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| --- | --- |
| Staff Name: | Today’s Date: |
| Referral Source Notified of Outreach and Decision to Enroll?  Yes  No | |

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| **Member Demographic Information** | | | | | | | | |
| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Gender:  Male  Female  Transgender | | | |
| CIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Are you a Veteran?  Yes  No | Preferred Pronouns:  He  She  They | | | | |
| DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Marital Status:  Married  Divorced/Separated  Living as Married/Domestic Partner  Single | | | | | |
| Street Address, City, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Alt. Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Okay to leave a message?  Yes  No | |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Preferred method of contact: | | | | | | Phone  Text  Email  Mail |
| Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| *(Be sure to obtain consent via the DOH 5055 for emergency contact)* | | | | | | | | |
| MCO:  CDPHP  MVP  Fidelis  Excellus United Healthcare  Molina  None  Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Include VA benefits and any other potential insurance sources)* | | | | | | | | |

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| **Language / Culture Information** | |
| Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Prefer materials/communication in another language:  No  Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Are you able to read in your primary language?  Yes  No | |
| If no, do you have someone to assist you with reading?  Yes  No | |
| Do you have any cultural beliefs or customs that you would like to share? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Basic Needs**

1. Are you able to afford food for you / your dependents each month?  Always  Sometimes  Never
2. Do you receive support or assistance from:  Meals on Wheels  Food Pantry  None

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you able to pay for utilities / other financial obligations each month? Always  Sometimes  Never
2. Do you have stable housing?  Yes, stable (renting, homeowner)

Somewhat, at risk (rent late, threat of eviction)

Imminent risk (losing home within 14 days, guested homeless)

No, literally homeless (emergency shelter, uninhabitable)

1. Who else lives in your household?

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| **Name** | **Relationship** | **Age** |
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1. Do you have childcare in place?  Yes  No  N/A, no children in need of childcare
2. Are you connected with any community supports? *(Check all that apply)*

Peer Supports  Self Help  Religious Organizations  None

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have your own transportation?  Yes  No

1. What do you typically rely on for transportation? *(Check all that apply)*  Friends/Family  CDTA Public Bus  Taxi  MAS/Starbus  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What are your interests / hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Healthcare Information**

1. What are your current diagnoses, medical or mental health?

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1. What providers are you currently working with currently? *(This list should coincide with the DOH 5055 consent.)*

*If the Member does not need a listed provider, select “N/A.”*

*If the Member has a need for a provider, but is not connected to a provider, select “Provider Needed.”*

| **Name of Practice/Provider** | **Phone**  **Number** | **Last**  **App’t** | **Next**  **App’t** | **N/A** | **Provider Needed** |
| --- | --- | --- | --- | --- | --- |
| PCP: |  |  |  |  |  |
| Cardiologist: |  |  |  |  |  |
| Pulmonary: |  |  |  |  |  |
| Endocrinologist: |  |  |  |  |  |
| MH/BH Counselors: |  |  |  |  |  |
| Substance Abuse Counselor: |  |  |  |  |  |
| Psychiatrist: |  |  |  |  |  |
| Pharmacy: |  |  |  |  |  |
| Dental: |  |  |  |  |  |
| Optical: |  |  |  |  |  |
| OB/GYN: |  |  |  |  |  |
| GI: |  |  |  |  |  |
| Podiatry: |  |  |  |  |  |
| Neurology: |  |  |  |  |  |
| Pain Management: |  |  |  |  |  |
| Dialysis: |  |  |  |  |  |
| Preferred Hospital: |  |  |  |  |  |
| Legal (Parole, Probation, CPS): |  |  |  |  |  |
| Housing (OMH, RSS, MO): |  |  |  |  |  |
| Home Care Agency (CHHA or LTC): |  |  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |

1. On a scale of 1 to 10, one being “Extremely Poor” and 10 being “Excellent,” how would you rate your health in the last 30 days?

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | |  | |  | |  | |  | | |  | |  | |  | |  | |  |
| 0 | 1 | | 2 | | 3 | | 4 | | 5 | | | 6 | | 7 | | 8 | | 9 | | 10 |
| Extremely Poor | |  | |  | |  | |  | | **Good** |  | |  | |  | |  | | Excellent | |

1. During the **past year,** how often did you visit your primary care provider?

0 times  1 time  2 times  3 times  4 or more times  N/A, no PCP

1. During the **past three months,** how often did you visit the Emergency Room?

0 times  1 time  2 times  3 times  4 or more times

1. What was the reason for the visit(s)? *(Check all that apply)*  Medical  Mental Health
2. During the **past three months,** how many times were you admitted to the hospital?

0 times  1 time  2 times  3 times  4 or more times

1. What was the reason for the admission(s)? *(Check all that apply)*  Medical  Mental Health
2. What are your barriers to managing your healthcare needs?

|  |  |  |
| --- | --- | --- |
| Forget appointments | Forget Medication | Don’t agree with treatment |
| Transportation | Anxiety | Not educated on diagnoses |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | None identified |

**Legal**

1. Do you have any pending charges at this time?  Yes  No
   1. If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Are you currently on: Probation?  Yes  No

Parole?  Yes  No

*(Be sure to obtain consent via the DOH 5055 for any involvement if Member is willing to provide.)*

1. Do you have an open case with: Child Protective Services  Yes  No

Adult Protective Services  Yes  No

*(Be sure to obtain consent via the DOH 5055 for any involvement if Member is willing to provide.)*

1. Do you have a history of criminal justice involvement, such as arrests or convictions?  Yes  No
2. If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Do you have a history of incarceration?  Yes  No
2. If yes, what is your most recent release date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Care Coordination / Outreach Specialist Use Only**

*To be eligible for Health Home services, the individual must meet diagnostic criteria and must have significant risk factors that deem them appropriate.*

1. Identify the risk factors that make the individual appropriate for Health Home services. *(Check all that apply)*

|  |
| --- |
| Lack of or inadequate social / family / housing support  Learning or cognition issues  Lack of or inadequate connectivity with healthcare system  Deficits in activities of daily living (e.g., dressing, eating)  Non-adherence to or difficulty managing treatment(s) or medication(s)  Repeated recent hospitalizations or ER visits for preventable conditions  Probable clinical risk or adverse event (e.g., death, disability, inpatient, nursing home admission)  Recent release from incarceration or psychiatric hospitalization |