Status: Published **Version** 1.5

Health Home Comprehensive Assessment Tool

Assessment Date :

Client Name:

DOB: 03/23/1985

Age: 35 years, 4 months and 29 days

Client Address: 638 North Green Second Road 253
White Hague Way Dunlap TN 37327

Phone Number:131-594-0879

Relationship Status: 4. other

Gender:

Sexual Orientation:

Ethnicity: Declined to Specify

Race: Puerto Rican

Writing:

Languages Spoken:

Reading:

Support Needed?

Medicaid / Seq #:

MCO:

Verified? :

SS#:

Can be reached by: Mail: Phone: ● Home Visit:

Medication

N/A

1. Diagnoses

List all current conditions and the most recent test date and result, if applicable, associated with each condition.For example: Hypertension(BP / date measured); Diabetes(HbA1c / result date); Asthma; Hyperlipidemia (LDLC / result date); Congestive Heart Failure; COPD; HIV / AIDS(CD4 count / result date); cancer; renal disease;liver disease; obesity; stroke history; vision / hearing impairment; neuropathy; incontinence, etc.

Condition	Last Test Result	Result Date
No Records		

2. Medications (Prescriptions and Adherence)

List all current medications, including over - the - counter medicines and vitamins.In the event of a home visit,please ask the member to gather all of the medications in order to obtain the most accurate medication historypossible.

Medication / Dosage
No Records

For Questions 2a – 2c, check the number next to the appropriate answer. Then add up the checked numbers to calculate a score.

2a. How often does the member (in his/her own perception) have difficulty taking medications on time? On time means no more than 2 hours before or 2 hours after the time that the doctor instructed.

Never [has difficulty taking medications on time]
Rarely [has difficulty taking medications on time]
Most of the time [has difficulty taking medications on time]
Always [has difficulty taking medications on time]

2b. On average, how many days PER WEEK does the member (in his/her own perception) miss at least one dose of medication?

Every day
4 – 6 days/week
2 – 3 days/week
Once a week
Less than once a week
Never

2c. When was the last time the member missed at least one dose of medication?

Within the past week
1 – 2 weeks ago
3 – 4 weeks ago
Between 1 and 3 months ago
More than 3 months ago
Never

SCORE: _____

>10 = Good adherence ≤10 = Poor adherence

3. Medications (Health Literacy)

3a. Does the member understand the consequences of missing doses? Yes No

3b. Does the patient feel that they know enough about the medications they are taking? Yes No

4. Hospitalizations/Emergency Department (ED) Visits

Describe the member's last visit to the ED/last hospitalization. Why did the member go to the ED? Why was the member admitted to the hospital?

5. Allergies

List all medication and other (e.g. food, latex) allergies. Include the type of reaction (rash, difficulty breathing, etc.).

6. Pain Assessment

6a. Does the member have pain? Yes No [If no, SKIP to Question 7: General Health]

6b. Where is the pain?

6c. When did the pain start? How often does it occur? Has it gotten worse?

6d. What does the pain feel like (e.g. stabbing, throbbing, burning, aching, etc.)?

6e. How much pain does the member report currently, on a scale of 0 – 10 (with 0 being no pain, and 10 being the worst pain imaginable)?

6f. How bad is the pain, on a scale of 0 – 10, at its worst?

6g. How bad is the pain, on a scale of 0 – 10, at its best?

6h. What makes the pain better?

6i. What makes the pain worse?

6j. What has the member tried to relieve the pain? Was it effective?

6k. How does the pain affect physical and social functioning?

7. General Health

7a. Are there important things the member wants to share about his/her health? How do these things affect the member socially?

7b. When did the member last see his/her…
Primary Care Provider (PCP):

Psychiatrist:

Pain Management Physician:

Mental Health N/A

8. Diagnoses and Medications

8a. Is the member being treated for – or has the member been diagnosed with – any of the following conditions (check all that apply):

Bipolar Disorder
Schizophrenia
Severe Depression
Schizoaffective Disorder
None of the above [If none, SKIP to Question 9: Hospitalizations]

For the condition(s) checked off above, please indicate:

8b. The type of treatment received (e.g., outpatient clinic; PROS; private provider, partial hospitalization, inpatient setting).

8c. Names, phone numbers, and addresses of providers (include title: therapist; psychiatrist, etc.).

8d. How often does the member see the providers listed above?

8e. What medications are prescribed for the conditions listed above?

" this table is showing on next page. "

8f. What, if anything, makes it difficult for the member to take their medications as prescribed? (Check all that apply)

Confusion about when/how to take medications.
Medication instructions are not written in the member's native language.
Difficulty paying for medications.
The medication has unpleasant side effects.
Lack of understanding about why to take the medications.
Difficulty remembering to take medications.
Other barrier(s) – Please describe.

8e. What medications are prescribed for the conditions listed above ?

Medication / Dosage
No Records

8g. How does the member feel when taking his/her medication?

8h. How does the member feel when ***not*** taking his/her medication?

8i. Does the member have any allergies to psychiatric medications? What are the reactions?

9. **Hospitalizations**

9a. How many times has the member been to the ED for psychiatric reasons in the past year?

9b. Date of most recent visit/reason:

9c. How many times has the member been admitted to an inpatient psychiatric unit in a hospital in the past year?

9d. Date of most recent admission/reason:

9e. Age of onset of symptoms and first psychiatric hospitalization:

9f. Other details of psychiatric history:

10. **Safety Risk (Appendix A)**
11. **Depression Screening (Appendix B)**
12. **Trauma Screening**

12a. Has the member ever experienced trauma, abuse, or domestic violence? Yes No [If no, SKIP to Question 13: Substance Use]

12b. Has the member received help for coping with this experience? Yes No

12c. Does the member wish to be referred for help at this time? Yes No

13. **Substance Use**

13a. Diagnosis

Is the member (currently or previously) in treatment for drug or alcohol use (specify)? Yes No [If no, SKIP to Question 14: History of use and hospitalizations]

13b. What type of treatment does the member receive (Crisis; Detox; Inpatient Treatment; Outpatient Treatment or Outpatient Rehab; SU Residential Treatment; Methadone Maintenance Program, etc.)?

13c. List names, titles, phone numbers, and addresses of providers:

13d. How often does the member see the provider(s) listed above?

14. **History of Use and Hospitalizations**

14a. How many times has the member been to the ED or admitted for detox treatment in the past year?

14b. Date of most recent visit/admission and reason/treatment modality:

14c. How many times has the member been admitted to a rehab facility in the past year?

14d. Date of most recent rehab admission and reason/treatment modality:

14e. Age of first use of alcohol or other substance:

14f. If sober, duration of sobriety:

14g. What treatment modalities have been effective?

14h. What are the member's alcohol/substance use triggers (e.g. people, places, circumstances, etc.)?

14i. How does the member protect him/herself (e.g. clean needles, safe environment when using, etc.)?

14j. In the member's perception, what is good about his/her substance use?

14k. In the member's perception, what is ***not*** good about his/her substance use?

14l. Other details of alcohol/substance use history and patterns/trends:

15. Tobacco Screening

15a. Does the member currently use tobacco products (specify)? Yes No [If no, SKIP to 15c]

15b. How often does the member use tobacco products/how many cigarettes smoked per day?

