WIC* | *SNAP* | *Foster Care Subsidy* | *Employment* | *None* |

3. Does the member have financial supports/representative payee?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Member is under 18 years old* |

# Medical

Starred (\*) questions are required.

\*1. Does the member have any medical problems/issues/diagnoses?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

\*1a. What are your medical problems/issues/diagnoses?

2. Have you been to the emergency room or admitted to the hospital in the past year for any of those issues?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

2a. How many times?

|  |  |
| --- | --- |
|  | *Choose answer:* |
| ER | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |
| Hospital Admission | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |

\*3. Do you have a primary care doctor?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

3a. What is the name of your primary care doctor? (Document the Provider in the Professional Network Section)

4. Do you see any medical specialists?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

4a. What medical specialists do you see? (Document the Provider in Professional Network Section)

5. Are any of your medical issues bothering you especially/more than usual right now?

|  |  |
| --- | --- |
| *Yes* | *No* |

\*6. When did the member last see their dentist?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Under 6 months* | *Over 6 months* | *Over a year* | *Do not recall* | *Never* |
|  |  |  |  |  |

\*7. What are the member’s current dental concerns and needs? Check all the apply:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Routine Care* | *Reports Pain* | *Gum Disease* | *Tooth Decay* | *Orthodontics* | *Phobia* | *None* |

\*8. *For members self-consenting:* Decisions about health and medical care can be so complicated. Is there someone in your life that you have identified or formally designated who would help you make decisions about your health care if you were unable to make those decisions for yourself?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

\*8a. Is this something you would like to learn more about?

|  |  |
| --- | --- |
| *Yes* | *No* |

# HIV/AIDS

Starred (\*) questions are required.

\*1. Has the member consented to share information about HIV/AIDS?

|  |  |  |  |
| --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Denies history* |

\*2. Does the member engage in risk behaviors for HIV?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Injecting* | *Unprotected Sex* | *History of STIs* | *Refused to answer* | *Not age appropriate* | *Denies history* | *No* |

3. Has the member ever had an HIV test?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

3a. When was the date of the member’s last test?

4. Would the member like a referral for HIV testing?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

5. Has the member engaged in risky behaviors since the member last test?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

6. Has the member ever been educated on HIV?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

7. Would the member like a referral for HIV education?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

8. Would the member like a referral for HIV testing?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

\*9. Are you HIV+ or do you have AIDS??

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

9a. Was the member exposed to HIV Perinatally or after birth?

|  |  |
| --- | --- |
| *Perinatal* | *After birth* |

9b. Is the member receiving medical care for HIV?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

10. What are the barriers to accessing medical care?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *Financial* | *Lack of Transportation* | *Need for Psychoeducation* | *Concerns about Side Effects* | *Communication Issues* | *Lack of Child Care* | *None* | *Other* |

10a. If Other, please specify

11. When was the member’s last lab test that checked for CD4 count and Viral Load?

12. Does the member understand the meaning of Viral Load & CD4 count and how to read lab results?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

13. What is the member’s current CD4 count?

|  |  |  |
| --- | --- | --- |
|  *>200* | *< or =200* | *Does not know* |

14. What is the member’s current viral load?

|  |  |  |
| --- | --- | --- |
| *Undetectable* | *Detectable* | *Unknown* |

# Trauma

All questions in this section are required, or conditionally required.

1. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that you have had nightmares about it or thought about it when you did not want to?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Not Sure* |

2. Have you tried hard not to think about it or went out of your way to avoid situations that reminded the member of it?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Not Sure* |

3. Were constantly on guard, watchful, or easily startled?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Not Sure* |

4. Have you felt numb or detached from others, activities, or your surroundings?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Not Sure* |

# Mental Health Services

Starred (\*) questions are required.

\*1. Does the member have any behavioral/psychiatric problems/issues/diagnoses?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

**If the answer to question 1 is yes please answer questions 2-7, otherwise skip.**

2. What are the member’s mental health/behavioral/psychiatric problems/issues/diagnoses?

3. At what age didthe member’s mental health/behavioral/psychiatric problems/issues /diagnoses begin?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *0-5* | *6-11* | *12-17* | *18-21* | *Over 21* |

4. Has the member been to the emergency room or admitted to the hospital in the past year for any of those issues?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

4a. How many times?

|  |  |
| --- | --- |
|  | *Choose answer:* |
| ER | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |
| Hospital Admission | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |

5. Does the member have a psychiatrist (or psychiatric nurse practitioner)?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

5a. When did the member last see their psychiatrist (or psychiatric nurse practitioner)?

6. Does the member see a therapist?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

6a. When did the member last see their therapist?

