Health Home	CNY
Care Management Agency	_____
Patient Name	_____
Gender	_____
Date of Birth	_____
Medicaid ID	_____
NYS ID	_____
Home Phone	_____
Cell Phone	_____
Other phone	_____
Primary address	_____
Other address	_____

IDENTIFIED RISK FACTORS

Identified risk Factors are not to be completed with the member. Please check all risk factors that the member currently has at time of enrollment and/or reassessment. **These questions are not meant to be asked to the member**, but identified via other records, third party sources and/or completing the Comprehensive Assessment. At least one risk factor must be present in order for the member to be enrolled in Health Home.

1. **Member has probable risk for adverse events (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)** *
   Select ONE option.
   a. Yes b. No

2. **If yes, provide details:** *
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select AT LEAST one option.
   a. Has various Quality flags in PSYCKES, such as “Preventable admissions for asthma” “Preventable admissions for Diabetes”, etc.
   b. Anyone with a HH+ flag in PSYCKES at the time of enrollment
   c. Anyone with a POP flag in PSYCKES at the time of enrollment
   d. Anyone with an H-code in EMEDNY at the time of enrollment (eligible or enrolled)
   e. Direct referral from an inpatient medical, psych, or detox admission
   f. Direct referral from ER also possible if member frequents the ER (this could be captured as a PSYCKES category)
   g. Direct referral from APS, CPS, or preventive program
   h. Direct referral from MCO or medical provider i. Other:

3. **Other:**
   Please answer if question 2 is answered with any of the following option(s): Other:

4. **Member has a lack of or inadequate social/family/housing support, or serious disruptions in family relationships; needs benefits; nutritional insufficiency** *
   Select ONE option.
   a. Yes b. No

5. **If yes, provide details:** *
   Please answer if question 4 is answered with any of the following option(s): Yes
   Select AT LEAST one option.
   a. Meeting one of the HUD definitions for homelessness (HUD 1, 2 and 4 housing)
   b. Lack of social supports as evidenced by fewer than 2 people identified as a support by the member, change in guardianship
   c. The institutionalization or nursing home placement of primary support member
   d. Needs assistance applying for/accessing benefits such as SNAP, SSI, etc.
   e. Unable to access food due to financial limitations or ability to shop or access food site, dietary restrictions, etc.
   f. Intimate Partner Violence g. Other:

6. **Other:**
   Please answer if question 5 is answered with any of the following option(s): Other:

7. **Member has a lack of or inadequate connectivity with healthcare system** *
   Select ONE option.
   a. Yes b. No

8. **If yes, provide details:** *
   Please answer if question 7 is answered with any of the following option(s): Yes
   Select AT LEAST one option.
   a. Individual does not have healthcare connectivity or utilization e.g., does not have a PCP or specialist to treat a chronic condition, or has not seen their provider in the last year.
   b. Individual is unable to appropriately navigate the health care system for the treatment or care of the diagnosed or undiagnosed physical or behavioral health condition.
   c. Potentially preventable utilization based on identified flags in the RHIO, from the Plan, or in PSYCKES (such as 2 or 3+ ED visits in the past year, 1 BH or substance use inpatient visit in the past year, etc.)
   d. Other:

9. **Other:**
   Please answer if question 8 is answered with any of the following option(s): Other:

10. **Member has non-adherence to treatments or medication(s) or difficulty managing medications (define source e.g. self-reported or other source with knowledge)** *
Select ONE option.
a. Yes b. No

11. **If yes, provide details:** *
Please answer if question 10 is answered with any of the following option(s): Yes
Select AT LEAST one option.
a. Identify which medication(s) and/or treatment(s) are involved per individual or referral source.
b. Per PSYCKES flag (e.g., Adherence to Mood Stabilizers, Antipsychotics, and Antidepressants; No Diabetes Monitoring)
c. Other:

12. **Medication(s)/treatment(s):**
Please answer if question 11 is answered with any of the following option(s): Identify which medication(s) and/or treatment(s) are involved per individual or referral source.

13. **Other**
Please answer if question 11 is answered with any of the following option(s): Other:

14. **Member has deficits in activities of daily living, learning or cognition issue (define source e.g., self-reported, reported by other, observed by HHCM, etc.) (This should not be the only risk factor)** *
Select ONE option.
a. Yes b. No

15. **If yes, provide details:** *
Please answer if question 14 is answered with any of the following option(s): Yes
Select AT LEAST one option.
a. Instrumental Activities of Daily Living (IADLs) include transportation, shopping, managing finances, meal preparation, housecleaning, home maintenance, communications, and managing medications
b. Deficits can be caused by medication side effects, social isolation, home environment, cognitive or mental decline (e.g. dementia), aging, Musculoskeletal, neurological, circulatory, sensory conditions, lack of Durable Medical Equipment (DME), hospitalization, or acute illnesses.
c. Other:

16. **If other, describe:**
Please answer if question 15 is answered with any of the following option(s): Other:

17. **Member has been recently released from incarceration, detention, psychiatric hospitalization or placement; other justice referrals for those not incarcerated** *
Select ONE option.
a. Yes b. No

18. **If yes, provide details:** *
Please answer if question 17 is answered with any of the following option(s): Yes
Select AT LEAST one option.
a. Released within the last 90-120 days
b. Identify name of institution, approximate date of release, or name of “other justice referral for those not incarcerated”

19. **Provide details:**
Please answer if question 18 is answered with any of the following option(s): Identify name of institution, approximate date of release, or name of “other justice referral for those not incarcerated”

20. **Risk Factor Assessment by Care Team, LGU, and/or MCO** *
Select ONE option.
a. Yes b. No

21. **If yes, please explain in detail reasons why member has been authorized by Care Team, LGU, and/or MCO to be initially enrolled or to stay enrolled for 1 more year.** *
Please answer if question 20 is answered with any of the following option(s): Yes

22. **Creation of Plan of Care. This section is an opportunity to make notes on goals related to the member's identified risk factors:**

PRE-ASSESSMENT

The intention of this section is to gather background information on the member.

1. **How do you wish to be referred to (name/pronoun):** *
Select AT LEAST one option.

a. Male/man b. Female/Woman c. Transgender Male/Man
d. Transgender Female/Woman e. Two Spirit f. Intersex g. Gender fluid
h. Gender Non-conforming i. Other:

2. **If other, please let us know your preference:**
Please answer if question 1 is answered with any of the following option(s): Other:

3. **Is there anything about your gender or sexuality that you would like to share?***
Select ONE option.
a. Yes b. No c. Refused to answer d. Unknown

4. **If yes, what would you like to share?***
Please answer if question 3 is answered with any of the following option(s): Yes

5. **What is your primary language?***

6. **Is there another language spoken in the home?***
Select ONE option.
a. Yes b. No c. Refused to answer

7. **If yes, what language?**
Please answer if question 6 is answered with any of the following option(s): Yes

8. **Do you need an interpreter for oral or written communication?**
Select ONE option.
a. Oral b. Written c. Both d. Neither e. Unknown f. Refused to answer

9. **What is your preference for interpreting services?**
Please answer if question 8 is answered with any of the following option(s): Oral, Written, Both

10. **Do you need assistance with completing forms/paperwork?***
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

11. **If yes, is there anyone in your support network (family or friends) that can assist in reviewing paperwork and filling out forms?***
Please answer if question 10 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

12. **Do you have any hearing or vision needs that need accommodation when meeting with providers?***
Select ONE option.

a. Yes b. No c. Unknown d. Refused to answer

13. **If yes, what accommodations do you need?**
Please answer if question 12 is answered with any of the following option(s): Yes

14. **Is there anything I should know about culture, beliefs or religious practices that would help me work with you?***
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

15. **If yes, what would you like to share?***
Please answer if question 14 is answered with any of the following option(s): Yes

16. **Is there anything else we should know about you or any preferences you have that will help me provide care management services?**

17. **Creation of Plan of Care. This section is an opportunity to make notes regarding any strengths, barriers or needed goals related to information that was gathered in the Pre-Assessment Section:**

SOCIAL DETERMINANTS OF HEALTH

1. **Within the past 12 months, were you worried that your food would run out before you were able to buy more?***
Select ONE option.
a. Often true b. Sometimes true c. Never true

2. **Within the past 12 months, the food you bought didn't last and you didn't have money to buy more***
Select ONE option.
a. Often true b. Sometimes true c. Never true

3. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?** *
   Select ONE option.
   a. Yes b. No c. Already shut off

4. **What is your living situation today?** *
   Select ONE option.
   a. I have a steady place to live
   b. I have a steady place to live today, but I am worried about losing it in the future
   c. I do not have a steady place to live (I am temporarily staying with other, in a hotel, in a shelter, living outside on the street, one a beach, in a car, abandoned building, bus or train station, or in a park)

5. **Are you worried that in the next 2 months, you may not have stable housing?** *
   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer

6. **Where do you live now?** *
   Select ONE option.
   a. Own my home b. Live in friend or relative's home/apartment
   c. Rent my home/apartment d. Supportive housing e. Shelter
   f. Street homeless g. Other h. Unknown i. Refused to answer

7. **If other, explain:**
   Please answer if question 6 is answered with any of the following option(s): Other

8. **Do you need help with your housing situation?** *
   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer

9. **Have you ever been evicted or homeless in the past?** *
   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer

10. **Think about the place you live. Do you have problems with any of the following? (Choose all that apply)** *
    Select AT LEAST one option.
    a. Pests such as bugs, ants, or mice b. Mold c. Lead paint or pipes
    d. Lack of heat e. Oven or stove not working
    f. Smoke detectors missing or not working g. Water Leaks h. None of the above

11. **Do problems getting child care make it difficult for you to work, study or attend appointments?** *
    Select ONE option.
    a. Yes b. No c. Unknown d. Refused to answer

12. **In the last 12 months, have you needed to see a doctor, but could not because of cost?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

13. **Do you currently have any issues related to transportation?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

14. **In the past 12 months, has a lack of reliable transportation kept you from attending medical appointments, meetings, work or from getting things needed for daily living?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

15. **Do you ever need help reading or understanding materials that you get from your doctor or other health care providers?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

16. **Is there anything that we just discussed related to your living situation or ability to pay bills that you would like to add to your Plan of Care?** *
Select ONE option.
a. Yes b. No c. Unsure d. Refused to answer

17. **If yes, describe:**
Please answer if question 16 is answered with any of the following option(s): Yes

18. **Is there anything that you would like to add to your Plan of Care regarding understanding your treatment and information you receive from your treatment providers?** *
Select ONE option.
a. Yes b. No c. Unsure d. Refused to answer

19. **If yes, describe:**
Please answer if question 18 is answered with any of the following option(s): Yes

20. **Is there anything we discussed regarding access to food, transportation, treatment and childcare that you would like to add to your Plan of Care?** *
Select ONE option.
a. Yes b. No c. Unsure d. Refused to answer

21. **If yes, describe:**
Please answer if question 20 is answered with any of the following option(s): Yes

SAFETY

Because violence and abuse happens to a lot of people and affects their health, we are asking everyone the following questions:

1. **Are you afraid you might be hurt by another person in your apartment building, house, life, or community?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

2. **If yes, I acknowledge that I need to develop a safety plan with the member and report to a supervisor. The Safety Plan is located in the Assessment Section.**
Please answer if question 1 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes
b. Member is refusing to develop a Safety Plan at this time. CM acknowledges that they need to discuss this again with the member.