15c. Does the member currently use e-cigarettes? Yes No

15d. Has the member ever completed a smoking cessation program? Yes No

15e. Is the member interested in being referred to a smoking cessation program or receiving support services to reduce smoking? Yes No

Referral made? Yes No

16. Substance Abuse Screening (Appendix C – administer if history of substance abuse is present)

Financial N/A

17. What is the member's monthly income?

18. What is the source(s) of the member's income?

19. How many people reside in the member's household?

20. How many of the people residing in the member's household are financial dependents of the member?

21. What is the monthly cost of the member's rent?

22. What is the member’s status regarding the following entitlements?

Member Status Type	Receives/Amount	Needs/Needs Recertification(list recertification date if applicable)	Stable/No Needs
No Records			

23. What are the member’s needs regarding the following financial elements?

Member Needs	Assistance Needed (Describe)	Stable/No Needs
No Records		

Housing

24. Where is the member currently living (check one)?

House/Apartment

- Private Public NYCHA
- Is the lease or mortgage in the member's name Yes No
- Is the placement in the house/apartment stable? Yes No

Friend's/Relative's Home

- How long may the member remain?

Parent/Immediate Family Guardian

- How long may the member remain?

Respite Care

- How long may the member remain?

Half –Way House

- How long may the member remain?

Homeless/in the street

- Homeless/Doubled Up living with others
  - How long may the member remain? lonhdf df

Homeless/registered in shelter

- Name of Shelter

Supportive/Supported Housing

- Agency Affiliation

25. Does the member give consent to the care manager to speak with his/her caseworker, landlord, and/or building management? Yes ● No

26. Does the member receive any of the following housing subsidies?

Housing Subsidies Type	Other Details	Receives (Details,Including Case #)	Pending
Section 8		aasd	
HASA		ds	
Other (specify)	dfdf	df	
FEPS		dfd	

27. How long has the member been residing at his/her current location?

dsda

28. Does the member have any serious concerns related to their current living situation (describe)? Yes ● No

29. Is the member at risk of losing his/her current housing? Yes No [If no, SKIP to next section: Domestic Violence]

29a. Why is the member at risk of losing his/her current housing?

Rent Arrears (Specify Amount)

Loss of housing subsidy

Landlord issue

Other (Specify)

29b. Has the member received a vacate notice from a City Marshall? Yes No

29c. What steps, if any, has the member taken to address the loss of housing, or the threat of the loss of housing?

29d. Is the member in court for eviction proceedings? Yes No

29e. Is the member working with an attorney? Yes No

Does the member give consent for the care manager to speak with the attorney? Yes No

29f. Is Adult Protective Services (APS) involved with the case? Yes No

29g. Does the member have any other housing options (describe)? Yes No

29h. Is the member willing to accept a referral to a shelter? Yes No

Domestic Violence

N/A

30. List all the people who reside with the member, and their relationship to the member.

" this table is showing on next page "

31. Does the member feel safe in his/her relationships with the people listed above? Yes No

If no, please explain:

30. List all the people who reside with the member, and their relationship to the member.

Name	Relationship
No Records	

32. Are there any relationships with people with whom the member does *not* reside, in which s/he does not feel safe? Yes No

If yes, please explain:

33. Does the member feel s/he is a victim of domestic violence? Yes No

If yes, please explain:

34. Does the member feel that his/her life is in danger? Yes No

35. Does the member understand what domestic violence is? Yes No (care manager should be able to educate the member if appropriate)

36. Ask the member, "Sometimes one person in a relationship makes the other person feel afraid or scared, either by intimidating them, threatening to hurt them or someone they care about, or by their physical actions. Has someone in your life done anything like this to you?"

Yes No

If yes, please explain:

"Have you done anything like this to someone in your life?"

Yes No

If yes, please explain:

37. Ask the member, "What happens when you and the person/people mentioned above disagree?"

[If physical abuse is suspected, ask questions 38-40]

38. Has there been any physical fighting such as hitting, pushing etc. in the relationship (describe, including any injuries)? Yes No

39. Has the member ever had police involvement related to a domestic incident? Yes No

40. Is there (or has there been) an order of protection against the member or the identified abuser? Yes No

[If psychological abuse is suspected, ask questions 41-43]

41. Ask the member, "In some relationships, one person tries to make the other feel bad about themselves or puts them down a lot, for example by calling them names, constantly criticizing them, or telling them they're stupid. Has someone in your life done anything like this to you?"

Yes No

If yes, please explain:

42. Have the member ever been threatened with punishment or institutionalization? Yes No

If yes, please explain:

43. Have the member ever been isolated from everyday living? Yes No

If yes, please explain:

[If sexual abuse is suspected, ask questions 44-45]

44. Ask the member if s/he has ever felt coerced or obligated to have sex with the identified abuser.

Yes No

If yes, please explain:

45. Ask the member if s/he has ever been touched in a sexual way without permission.

Yes No

If yes, please explain:

[If financial abuse is suspected, ask questions 46-48]

46. Is the member's money being controlled, stolen or used inappropriately by someone other than him/herself?

Yes No

If yes, please explain:

47. Has the member been forced to make financial decisions against his/her wishes?

Yes No

If yes, please explain:

48. Has the member been forced to sign any important document(s) against his/her wishes?

Yes No

If yes, please explain:

****If any abuse is suspected, the care manager should initiate a safety plan (Appendix D).**

Legal

N/A

Answer the applicable questions below to provide a legal history and summary of ongoing and exigent legal needs.

49. Income supports and insurance (e.g. benefits, entitlements, denials, appeals, etc.)

Exigent Needs

Ongoing Legal Activity

Legal History

50. Housing and Utilities

Exigent Needs

Ongoing Legal Activity

Legal History

51. Legal status (e.g. immigration)

Exigent Needs

Ongoing Legal Activity

Legal History

52. Personal and family stability (e.g. custody, guardianship, ACS, restraining orders/orders of protection, criminal justice, advance care planning/advance directives, etc.)

Exigent Needs

Ongoing Legal Activity

Legal History

53. Criminal Background

53a. Is the member a registered sex offender? Yes No [If no, SKIP to Question 53b]

If yes, please explain:

State:

TN

City:

Dunlap

County:

53b. Has the member ever been incarcerated? Yes No

If yes, please explain:

53c. Parole (if applicable)

Name of Officer:

Number:

Length of Time:

Consent for care manager to speak with Parole Officer? Yes No

53d. Probation (if applicable)
Name of Officer:

Number:

Length of Time:

Consent for care manager to speak with Probation Officer? Yes No

53e. Upcoming Court Dates (if applicable)

Date	Details

" this table is showing on next page "

53f. Does the member have an attorney? Yes No
If yes:
Attorney Name and Contact Number

Consent for care manager to speak with Attorney? Yes No

53g. Does the client need a referral for legal services? Yes No

53h. Are there court ordered services (e.g. AOT)? Yes No
If yes, please explain:

53i. Does the member need assistance with transportation to appointments with attorney/caseworker/parole officer/probation officer or to court appearances? Yes No

Choking

Yes No

Comments :

Risk of falls

Yes No

Comments :

Self-harm behaviors

Yes No

Comments :

Fire safety

Yes No

Comments :

Safety in the community

Yes No

Comments :

Housing and/or food instability

Yes No

Comments :

Emergency evacuation and notification – i.e. ability to call 911

Yes No

Comments :

Backup plan for emergency situations

Yes **No**

Comments :

Level of independence with medication

Yes **No**

Comments :

Level of supervision at home, overnight, and in the community

Yes **No**

Comments :

Independent Living Skills

N/A

Language skills (receptive and expressive)

Memory/learning

Ability to dress, bathe self; personal hygiene; toileting, mobility, positioning, transferring

Needs assistance eating

Meal preparation

Housekeeping/cleanliness

Managing finances, ability to shop

Managing medications

Phone use

Transportation

Problematic social behaviors

Tie back to medical/behavioral health components

Does the individual have support to help with ADLs and/or IADLs?

Developmental milestones (children)

Self-preservation skills

Need for behavioral support services

N/A

Challenging behaviors

Does the individual have a Behavior Support Plan (BSP)?

Yes No

Comments :

Describe Use of approved restrictive physical interventions

Describe Skills and resources needed to achieve goals.

Describe Strengths of the individual.

Is there engagement in the treatment plan/services?

Yes No

Comments :

Identify barriers to service.

Educational/Vocational Status

N/A

Education

Level of education

If in school: Yes No

Pre-school and/or childcare information

Current Educational Program/ Individualized Education Plan (IEP), 504 Plan (if applicable)

Current services and accommodations in educational setting (if applicable)

My day

Self-Directed Services

N/A

Interest to self-direct services
Yes No

Education on self-directing
Yes No

Services to self-direct (i.e. brokerage, Community Habilitation (Self-Hire, FI Employer of Record, etc.)

Skills and resources needed to successfully self-direct

Identify barriers to self-directing services

Transition Planning (for students ages 14-21)

N/A

Vocational (when applicable)
Yes No
Comments :

Prevocational skills
Yes No

Comments :

History of employment
Yes No
Comments :

ACCESS-VR
Yes No
Comments :

Access to vocational rehabilitation and employment programs
Yes No
Comments :

Ticket to work if applicable
Yes No
Comments :

Welfare to work if applicable
Yes No
Comments :

Day Activities for over the age of 21
Yes No
Comments :

Competitive employment without staff support
Yes No
Comments :

Community Based Prevocational Services
Yes No
Comments :

Self-Directed Individualized Budget with Blended Service
Yes No

Comments :

Day Habilitation
Yes No
Comments :

Day Habilitation without Walls
Yes No
Comments :

Day Treatment
Yes No
Comments :

Community Habilitation
Yes No
Comments :

Community First Choice Option (CFCO)
Yes No
Comments :

Mental Health (MH) Program (e.g. MH Day Program, Social Club)
Yes No
Comments :

Adult Day Services (e.g. Department of Aging or Health Services)
Yes No
Comments :

Volunteer
Yes No
Comments :

I am Retired
Yes No
Comments :

No Structured Daytime Activity
Yes No
Comments :

Adult Education/College Classes
Yes No
Comments :

Interest in services (i.e. Community Habilitation, Day Program, etc.)
Yes No
Comments :

SEMP Yes No
Comments :

Employment not integrated Yes No
Comments :

Pathway to employment Yes No
Comments :

Site Based Prevocational Services Yes No
Comments :

General

N/A

Notes :

Electronic Signature

Date

Staff Name

Staff Title

Staff Credentials

Signed Date and Time

Ask the member the following questions.

a. Have you ever had thoughts of hurting yourself or others?
   Yes No

b. Have you ever acted on thoughts to hurt yourself or others?
   Yes No

c. What are ways you or others around you can tell that you are not feeling well and may need help (triggers, symptoms/behaviors of client)

d. Do you have thoughts of harming yourself or ending your life?
   Yes No

e. Do you have a plan on how you would end your life?
   Yes No

f. Do you feel that you may now or in the near future act on that plan?
   Yes No

g. Have you ever attempted suicide before?
   Yes No

h. Has anyone in your family ever committed suicide?
   Yes No

i. Would you tell me if you felt like harming yourself or ending your life?
   Yes No

j. Do you hear voices telling you to harm or kill yourself?

Yes No

k. Do you feel that you might act on those voices?

Yes No

Depression Screening

N/A

Complete the Patient Health Questionnaire (PHQ-2) below. If an answer in the PHQ-2 is positive, complete the PHQ-9.

Over the last 2 weeks, how often have you been bothered by any of the following problems:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				

Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)

Directions: The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. There are no right or wrong answers. Please check the box for the answer that best fits for you. Try to be as honest as you can be. Filling out this form will give us information to provide you with the services, care or treatment that best meet your specific needs.

