



LA County 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 Yes. Date Completed: _____ No N/A

If no ACEs completed: refer to PCP/SW for screening.

Needs Evaluation Tool¹ 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		
1. Today's date:	2. Patient name:	
3. Date of Birth:	4. Medi-Cal ID:	5. Opt-in to ECM Date: _____ <input type="checkbox"/> Verbal <input type="checkbox"/> Written <input type="checkbox"/> N/A - Grandfathered from HHP/WPC
6. Population of Focus (As identified on the referral/authorization form): <input type="checkbox"/> Experiencing Homelessness <input type="checkbox"/> Homeless Families <input type="checkbox"/> At Risk for Avoidable Hospital or ED Utilization <input type="checkbox"/> Serious Mental Health and/or SUD Needs <input type="checkbox"/> Transitioning from Incarceration <input type="checkbox"/> Living in the Community who are at Risk for LTC Institutionalization <input type="checkbox"/> Nursing Facility Residents Transitioning to the Community <input type="checkbox"/> Birth Equity		
7. Is anyone else in the family enrolled in ECM? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Language:	
13. Nationality/tribe/ethnicity: (Select all that apply) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Other:		
14. Relationship status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic partnership <input type="checkbox"/> Widower <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined to Answer	15. Veteran/Discharged from the U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	
16. Home phone(s):	17. Cell phone(s):	18. Email Address(es):
19. Where would you like to receive mail? (include physical address and location type, e.g., home, friend's house, DPSS office, etc.)		20. Is in-person contact ok? <input type="checkbox"/> Yes <input type="checkbox"/> No (Reminder: ECM preferred contact is in-person) If No , what is your preferred method of contact? <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> 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 info, 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 ago
Less than 6 months ago 6-12 months ago More than 1 year ago 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's name/phone #:
9. **Do you have any problems eating (for example, appetite, chewing, or swallowing)?**
 Comments:
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/quadruplegic/amputation Recent fracture Seizures
Sickle Cell Disease Transplant: _____ History of TB Urinary problems
Other conditions not listed above (including a wound that needs care):

Section 3. Physical Health

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:

Preventative 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):

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

17. Have you had the following screenings/tests? Colonoscopy (5 yrs) Mammogram (2 yrs) Pap smear (3-5 yrs) Bone density Blood sugar (HbA1C, 12 month) 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.

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 <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	Going up the stairs <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:
Eating <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	Getting Dressed <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:
Brushing teeth, brushing hair, shaving <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	Making meals or cooking <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:

Section 5. Activities of Daily Living (ADLs)

Getting out of a bed or a chair <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	Shopping and getting food <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Using the toilet <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	Walking <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Washing dishes or clothes <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	Writing checks or keeping track of money <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Getting a ride to the doctor or to see your friends <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	Doing house or yard work <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Going out to visit family or friends <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:	Using the phone <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
Keeping track of appointments <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:			
2. If yes to any of the above, are you getting all the help you need with these actions? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:			
3. Have you fallen in the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Are you afraid of falling? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:			
5. Do friends or family members express concerns about your ability to care for yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, consult with the clinical consultant and supervisor.</i> Comments:			
6. Do you use or need any of the following? (Select all that apply)			
<input type="checkbox"/> Glasses <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Cane <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Walker <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Hearing device <input type="checkbox"/> Use <input type="checkbox"/> Need
<input type="checkbox"/> TTY (<i>visual support</i>) <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Crutches <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Grab bars <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Raised toilet seat/chair <input type="checkbox"/> Use <input type="checkbox"/> Need
<input type="checkbox"/> Feeding tube <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Food supplements <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Hospital bed <input type="checkbox"/> Use <input type="checkbox"/> Need
<input type="checkbox"/> Oxygen <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Ostomy supplies <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> CPAP/BiPAP <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Diabetes supplies <input type="checkbox"/> Use <input type="checkbox"/> Need
<input type="checkbox"/> Large print <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Sideboard <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Urinary catheter <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> IV infusions for meds <input type="checkbox"/> Use <input type="checkbox"/> Need
<input type="checkbox"/> Incontinence supplies <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Trach/suction supplies <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Lift device (<i>for transferring</i>) <input type="checkbox"/> Use <input type="checkbox"/> Need	<input type="checkbox"/> Other: <input type="checkbox"/> Use <input type="checkbox"/> Need
Comments:			

Section 6. Pain Management

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

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 CCS, or ECM 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:

Section 7. Pregnancy/Postpartum

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 needs 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)
- 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 needs 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 1 year of age)

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 themselves, unless they have limited English or has 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:

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

Name of Provider:

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 MH 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.

1. In the past 6 months, how often have you used the following:	Never	1-2 times	Monthly	Weekly	Daily
A. Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Nicotine Products (cigarettes, vaping, chewing tobacco)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Using Prescription drugs not as prescribed (circle any relevant): Pain medicines, ADHD medicines, Sleeping pills, Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Marijuana or products with THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Other substances: For example cocaine, meth, heroin, hallucinogens, inhalants, designer drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?

Name of Provider:

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:**

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 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

Section 12. Social Determinants of Health (SDoH)

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? _____
Name of IHSS worker:
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? Declined to Answer Part-time Full-time Student Retired
 Other: _____
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:

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:

Section 14. Legal Involvement

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

3. In the past year, have you spent more than 2 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? – *provide 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 Assessment:

Next Steps	Person Responsible
1.	
2.	
3.	

Next Appointment/Location: