|  |  |
| --- | --- |
| 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?

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|   |   |   |   |   |   |   |   |   |   |  |
| 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 |