Enhanced Care Management (ECM) Comprehensive Assessment

Background Information

This assessment is designed as a tool for you, as Lead Care Manager, to assess a member's health needs and help the member participate in the Enhanced Care Management benefit. Today and over the next 1-3 visits, you and the member will complete this assessment together, and from there develop goals and next steps that support the 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.

☐ACEs or PEARLS If no ACEs completed: refer to PCP/SW for screening.	☐Yes. Date completed:_____☐No ☐N/A
☐Needs Evaluation Tool[1]	☐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):	

[1]The Needs Evaluation Tool is used by Department of Mental Health.

Section 1. Demographics		
1. Today's date:	**2. Patient name:**	
3. Date of birth:	**4. Medi-Cal ID:**	**5. Opt-in to ECM date:** _____ ☐Verbal ☐Written ☐N/A – Grandfathered from HHP/WPC
6. Population 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		
7. Is anyone else in the family enrolled in ECM? ☐Yes ☐No ☐N/A ☐Declined to answer **8. If yes, list family member name(s), relationship(s) to member and their ECM Provider(s):**		
9. Preferred name and/or pronouns:		**10. Gender identification:**
11. Preferred written/spoken language:		**12. Interpreter needed**: ☐Yes ☐No If **yes**, list language:
13. Nationality/tribe/ethnicity (Select all that apply)**:** ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Hispanic or Latino ☐Pacific Islander/Native Hawaiian ☐White ☐Other:		
14. Relationship status: ☐Single ☐Married ☐Divorced ☐Domestic partnership ☐Widower ☐Other: _____ ☐Declined to answer		**15. Veteran/discharged from the U.S. Armed Forces?** ☐Yes ☐No ☐Declined to answer
16. Home phone(s):	**17. Cell phone(s):**	**18. Email address(es):**

24-420 (4/24)

Section 1. Demographics, continued

19. Where would you like to receive mail? (include physical address and location type, e.g., home, friend's house, Department of Public Social Services (DPSS) office, etc.)	**20. Is in-person contact ok?** ☐Yes ☐No *(Reminder: ECM preferred contact is in-person)* If **No**, what is your preferred method of contact? ☐Phone ☐Email ☐Text

21. Preferred location(s) of contact (Are you comfortable meeting at your home? Where would you generally like to meet):

22. 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 information or location address and description – e.g., shelter)

Section 2. Culture

1. **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

1. **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:

2. **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:

3. **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/Not sure ☐Declined to answer
   Comments:

4. **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/Not sure ☐Declined to answer
   Comments:

5. **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)):

6. **Do you know who your regularly assigned healthcare 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 ☐Less than 6 months ☐6-12 months ☐More than 1 year ☐Not sure

7. **Do you have a provider for women's health**? ☐Yes ☐No ☐N/A
   Provider name/clinic/phone #:

8. **Have you had a dental visit in the past 12 months?** ☐Yes ☐No ☐Not sure ☐Declined to answer
   Dentist name/phone #:

9. **Do you have any problems eating (for example, appetite, chewing or swallowing)?**
   Comments:

Section 3. Physical Health, continued

10. Have you been told by a doctor or 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
☐Seizures
☐Sickle Cell Disease
☐Transplant:_____
☐History of tuberculosis (TB)
☐Urinary problems

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

11. Do you have trouble with your vision? ☐Yes ☐No

If **yes**, describe:

12. If you have diabetes, have you had a Diabetic Eye Exam done in the last year? ☐Yes ☐No ☐N/A

13. Do you have trouble with your hearing? ☐Yes ☐No

If **yes**, describe:

Preventive Care

14. 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):

15. Do you have any questions or need support getting your vaccinations? ☐Yes ☐No

16. Have you had the following screenings/tests?

☐Colonoscopy (5 yrs) ☐Mammogram (2 yrs) ☐Pap smear (3-5 yrs) ☐Bone density
☐Blood sugar (HbA1C, 12 months) ☐Kidney function/date:_____ ☐Eye exam/date:_____

Section 4. Medications

1. Please tell me what medications (including birth control, over-the-counter medications, vitamins, etc.) **you are currently taking.** *If more space is needed, please 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 (e.g., medication for diabetes, high blood pressure)*

Medication Name	How Often (Frequency)	How Administered (Route)	Dosage

Please attach list for additional medications.

Section 4. Medications, continued

2. Are you having any trouble getting or filling your medications? ☐Yes ☐No
If **yes**, comments:

3. 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:

4. Do you need help taking your medicines? ☐Yes ☐No ☐N/A ☐Declined to answer

Section 5. Activities of Daily Living (ADLs)

1. Do you need help with any of these actions?

Taking a bath or shower ☐Yes ☐No Comments:	Going up the stairs ☐Yes ☐No Comments:
Eating ☐Yes ☐No Comments:	Getting Dressed ☐Yes ☐No Comments:
Brushing teeth, brushing hair, shaving ☐es ☐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 see your friends ☐Yes ☐No Comments:_____	Doing house or yard work ☐Yes ☐No Comments:
Going out to visit family or friends ☐Yes ☐No Comments:	Using the phone ☐Yes ☐No Comments:
Keeping track of appointments ☐Yes ☐No Comments:	

2. If yes to any of the above, are you getting all the help you need with these actions? ☐Yes ☐No
Comments:

3. Have you fallen in the last month? ☐Yes ☐No

4. Are you afraid of falling? ☐Yes ☐No
Comments:

5. Do friends or family members express concerns about your ability to care for yourself? ☐Yes ☐No
If yes, *consult with the clinical consultant and supervisor.*
Comments:

6. 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

Section 5. Activities of Daily Living (ADLs), continued

☐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

1. **Do you experience pain?** ☐Yes (answer below) ☐No ☐Declined to answer
2. **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 section *(e.g., not of child-bearing age, etc.)*** *(continue to Section 8)*

1. **Are you currently pregnant?**
   ☐Yes ☐No ☐Declined to answer
   Comments:
2. **Have you given birth in the last 12 months?** *Includes live or stillbirth delivery; miscarriage (SAB - spontaneous abortion); or an abortion induced for medical reasons (TAB - therapeutic abortion).*
   ☐Yes ☐No ☐Declined to answer
   Comments:
3. **Are you planning to become pregnant?** ☐Yes ☐No ☐Not sure ☐Declined to answer
   Comments:

If yes to currently pregnant, the following questions must be completed. ☐N/A

4. **How many months pregnant are you?** _____ ☐Not sure ☐Declined to answer
5. **Due Date:** _____ ☐Not sure ☐Declined to answer
6. **Have you been told you are carrying more than one baby?** ☐No ☐Yes ☐Not sure ☐Declined to answer
7. **Do you have the following plans for pregnancy and labor and delivery?**
   A. Birth plan: ☐Have ☐Don't have, but want ☐Don't have and don't want
   B. Delivery wishes: ☐Vaginal ☐Natural (unmedicated/no epidural) ☐C-Section ☐Vaginal birth after C-Section (VBAC)
   C. Delivery location: _____
   D. Birthing classes: ☐Have ☐Don't have, but want ☐Don't have and don't want
   E. Labor support person(s) (including doulas): ☐Have ☐Don't have, but want ☐Don't have and don't want
      If have, list:_____
   F. Going into labor: When to call someone and/or go to your birthing location:
      ☐I know what to do ☐I need help with this
   G. Goals/plan for transportation to the hospital: ☐Have ☐Don't have, but want ☐Don't have and don't want
   H. Childcare goal/plans for other kids: ☐Have ☐Don't have, but want ☐Don't have and don't want ☐ N/A
   I. 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
** Includes live or stillbirth delivery; miscarriage (SAB - spontaneous abortion); or an abortion induced for medical reasons (TAB - therapeutic abortion)*

Section 7. Pregnancy/Postpartum, continued

8. Did you have any issues with delivery? ☐Yes ☐No ☐Declined to answer
Comments:

9. Does your baby (babies) have any special health care needs?
☐Yes* ☐No ☐Unsure ☐N/A (e.g. stillbirth, SAB, TAB)
Comments:

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

*Note: consider needed connections for baby, such as California Children's Services or Enhanced Care Management services.

11. What are you enjoying most about your new baby? _____

12. What is most challenging? _____
☐N/A ☐Declined to answer

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

14. Are you breastfeeding? ☐Yes ☐No ☐N/A ☐Declined to answer

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

16. 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 (*e.g., pregnancy resulted in still birth, SAB, or TAB, or only ask applicable questions)*

17. When was your most recent prenatal or postpartum appointment: _____
☐Not sure ☐Declined to answer ☐Have not gone to an appointment.
Include comments:

18. When is your next prenatal or postpartum appointment: _____
☐Not sure ☐Declined to answer ☐No appointment scheduled

19. Has the doctor told you that there are health issues that need follow up? ☐Yes ☐No ☐Not sure
If **yes**, do you need support in following up with those issues? ☐Yes ☐No ☐Not sure
Comments:

20. 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.

21. 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 ☐Not sure ☐Declined to answer

22. 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)

Section 7. Pregnancy/Postpartum, continued

☐Car seat
☐Finding childcare or assistance paying for childcare
☐Other:
☐Declined to answer

23. Do you have a doctor for your baby? ☐Yes ☐No ☐N/A ☐Declined to answer
If **yes**, provider name/phone #:

24. When (day and or month) did you most recently take your baby to the doctor? _____
☐Not sure ☐N/A ☐Declined to answer

25. Has the doctor told you that there are health issues with your baby that need follow up?
☐Yes ☐No ☐Not sure
If **yes**, do you need support in following up with any of those issues? ☐Yes ☐No ☐Not sure

26. Do you have a dentist for your baby? ☐Yes ☐No ☐N/A *(no teeth present and less than age 1)*
☐Declined to answer
If **yes**, provider name/phone #:
Date of last visit (if known, or an approximate date):

27. Edinburgh Postnatal Depression Scale (EPDS) Screener
☐Declined to complete (and reason, if provided):_____

- **Have Member self-complete** the screener here: https://www.mcpapformoms.org/Docs/EdinbPostDepScale%20english%20no%20numbers.pdf. The member should complete the scale themself, unless they have limited English or have difficulty with 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.

Section 8. Behavioral Health

Mental Health History

1. 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, what diagnosis have you been given: ☐Depression ☐Bipolar Disorder ☐Schizophrenia ☐Anxiety ☐PTSD ☐Other(s): _____ ☐Declined to answer
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:

Section 8. Behavioral Health, continued

2. Can you provide the contact information of your current or past mental health provider?
Provider name:_____Contact number:_____

3. 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 #1, #2, and #9
☐Not completed because the EPDS was completed above.

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

a. Little interest or pleasure in doing things?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

b. Feeling down, depressed or hopeless?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

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

If "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]

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

a. Feeling nervous, anxious, or on edge?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

b. Not being able to stop or control worrying?
☐Not at all ☐Several days ☐More than half the days ☐Nearly every day

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

Trauma and Stressors

6. 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 (e.g., referral behavioral health professional, support groups, coping skills, etc.)?
☐Yes ☐No ☐Declined to answer
Comments:

Cognitive Functioning

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

8. 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 Use

☐**Member declined to complete this section.**
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.

Section 9. Substance Use, continued

1. In the past 6 months, how often have you used the following:	Never	1-2 times	Monthly	Weekly	Daily
A. Alcohol	☐	☐	☐	☐	☐
B. Nicotine products (cigarettes, vaping, chewing tobacco)	☐	☐	☐	☐	☐
C. Using Prescription drugs not as prescribed (circle any relevant): pain medicines, ADHD medicines, sleeping pills, other:	☐	☐	☐	☐	☐
D. Marijuana or products with Tetrahydrocannabinol (THC)	☐	☐	☐	☐	☐
E. Other substances: For example, cocaine, meth, heroin, hallucinogens, inhalants, designer drugs	☐	☐	☐	☐	☐

2. **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.