7. Has the member been ordered by court to attend a program?

|  |  |  |  |
| --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Completed* |

\*8. **Patient Health Questionnaire: PHQ-9**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Several days | More than half the days | Nearly every day |
| 1. Little interest or pleasure in doing things
 | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed, or hopeless
 | 0 | 1 | 2 | 3 |
| 1. Trouble falling or staying asleep, or sleeping too much
 | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy
 | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating
 | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself, or that you are a failure or have let yourself or your family down
 | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television
 | 0 | 1 | 2 | 3 |
| 1. 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
 | 0 | 1 | 2 | 3 |
| 1. Thoughts that you would be better off dead, or of hurting yourself
 | 0 | 1 | 2 | 3 |
|  **Total Score:** |
| 1. 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 |

\*8a. Is the PHQ-9 score positive?

|  |  |
| --- | --- |
| *Yes* | *No* |

\*9. What are the member’s triggers (what people, places, or things upset the member); how does the member know when they are upset?

|  |  |
| --- | --- |
| **Trigger** | **How the member knows that they are upset** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

\*10. When the member is upset, what activities can they do to feel better (for example, take a walk, listen to music, watch TV)?

\*11. Does the member have any current at-risk behavior related to suicide?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

11a. If yes, choose all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| *Ideation* | *Plan* | *Gestures/Threats* | *Attempts* |

11b. Please elaborate:

12. Has the member been to the emergency room or admitted to the hospital in the past year for issues related to suicidal behavior?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

12a. How many times?

|  |  |
| --- | --- |
|  | *Choose answer:* |
| ER | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |
| Hospital Admission | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |

\*13. Has the member ever been to the emergency room or admitted to the hospital for issues related to homicidal/aggressive/assaultive behavior?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

13a. How many times?

|  |  |
| --- | --- |
|  | *Choose answer:* |
| ER | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |
| Hospital Admission | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |

#

# Medications

 All questions in this section are required, or conditionally required.

1. Is the member currently prescribed medication?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |
|  |  |  |  |  |

1a. What medications are currently prescribed? (Remember to attach the member’s medication list)

1b. Does the member understand the reason for each medication?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

1c. Does the member ever have problems taking or remembering to take their medications?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Yes* | *No* | *Yes, for medical conditions only* | *Yes, for behavioral health conditions only* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

1d. What difficulties does the member experience taking their medication as prescribed? Select all that apply.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Financial* | *Lack of Transportation* | *Need for Psychoeducation* | *Concerns about Side Effects* | Communication Issues |
| *Provider Issue* | *Lack of Child Care* | *Child Declines* | *No difficulties noted* |  |

*1e.* Would the member like assistance in identifying supports to follow their prescription medications regimen?

|  |  |
| --- | --- |
| *Yes* | *No* |

2. What Pharmacy does the member go to?

3. Does the member have allergies?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

3a. What are the member’s allergies?

# Substance Use

Starred (\*) questions are required.

1. Have you ever gone to anyone for help for a drug or alcohol issue?

|  |  |
| --- | --- |
| *Yes* | *No* |

1a. If yes, specify:

2. Have you ever been in a hospital for medical issues related to your drug or alcohol use?

|  |  |
| --- | --- |
| *Yes* | *No* |

2a. When was the last time you were in a hospital for an issue related to your drug or alcohol use?

3. Are you currently, involved in an outpatient treatment program specifically related to drug or alcohol use?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Refused to Answer* |

3a. If yes, what substance?

4. Have you, in the past, been treated for problems related to drug or alcohol abuse?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes – Detox – Inpatient* | *Yes – Inpatient treatment services (30 day rehab)* | *Yes – Methadone treatment – Methadone clinic* | *Yes – Outpatient services – Outpatient clinic* | *Yes – Outpatient services – Outpatient rehabilitation* |
| *Yes – residential services* | *Yes – Recovery center* | *Yes – Self-help group* | *No* |  |

5. Do you smoke cigarettes, vape, or use other tobacco products?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

5a. Would you like information about, or a referral for, smoking cessation?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

6. Does the member’s substance use/dependence affect their daily living?

\*7. **Drug Abuse Screening Test: DAST-10**

These questions refer to the past 12 months:

* Have you used drugs other than those required for medical reasons? Y/N
* Do you use more than one drug at a time? Y/N
* Are you always able to stop using drugs when you want to? Y/N
* Have you woken up and not remembered the period of time before you went to bed or passed out as a result of using drugs? Y/N
* Do you ever feel bad or guilty about your drug use? Y/N
* Does your partner (or family/loved ones) ever complain about your involvement with drugs? Y/N
* Have you neglected your family because of your use of drugs? Y/N
* Have you engaged in illegal activities in order to obtain drugs? Y/N
* Have you ever experienced symptoms of withdrawal (felt sick) when you stopped taking drugs? Y/N
* Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? Y/N

\*8. **Alcohol Use Disorders Identification Test: AUDIT-C?**

* How often do you have a drink containing alcohol?