3. **How often does anyone, including family and friends, physically hurt you?** *
Select ONE option.
a. Never b. Rarely c. Sometimes d. Fairly often e. Frequently

4. **How often does anyone, including family and friends, insult or talk down to you?** *
Select ONE option.
a. Never b. Rarely c. Sometimes d. Fairly often e. Frequently

5. **How often does anyone, including family and friends, threaten you with harm?** *
Select ONE option.
a. Never b. Rarely c. Sometimes d. Fairly often e. Frequently

6. **How often does anyone, including family and friends, scream or curse at you?** *
   Select ONE option.
   a. Never b. Rarely c. Sometimes d. Fairly often e. Frequently

7. **Are there any other situations at home that make it hard for you to take care of yourself?** *
   Select ONE option.
   a. Yes b. No

8. **If yes, specify:**
   Please answer if question 7 is answered with any of the following option(s): Yes

9. **Is there anything regarding safety concerns that you have that you would like to add to your Plan of Care?** *
   Select ONE option.
   a. Yes b. No c. Unsure d. Refused to answer

10. **If yes, describe:**
    Please answer if question 9 is answered with any of the following option(s): Yes

BENEFITS

1. **Do you receive any of the following benefits or subsidies?** *
   Select AT LEAST one option.
   a. SNAP b. PA/HASA/SSI/SSDI c. Section 8 d. FEPS e. MRT
   f. None g. Unknown h. Refused to answer i. Other

2. **If other, describe:**
   Please answer if question 1 is answered with any of the following option(s): Other

3. **Do you need help getting any of the following benefits or subsidies?** *
   Select AT LEAST one option.
   a. SNAP b. PA/HASA/SSI/SSDI c. Section 8 d. FEPS e. MRT
   f. None g. Unknown h. Refused to answer i. Other

4. **If other, describe:**
   Please answer if question 3 is answered with any of the following option(s): Other

5. **Do you want to add a goal regarding benefits to your Plan of Care?** *
   Please answer if question 3 is answered with any of the following option(s): SNAP, PA/HASA/SSI/SSDI, Section 8, FEPS, MRT
   Select ONE option.
   a. Yes b. No c. Unsure d. Refused to answer

6. **If yes, describe:**
   Please answer if question 5 is answered with any of the following option(s): Yes

MEDICAL

1. **Do you have any medical conditions/concerns/diagnoses?** *
   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer

2. **If yes, what are your conditions/concerns/diagnoses?** *
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select AT LEAST one option.
   a. Alcohol Addiction b. Drug Addiction c. Opioid Addiction
   d. Other Addiction e. Advanced Coronary Artery Disease
   f. Alcohol and Liver Disease g. Asthma h. Cerebrovascular Disease
   i. Chronic Alcohol Abuse j. Chronic Obstructive Pulmonary Disease
   k. Chronic Renal Failure l. Cocaine Abuse m. Congestive Heart Failure
   n. Diabetes o. Drug Abuse - Cannabis/NOS/NEC p. Hepatitis C q. HIV/AIDS
   r. Hypertension s. Kidney/Renal Disease t. Nicotine Dependence
   u. Obesity v. Opioid Abuse w. Other Significant Drug Abuse
   x. Peripheral Vascular Disease y. Unknown z. Refused to answer aa. Other

3. **If other, please specify:**
   Please answer if question 2 is answered with any of the following option(s): Other Addiction, Other Significant Drug Abuse, Other

4. **Have you been to the emergency room or admitted to the hospital in the past year?** *
   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer

5. **If yes, how many times in the past year have you been to the ER?** *
   Please answer if question 4 is answered with any of the following option(s): Yes

6. **If yes, how many times in the past year have you been admitted to the hospital?** *
   Please answer if question 4 is answered with any of the following option(s): Yes

7. **Do you have a primary care doctor?** *
   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer

8. **Who is your primary care doctor?**
   Please answer if question 7 is answered with any of the following option(s): Yes

9. **Can I add your primary care doctor to your consent and Care Team on your Plan of Care?**
   Please answer if question 7 is answered with any of the following option(s): Yes
   Select ONE option.
   a. Yes b. No c. Unsure at this time

10. **Do you want to add a goal to your Plan of Care regarding connecting to a primary care provider?***
    Please answer if question 7 is answered with any of the following option(s): No, Unknown
    Select ONE option.
    a. Yes b. No c. Unsure d. Refused to answer

11. **If yes, have you had an annual physical in the last 12 months?***
    Please answer if question 7 is answered with any of the following option(s): Yes
    Select ONE option.
    a. Yes b. No c. Unknown d. Refused to answer

12. **If yes, when?**
    Please answer if question 11 is answered with any of the following option(s): Yes
    __/__/____

13. **Do you see any medical specialists?***
    Select ONE option.
    a. Yes b. No c. Unknown d. Refused to answer

14. **Name(s) of medical specialist(s) and what condition you are being treated for:***
    Please answer if question 13 is answered with any of the following option(s): Yes

15. **Can I add your specialists) to your consent and the Care Team on your Plan of Care?** *
Please answer if question 13 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Unsure at this time d. I don't have providers at this time

16. **Do you need assistance with a referral to a medical specialist for any conditions that you have?** *
Please answer if question 13 is answered with any of the following option(s): No, Unknown
Select ONE option.
a. Yes b. No c. Unsure at this time

17. **Do you understand the directions that the doctor or medical specialist gave you?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer
e. I do not have a doctor at this time

18. **If no, would you like help following up with your doctor or medical specialist to understand the directions given to you by your doctor?** *
Please answer if question 17 is answered with any of the following option(s): No
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

19. **Are you following the directions the doctor or medical specialist gave you?**
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

20. **Are you already linked to support services for your condition(s)?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

21. **If yes, what services?** *
Please answer if question 20 is answered with any of the following option(s): Yes

22. **If no, do you need help to better understand your condition(s)?** *
Please answer if question 20 is answered with any of the following option(s): No
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

23. **Do you need help to be linked to supports for your condition(s)?** *
Please answer if question 22 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

24. **Are any of your medical issues bothering you especially/more than usual right now?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

25. **If yes, please specify:**
Please answer if question 24 is answered with any of the following option(s): Yes

26. **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?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

27. **Would you be willing to share copies of the designation of a health care proxy and/or these advanced directives such as living wills, feeding tube, MOLST (medical orders for life-sustaining treatment) or resuscitation?**
Please answer if question 26 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

28. **If “yes”, remember to discuss proxy and/or other advanced directives with member, upload appropriate documents to External Documents, and update care team and consent form**
Please answer if question 26 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes

29. **If no, is this something you would like to learn more about or put in place?** *
Please answer if question 26 is answered with any of the following option(s): No
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

30. **If yes, make a referral to services.**
Please answer if question 29 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes

31. **Is there anything related to your medical condition(s) that you would like to add to your Plan of Care (i.e. linking to PCP/specialist/support; supports for diagnosis; Advance Directives; physical within 12 months; etc.)?** *
Select ONE option.
a. Yes b. No c. Unsure at this time d. Refused to answer

32. **If yes, describe:**
Please answer if question 31 is answered with any of the following option(s): Yes

HIV STATUS

1. **Have you been tested for HIV/AIDS?***
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

2. **Are you diagnosed as HIV+ or do you have AIDS?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

3. **What is your CD4 Count?** *
Please answer if question 2 is answered with any of the following option(s): Yes

4. **What is your Viral Count?** *
Please answer if question 2 is answered with any of the following option(s): Yes

5. **Do you understand the meaning of viral load and T-cell count and how to read lab results?***
Please answer if question 2 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

6. **Do you need additional resources related to your HIV status?**
Please answer if question 2 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

7. **What doctor do you see regarding your HIV/AIDS?***
Please answer if question 2 is answered with any of the following option(s): Yes

8. **Can I add your provider to the consent form and to the Care Team in the POC?***
Please answer if question 7 is answered

Select ONE option.
a. Yes b. No c. Refused to answer

9. **Do you regularly follow-up with your doctor regarding your HIV/AIDS?** *
Please answer if question 7 is answered
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

10. **Do you have a history of sexually transmitted infections (STIs)?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

11. **Do you need think you need to be tested for HIV or STIs?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

12. **If yes, do you need additional information on testing?** *
Please answer if question 11 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

13. **Is there anything regarding HIV or STI needs that you would like to add to your Plan of Care?** *
Select ONE option.
a. Yes b. No c. Unsure at this time d. Refused to answer

14. **If yes, describe:**
Please answer if question 13 is answered with any of the following option(s): Yes

BEHAVIORAL HEALTH

1. **Do you have any behavioral/psychiatric conditions/ concerns/diagnoses?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

2. **What are your mental health/behavioral/psychiatric conditions/ concerns/diagnoses?** *
Please answer if question 1 is answered with any of the following option(s): Yes
Select AT LEAST one option.

a. Anxiety Disorder b. Bi-Polar Disorder
c. Conduct, Impulse control, and Other Disruptive Behavior Disorders
d. Dementing Disease e. Major Depressive Disorder f. Psychoses
g. Eating Disorders h. Major Personality Disorders
i. Post-Traumatic Stress Disorder (PTSD)
j. Psychiatric Disease (Except Schizophrenia) k. Schizoaffective Disorder
l. Schizoaffective Disorder m. Other n. Unknown o. Refused to answer

3. **If other, describe:**
Please answer if question 2 is answered with any of the following option(s): Other

4. **Have you been to the emergency room or admitted to the hospital in the past year?***
Please answer if question 1 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

5. **If yes, how many times in the past year have you been to the ER for mental health issues?**
Please answer if question 4 is answered with any of the following option(s): Yes

6. **If yes, how many times in the past year have you been admitted to the hospital?**
Please answer if question 4 is answered with any of the following option(s): Yes

7. **Do you have a psychiatrist (or psychiatric nurse practitioner)?***
Please answer if question 1 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

8. **Can I add your psychiatrist/nurse practitioner to your consent and Care Team on your Plan of Care?***
Please answer if question 7 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Unsure at this time d. Refused to answer

9. **Do you currently see a therapist or counselor?***
Please answer if question 1 is answered with any of the following option(s): Yes
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

10. **Can I add your therapist to your consent and Care Team on your Plan of Care?***
Please answer if question 9 is answered with any of the following option(s): Yes
Select ONE option.

a. Yes b. No c. Unsure at this time d. Refused to answer

11. **Are you linked to support services for your condition(s)?** *
Please answer if question 1 is answered with any of the following option(s): Yes
Select AT LEAST one option.
a. Yes – HARP HCBS Services b. Yes - CORE Services c. Yes - Other d. No
e. Unknown f. Refused to answer

12. **If yes, specify:**
Please answer if question 11 is answered with any of the following option(s): Yes – HARP HCBS Services

13. **If yes, specify:**
Please answer if question 11 is answered with any of the following option(s): Yes - CORE Services

14. **If other, describe:**
Please answer if question 11 is answered with any of the following option(s): Yes - Other

15. **Can I add your support services to your consent and Care Team on your Plan of Care?** *
Please answer if question 11 is answered with any of the following option(s): Yes – HARP HCBS Services , Yes - CORE Services, Yes - Other
Select ONE option.
a. Yes b. No c. Unsure at this time d. Refused to answer

16. **If no, do you need help to be linked to supports for your condition(s)?**
Please answer if question 11 is answered with any of the following option(s): No
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

17. **Have you ever attempted suicide?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

18. **If yes, when was the most recent attempt?** *
Please answer if question 17 is answered with any of the following option(s): Yes
Select ONE option.
a. Less than a month ago b. Within the past year c. More than one year ago
d. Unknown e. Refused to answer

19. **What are your triggers; how do you know when you are upset? What people, places, things upset you?** *
Please answer if question 1 is answered with any of the following option(s): Yes

20. **When you are upset, what activities can you do to feel better? e.g. take a walk, listen to music, watch TV?***
Please answer if question 1 is answered with any of the following option(s): Yes

21. **Is there anything regarding your mental health that you would like to add to your Plan of Care?***
Select ONE option.
a. Yes b. No c. Unsure at this time d. Refused to answer

22. **If yes, describe:**
Please answer if question 21 is answered with any of the following option(s): Yes

PHQ-9

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

Scoring: Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all (#) _____ x 0 = _____

Several days (#) _____ x 1 = _____

More than half the days (#) _____ x 2 = _____

Nearly every day (#) _____ x 3 = _____

Total score: _____

Interpreting PHQ-9 Scores

Diagnosis	Total Score	For Score	Action
Minimal depression	0-4	≤ 4	The score suggests the patient may not need depression treatment
Mild depression Moderate depression	5-9 10-14	5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression Severe depression	15-19 20-27	> 14	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

1. **Little interest or pleasure in doing things** *
   Select ONE option.
   a. Not at all b. Several days c. More than half the days d. Nearly every day
2. **Feeling down, depressed, or hopeless** *
   Select ONE option.
   a. Not at all b. Several days c. More than half the days d. Nearly every day
3. **Trouble falling asleep or staying asleep, or sleeping too much** *
   Select ONE option.
   a. Not at all b. Several days c. More than half the days d. Nearly every day
4. **Feeling tired or having little energy** *
   Select ONE option.
   a. Not at all b. Several days c. More than half the days d. Nearly every day
5. **Poor appetite or overeating** *
   Select ONE option.
   a. Not at all b. Several days c. More than half the days d. Nearly every day
6. **Feeling bad about yourself – or that you are a failure or have let yourself or your family down** *
   Select ONE option.
   a. Not at all b. Several days c. More than half the days d. Nearly every day
7. **Trouble concentrating on things, such as reading the newspaper or watching television** *
   Select ONE option.
   a. Not at all b. Several days c. More than half the days d. Nearly every day
8. **Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual** *
   Select ONE option.
   a. Not at all b. Several days c. More than half the days d. Nearly every day

9. **Thoughts that you would be better off dead or of hurting yourself in some way***
   Select ONE option.
   a. Not at all b. Several days c. More than half the days d. Nearly every day

10. **If you marked 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?***
    Select ONE option.
    a. Not at all b. Somewhat difficult c. Very difficult d. Extremely difficult

11. **Based on the scoring guide above, does the member require follow up for depressive symptoms?***
    Select ONE option.
    a. Yes b. No

MEDICATIONS

1. **Do you take any medications for your medical or mental health/psychiatric/behavioral health diagnoses?***
   Select ONE option.
   a. Yes, for medical conditions only b. Yes, for behavioral health conditions only
   c. Yes, for both medical and behavioral health conditions d. No e. Unknown
   f. Refused to answer

2. **Do you understand the purpose of the medications that have been prescribed to you?***
   Please answer if question 1 is answered with any of the following option(s): Yes, for medical conditions only, Yes, for behavioral health conditions only, Yes, for both medical and behavioral health conditions

   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer

3. **Do you ever have problems taking or remembering to take your medications?***
   Please answer if question 1 is answered with any of the following option(s): Yes, for medical conditions only, Yes, for behavioral health conditions only, Yes, for both medical and behavioral health conditions

   Select ONE option.
   a. Yes, for medical conditions only b. Yes, for behavioral health conditions only
   c. Yes, for both medical and behavioral health conditions d. No e. Unknown
   f. Refused to answer