3. **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

4. **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 (e.g., residential treatment, outpatient treatment, or Medication Assisted Treatment, such as Vivitrol, Suboxone, Naltrexone, Methadone, Subutex, etc.):
   - Can you provide the contact information of where you are/were receiving treatment?
     Provider name:
     Contact number:
   - ☐Currently receiving treatment ☐Previously received treatment

5. **Please share any additional information about your past substance use (e.g., longer than the past 6 months, family history):**

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

6. **Additional Comments:**

Section 10. Developmental Factors

Ask the following question only if this information is not already available to the ECM Provider Team.

1. **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

1. **Do you need help filling out health forms?** ☐ Yes ☐ No ☐ N/A ☐ Declined to answer
2. **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

1. **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:

2. **Are you worried about losing your housing?** ☐Yes ☐No ☐Declined to answer
   If **yes**, please explain:

3. **What concerns you the most about your housing situation?**

4. **Is anyone currently helping you with your housing support (for example, Housing Navigator, case management, or tenants' rights)?** ☐Yes ☐No ☐N/A

5. **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

6. **Do you feel physically and emotionally safe where you currently live?** ☐Yes ☐No*
   If **no**, please describe:
   *If no, consult with the clinical consultant and supervisor.

7. Is anyone staying in your home without your permission? ☐Yes* ☐No
   If **yes**, please explain:
   *If yes, consult with the clinical consultant and supervisor.

8. Are you afraid of anyone or is anyone hurting you? ☐Yes* ☐No
   If **yes**, please explain:
   *If yes, consult with the clinical consultant and supervisor.

9. Is anyone using your money without your OK? ☐Yes* ☐No
   If **yes**, please explain:
   *If yes, consult with the clinical consultant and supervisor.

Food Security

10. **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

11. **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

12. **Do you eat less than you feel you should because there is not enough food?**
    ☐Yes ☐No ☐Declined to answer

13. **Comments:**

Section 12. Social Determinants of Health (SDoH), continued

Social Connection/Support

14. 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/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

15. Do you have any children not already listed above (including ages)?

16. 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

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

If **yes**, describe:

Family Member/Individual Supports (Including Caregiver Resources and Involvement)

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

☐Yes ☐No ☐Declined to answer

Comments:

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

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

20. 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:

21. Do you have an In-Home Supportive Services (IHSS) worker? ☐Yes ☐No ☐Declined to answer

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

IHSS worker name:_____ Contact number:_____

22. Additional Comments:

Section 13. Benefits and Other Services

1. 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

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

☐Yes ☐No ☐Declined to answer

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

Unpredictable (e.g., day labor) ☐Yes ☐No

4. Are there any concerns or challenges with your job? ☐Yes ☐No ☐Declined to answer

If yes, describe:

Section 13. Benefits and Other Services, continued

5. 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
☐Others:_____☐None

Section 14. Legal Involvement

1. 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:

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

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

If **yes**, "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?"

4. 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.

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

2. Do you have an authorized representative to speak on your behalf about issues?

☐Yes ☐No ☐Declined to answer

If **yes**, provide name and relationship:

3. Do you want information on these topics? ☐Yes ☐No ☐Declined to answer

Section 16. Member Priorities

1. What concerns you most about your physical or mental health?

2. What is one thing you would like to do right now to improve your health (such as cutting back on caffeinated or sugary drinks)? P*rovide easy, harm reduction examples:*

3. What would you like to achieve from our work and time together?

4. From our meeting today what comes to mind as your top 2-3 goals for your health, wellness and social and/or living situation for the next 3-6 months?

   Goal 1:

   Goal 2:

   Goal 3:

Narrative Summary	
Include primary needs identified from the assessment:	
Next Steps	**Person Responsible**
1.	
2.	
3.	
Next appointment/location:	