Never, Monthly or less, 2-4 times a month, 2-3 times a week, 4 or more times a week

* How many standard drinks containing alcohol do you have on a typical day?

*1 or 2, 3 or 4, 5 or 6, 7 to 9, 10 or more*

* How often do you have six or more drinks on one occasion?

*Never, Less than monthly, Monthly, Weekly, Daily, almost daily*

9. Was the member’s DAST-10 score between 3-10?

|  |  |
| --- | --- |
| *Yes* | *No* |

10. Did the member’s AUDIT-C score meet the following criteria? Men > 4, Women > 3

|  |  |
| --- | --- |
| *Yes* | *No* |

# Justice

Starred (\*) questions are required.

\*1. In the last 12 months, have you had any interactions with the police or law enforcement?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

1a. Have you been detained by the police?

|  |  |
| --- | --- |
| *Yes* | *No* |

1b. Have you been arrested?

|  |  |
| --- | --- |
| *Yes* | *No* |

1c. If yes, provide arrest release date:

1d. Have you been incarcerated?

|  |  |  |
| --- | --- | --- |
| *Yes*  | *No* |  |

1e. If yes, provide incarceration release date:

1f. Are you on probation or parole?

|  |  |  |
| --- | --- | --- |
| *Yes – probation* | *Yes – parole* | *No* |

2. Are you a registered sex offender?

|  |  |
| --- | --- |
| *Yes* | *No* |

3. Have you ever had a case open with CPS, or APS?

|  |  |  |
| --- | --- | --- |
| *Yes – in the past* | *Yes – currently* | *No* |

# Activities of Daily Living

All questions in this section are required, or conditionally required.

1. In the past 7 days, did the member need help from others to perform every day activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet? (Select all that apply)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Eating* | *Getting dressed* | *Grooming* | *Bathing* | *Walking* | *Using the toilet* | *Not age appropriate* | *Other* | *None* |

1a. If Other, please specify:

1b. Who helped the member with the tasks selected above?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Relative* | *Friend* | *Neighbor* | *Home Attendant* | *Foster Parent* | *No One* | *Other* |

1c. If Other, please specify:

2. In the past 7 days, did the member need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking their own medications? (Select all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Laundry and Housekeeping* | *Banking* | *Shopping* | *Using the telephone* | *Food preparation* |
| *Transportation* | *Taking the member’s own medication* | *Not age appropriate* | *Other* | *None* |

2a. If Other, please specify:

2b. Who helped the member with the tasks selected above?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Relative* | *Friend* | *Neighbor* | *Home Attendant* | *Foster Parent* | *No One* | *Other* |
|  |  |  |  |  |  |  |

2c. If Other, please specify:

3. Does the member require use of adaptive equipment/technology?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

3a. If yes, specify adaptive equipment/technology:

# Social Support

Starred (\*) questions are required.

\*1. In the past month, rate how often:

* I have someone who understands my problems

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

* I have someone who will listen to me when I need to talk or if I am upset

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

* I have someone to talk to when I have a bad day

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

* I have someone I trust to talk with about my problems and feelings

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

* I can get helpful advice when dealing with a problem

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

* I get invited to go out and do things with other people

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

* I can find a friend when I need one

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

* I feel close to my friends

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

* I feel like I’m part of a group of friends

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

2. Have you ever worked with a peer support specialist or community health worker?

|  |  |  |
| --- | --- | --- |
| *Yes – in the past* | *Yes – currently* | *No* |

3. Do you live with anyone?

|  |  |
| --- | --- |
| *Yes* | *No* |

# Employment

Starred (\*) questions are required.

\*1. What is the highest level of school you have completed?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Elementary School* | *High School* | *Some College* | *College* | *Graduate School* |

2. Are you interested in completing any more school?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Not Sure* |

3. Is the member currently employed?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

3a. If no, is the member interested in getting a job?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |
|  |  |  |  |  |

4. Does the member want or need workforce development training and education?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |
|  |  |  |  |  |

4a. Does the member have access to vocational rehabilitation and employment programs?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Not Sure* |

4b. What programs does the member have access to?

5. Are there any barriers to gaining or maintaining employment?

# Priorities

1. What are the most important things to work on right now and how can the care manager help accomplish this?