4. **Do you ever have trouble getting or paying for your medications from the pharmacy?***
   Please answer if question 1 is answered with any of the following option(s): Yes, for medical conditions only, Yes, for behavioral health conditions only, Yes, for both medical and behavioral health conditions

Select ONE option.

a. Yes, for medical conditions only b. Yes, for behavioral health conditions only
c. Yes, for both medical and behavioral health conditions d. No e. Unknown
f. Refused to answer

5. **If yes, list of medications needs to be collected and entered into the Plan of Care** *
Please answer if question 1 is answered with any of the following option(s): Yes, for medical conditions only, Yes, for behavioral health conditions only, Yes, for both medical and behavioral health conditions

Select ONE option.

a. I acknowledge I need to complete this

6. **Is there anything that you would like to add to your Plan of Care regarding medications?** *
Select ONE option.

a. Yes b. No c. Unsure at this time d. Refused to answer

7. **If yes, describe:** *
Please answer if question 6 is answered with any of the following option(s): Yes

TRAUMA

1. **In your life, have you ever had any experience that was so frightening, horrible, or upsetting that you have had nightmares/thoughts about it when you did not want to in the past month?** *
Select ONE option.

a. Yes b. No c. Unknown d. Refused to answer

2. **If yes, have you tried hard not to think about it or went out of your way to avoid situations that reminded you of it?**
Please answer if question 1 is answered with any of the following option(s): Yes

Select ONE option.

a. Yes b. No c. Unknown d. Refused to answer

3. **Have you felt constantly on guard, watchful, or easily startled?** *
Select ONE option.

a. Yes b. No c. Unknown d. Refused to answer

4. **Have you felt numb or detached from others or your surroundings?** *
   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer
5. **Have you had an experience like that ever in your life?**
   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer
6. **If yes, when did you last experience symptoms of distress related to that experience?**
   Please answer if question 5 is answered with any of the following option(s): Yes
   Select ONE option.
   a. In the past three months b. In the past six months c. In the past year
   d. More than a year ago e. Unknown f. Refused to answer
7. **Is there anything that we just discussed that you would like to add to your Plan of Care?**
   Select ONE option.
   a. Yes b. No c. Unsure at this time d. Refused to answer
8. **If yes, describe:**
   Please answer if question 7 is answered with any of the following option(s): Yes

DAST-10

These questions refer to the past 12 months. **Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.**

Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

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

10. **Have you had medical problems as a result of your drug use (ex. memory loss, hepatitis, convulsions, bleeding)?** *
    Select ONE option.
    a. Yes b. No

11. **Based on the scoring guide above, does the member require follow up for drug use?** *
    Select ONE option.
    a. Yes b. No

SUBSTANCE USE

1. **If you answered yes to any of the above questions, what types of substances are you using?** *

2. **Do you or have you ever used needles to inject non-prescribed drugs?** *
    Select ONE option.
    a. Yes b. No

3. **If yes, have you ever shared a needle?** *
    Please answer if question 2 is answered with any of the following option(s): Yes
    Select ONE option.
    a. Yes b. No

4. **If yes, have you been tested for Hepatitis C and/or HIV?** *
    Please answer if question 3 is answered with any of the following option(s): Yes
    Select ONE option.
    a. Yes b. No

AUDIT-C TOOL

The AUDIT-C is scored on a scale of 0-12 points (scores of 0 reflect no alcohol use in the past year). In men, a score of 4 points or more is considered positive for alcohol misuse; in women, a score of 3 points or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety. The scores are represented in each answer. Add all of the scores together in order to determine if the tool is positive.

1. **How often do you have a drink containing alcohol?** *
    Select ONE option.
    a. (0) Never b. (1) Monthly or less c. (2) 2-4 times a month
    d. (3) 2-3 times a week e. (4) 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?***
   Select ONE option.
   a. (0) 1 or 2 b. (1) 3 or 4 c. (2) 5 or 6 d. (3) 7, 8 or 9 e. (4) 10 or more

3. **How often do you have six or more drinks on one occasion?***
   Select ONE option.
   a. (0) Never b. (1) Less than monthly c. (2) Monthly d. (3) Weekly
   e. (4) Daily or almost daily

4. **Based on the scoring above, does the member require follow up for alcohol misuse?***
   Select ONE option.
   a. Yes b. No

SUBSTANCE USE SECTION 2

1. **Were the results of either the DAST-10 or AUDIT-C positive?***
   Select ONE option.
   a. Yes b. No

2. **Do your substance use/dependence issues affect your daily living?***
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer

3. **Have you ever been in a hospital for medical issues related to your drug or alcohol use?***
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer

4. **If yes, when?***
   Please answer if question 3 is answered with any of the following option(s): Yes
   __/__/____

5. **Are you currently involved in a recovery program or an outpatient treatment program specifically related to drug or alcohol use?***
   Please answer if question 1 is answered with any of the following option(s): Yes
   Select AT LEAST one option.
   a. Yes, methadone treatment – methadone clinic
   b. Yes, outpatient services – outpatient clinic
   c. Yes, outpatient services – intensive outpatient treatment d. No e. Unknown
   f. Refused to answer g. Other

6. **If yes, who?** *
   Please answer if question 5 is answered with any of the following option(s): Yes, methadone treatment – methadone clinic, Yes, outpatient services – outpatient clinic, Yes, outpatient services – intensive outpatient treatment, Other

7. **Can I add your treatment provider to your consent and Care Team on your Plan of Care?***
   Please answer if question 5 is answered with any of the following option(s): Yes, methadone treatment – methadone clinic, Yes, outpatient services – outpatient clinic, Yes, outpatient services – intensive outpatient treatment, Other

   Select ONE option.
   a. Yes b. No

8. **Do you need help to connect to a treatment program?***
   Please answer if question 5 is answered with any of the following option(s): No

   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer
   e. NA - Member denies using substances and DAST and AUDIT-C were not positive

9. **Do you need additional resources to address your substance use concerns?***
   Please answer if question 1 is answered with any of the following option(s): Yes

   Select ONE option.
   a. Yes b. No c. Unknown d. Refused to answer

10. **Have you, in the past, been treated for problems related to drug or alcohol use?***
    Select AT LEAST one option.
    a. Yes, crisis services – medically supervised withdrawal (detox) – inpatient
    b. Yes, inpatient treatment services (30-day rehab)
    c. Yes, methadone treatment – methadone clinic
    d. Yes, outpatient services – outpatient clinic
    e. Yes, outpatient services, outpatient rehabilitation
    f. Yes, Peer Recovery Program (Peers, Recovery Center self/mutual help groups, Alcoholics Anonymous)
    g. No h. Unknown i. Refused to answer

11. **Do you smoke cigarettes or use other tobacco products?***
    Select ONE option.
    a. Yes b. No c. Unknown d. Refused to answer

12. **If yes, would you like information about, or a referral for, smoking cessation?***
    Please answer if question 11 is answered with any of the following option(s): Yes

    Select ONE option.
    a. Yes b. No c. Unknown d. Refused to answer

13. **Would you like to add anything to your Plan of Care regarding substance use?***
Select ONE option.
a. Yes b. No c. Unsure at this time d. Refused to answer

14. **If yes, describe:**
Please answer if question 13 is answered with any of the following option(s): Yes

JUSTICE

1. **In the last 12 months, have you had any interactions with the police or law enforcement?***
Select ONE option.
a. Yes, once b. Yes, more than once c. No d. Unknown e. Refused to answer

2. **If yes, what was the most recent date?***
Please answer if question 1 is answered with any of the following option(s): Yes, once, Yes, more than once
__/__/____

3. **Have you been detained by the police?***
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

4. **Have you been arrested?***
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

5. **Have you been incarcerated?***
Select ONE option.
a. Yes - Jail b. Yes - Prison c. No d. Unknown e. Refused to answer

6. **Have you been probation or parole?***
Select ONE option.
a. Yes - Probation b. Yes - Parole c. No d. Unknown e. Refused to answer

7. **If yes, are you currently on Probation or Parole?***
Please answer if question 6 is answered with any of the following option(s): Yes - Probation, Yes - Parole
Select ONE option.

a. Yes - Probation b. Yes - Parole

8. **What is the name and contact information of your Probation/Parole Officer?** *
Please answer if question 7 is answered with any of the following option(s): Yes - Probation, Yes - Parole

9. **Can I add your probation/parole officer to your consent and Care Team in your POC?** *
Please answer if question 7 is answered with any of the following option(s): Yes - Probation, Yes - Parole

Select ONE option.
a. Yes b. No

10. **Do you have an upcoming hearing or court date?**
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

11. **If yes, specify court type:**
Please answer if question 10 is answered with any of the following option(s): Yes

12. **If yes, date:**
Please answer if question 10 is answered with any of the following option(s): Yes

__/__/____

13. **Are you a registered sex offender?**
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

14. **If you needed help in an emergency, would you call the police?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

15. **Have you ever had a case open with ACS, CPS or APS?** *
Select ONE option.
a. Yes - in the past b. Yes - currently c. No d. Unknown e. Refused to answer

16. **If yes, specify agency/reason/contact information, if current:**
Please answer if question 15 is answered with any of the following option(s): Yes - in the past, Yes - currently

17. **Is there anything regarding legal matters/justice system that you would like to add to your Plan of Care?** *
Select ONE option.
a. Yes b. No c. Unsure at this time d. Refused to answer

18. **If yes, describe:**
Please answer if question 17 is answered with any of the following option(s): Yes

ACTIVITIES OF DAILY LIVING

1. **In the past 7 days, did you need help from others to perform every day activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?** *
Select AT LEAST one option.
a. Eating b. Getting dressed c. Grooming d. Bathing e. Walking
f. Using the toilet g. Other h. None i. Unknown j. Refused to answer

2. **If other, please specify:** *
Please answer if question 1 is answered with any of the following option(s): Other

3. **Who helped you with the tasks checked above? (If relevant, obtain contact information and update consent)** *
Please answer if question 1 is answered with any of the following option(s): Eating, Getting dressed, Grooming, Bathing, Walking, Using the toilet, Other
Select AT LEAST one option.
a. Relative b. Friend c. Neighbor d. Home Attendant e. No One
f. Other g. Unknown h. Refused to answer

4. **If other, please specify:**
Please answer if question 3 is answered with any of the following option(s): Other

5. **Contact Information:**
Please answer if question 3 is answered with any of the following option(s): Relative, Friend, Neighbor, Home Attendant, Other

6. **Do you need assistance in finding help to eat, get dressed, groom, bath, walk or use the toilet?** *
Select ONE option.
a. Yes b. No c. Unknown d. Refused to answer

7. **In the past 7 days, did you need help from others to take care of things such as**

laundry, and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?*

Select AT LEAST one option.

a. Laundry and housekeeping b. Shopping c. Banking
d. Using the telephone e. Food preparation f. Transportation
g. Taking your own medications h. Other i. None j. Unknown
k. Refused to answer

8. **If other, please specify:***

Please answer if question 7 is answered with any of the following option(s): Other

9. **Who helped you with the tasks checked above? (If relevant, obtain contact information and update consent)**

Please answer if question 7 is answered with any of the following option(s): Laundry and housekeeping, Shopping, Banking, Using the telephone, Food preparation, Transportation, Taking your own medications, Other

Select AT LEAST one option.

a. Relative b. Friend c. Neighbor d. Home Attendant e. No One
f. Other g. Unknown h. Refused to answer

10. **If other, please explain:**

Please answer if question 9 is answered with any of the following option(s): Other

11. **Contact Information:**

Please answer if question 9 is answered with any of the following option(s): Relative, Friend, Neighbor, Home Attendant, Other

12. **Is there anything regarding your ability to perform daily activities that you would like to add to your Plan of Care?***

Select ONE option.

a. Yes b. No c. Unsure at this time d. Refused to answer

13. **If yes, describe:**

Please answer if question 12 is answered with any of the following option(s): Yes

SOCIAL SUPPORT

In the past month, rate how often:

1. **I have someone who understands my problems** *
   Select ONE option.
   a. Never b. Rarely c. Sometimes d. Usually e. Always f. Unknown
   g. Refused to answer

2. **I have someone who will listen to me when I need to talk or if I am upset** *
   Select ONE option.
   a. Never b. Rarely c. Sometimes d. Usually e. Always f. Unknown
   g. Refused to answer

3. **I have someone to talk to when I have a bad day** *
   Select ONE option.
   a. Never b. Rarely c. Sometimes d. Usually e. Always f. Unknown
   g. Refused to answer

4. **I have someone I trust to talk with about my problems and feelings** *
   Select ONE option.
   a. Never b. Rarely c. Sometimes d. Usually e. Always f. Unknown
   g. Refused to answer

5. **I can get helpful advice when dealing with a problem** *
   Select ONE option.
   a. Never b. Rarely c. Sometimes d. Usually e. Always f. Unknown
   g. Refused to answer

6. **I get invited to go out and do things with other people** *
   Select ONE option.
   a. Never b. Rarely c. Sometimes d. Usually e. Always f. Unknown
   g. Refused to answer

7. **I can find a friend when I need one** *
   Select ONE option.
   a. Never b. Rarely c. Sometimes d. Usually e. Always f. Unknown
   g. Refused to answer

8. **I feel close to my friends** *
   Select ONE option.
   a. Never b. Rarely c. Sometimes d. Usually e. Always f. Unknown
   g. Refused to answer

9. **I feel like I'm part of a group of friends** *
   Select ONE option.
   a. Never b. Sometimes c. Usually d. Always e. Unknown
   f. Refused to answer

10. **Have you ever worked with a peer support specialist or community health worker?** *
Select ONE option.
a. Yes - in the past b. Yes - currently c. No d. Unknown e. Refused to answer

11. **If yes, provide name and contact information and update consent.**
Please answer if question 10 is answered with any of the following option(s): Yes - currently

12. **Do you live with anyone?***
Select ONE option.
a. Yes b. No c. Refused to answer

13. **If Yes, add name, relationship and contact information. Document whether or not the member would like to add this person tp the consent.**
Please answer if question 12 is answered with any of the following option(s): Yes

CRISIS/EMERGENCY PLAN

1. **I acknowledge that I need to develop a Crisis/Emergency Plan with the member. The Crisis/Emergency Plan is located in the Assessment Section.**
Select ONE option.
a. Yes

EDUCATION/EMPLOYMENT

1. **What is the highest level of schooling you have completed***
Select ONE option.
a. Elementary b. High School c. GED d. Trade School
e. Community College f. Some college g. College h. Graduate School
i. Unknown j. Refused to answer

2. **Are you interested in completing any more school?***
Select ONE option.
a. Yes b. No c. Unsure d. Refused to answer

3. **Are you currently employed?***
Select ONE option.
a. Yes b. No c. Refused to answer

4. **If no, are you interested in getting a job?***
Please answer if question 3 is answered with any of the following option(s): No

Select ONE option.
a. Yes b. No c. Unsure d. Refused to answer

5. **Is it a goal in the future to get a job?**
Please answer if question 3 is answered with any of the following option(s): No
Select ONE option.
a. Yes b. No c. Unsure d. Refused to answer

MOTIVATION

1. **I believe that I can make changes that will improve my physical health** *
Select ONE option.
a. Strongly agree b. Agree c. Unsure d. Disagree e. Strongly disagree

2. **If you agree, please tell me more about how you can make these changes** *
Please answer if question 1 is answered with any of the following option(s): Strongly agree, Agree

3. **I believe that I can make changes that will improve my mental health** *
Select ONE option.
a. Strongly agree b. Agree c. Unsure d. Disagree e. Strongly disagree

4. **If you agree, please tell me more about how you can make these changes** *
Please answer if question 3 is answered with any of the following option(s): Strongly agree, Agree

5. **I believe that I can make changes in my life that will increase my happiness and overall well being** *
Select ONE option.
a. Strongly agree b. Agree c. Unsure d. Disagree e. Strongly disagree

6. **If you agree, please tell me more about how you can make these changes** *
Please answer if question 5 is answered with any of the following option(s): Strongly agree, Agree