	During the last six months			**score**
1a)	Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, cocaine, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)	Yes (1)	No (0)	
1b)	Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan)	Yes (1)	No (0)	
2)	Have you felt that you use too much alcohol or other drugs? (Other drugs also include prescription or over-the-counter medication more than recommended.)	Yes (1)	No (0)	
3)	Have you tried to cut down or quit drinking or using alcohol or other Drugs?	Yes (1)	No (0)	
4)	Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)	Yes (1)	No (0)	
5)	Have you had any health problems? Please check the following list, if you have: Had blackouts or other periods of Injured your head after drinking Had convulsions, delirium tremens Had hepatitis or other liver problems Felt sick, shaky, or depressed when you stopped Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs Been injured after drinking or using Used needles to shoot drugs			
	For question #5, the total possible score is 1. If no items are checked score is 0	**Score for #5**		
6)	Has drinking or other drug use caused problems between you and your family or friends?	Yes (1)	No (0)	
7)	Has your drinking or other drug use caused problems at school or at work?	Yes (1)	No (0)	
8)	Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)	Yes (1)	No (0)	

9)	Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?	Yes (1)	No (0)	
10)	Are you needing to drink or use drugs more and more to get the effect you want?	Yes (1)	No (0)	
11)	Do you spend a lot of time thinking about or trying to get alcohol or other drugs?	Yes (1)	No (0)	
12)	When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break laws, sell things that are important to you, or have unprotected sex with someone?	Yes (1)	No (0)	
13)	Do you feel bad or guilty about your drinking or drug use?	Yes (1)	No (0)	

The next questions are about your lifetime experiences.

14)	Have you ever had a drinking or other drug problem?	Yes (1)	No (0)	
15)	Have any of your family members ever had a drinking or drug problem?	Yes (1)	No (0)	
16)	Do you feel that you have a drinking or drug problem now?	Yes (1)	No (0)	
			****Total SCORE for items 1-16**	

**If total score is 4 or more, it indicates need for further assessment and member should be referred for further Substance Abuse Assessment. If member is currently in Substance Abuse treatment, no actions necessary.

Total Score : -

Safety Plan

N/A

Sometimes a victim has difficulty developing a safety plan. Use the following questions to assist in developing a plan with the victim. Consider safety in the home, at work, and in the community.

1. Would you like to leave the perpetrator?
   Yes No
   If yes, start immediate intervention call 911 or Safe Horizon Domestic violence Hotline 800-621-Hope (4673). If the member wants to make plans to leave, assist in developing a plan.

2. Do you have an order of protection?
   Yes No
   If no, ask if the member would like assistance in obtaining one and locate a safe place to keep it in the home. Instruct the member to always keep the order on or near them.

   I will keep my order of protection in my

3. Are there children involved?
   Yes No
   If yes, care manager must report to supervisor immediately.
   Ask the member if they would like the situation reported to the school guidance counselor.

4. Are the children being abused?
   Yes No

5. Have they ever been abused?
   Yes No

6. Ask the member if there is a safe way to leave the apartment/house/room, in the event a decision to leave is made?
   Yes No
   If no, practice how to get out safely. What doors, window or stairwells can the member use?)

   I will leave my home by using the following exit

7. Is there a family member/friend/neighbor that the member trusts and with whom s/he can leave copies of important documents?
   Yes No
   If no, the care manager should make copies and keep in the member's file at the office.

   Copies of my important document will be kept with at their

8. Is there a safe place or person with whom the member can leave clothing for him/herself and any child/ren?
   Yes No
   If no, assist member in finding a safe place in the home or speak to your supervisor about leaving the clothes at your office.

   If I leave my home I will contact

9. Do the member's children know how to dial 911 and give their address?
   Yes No
   If no, you may want to take the time to practice with the member and her children. Use the space below to write the directions.

10. Is there a safe place in the home where the member and his/her child/ren can hide until help arrives?
    Yes No
    If no, assist the family in locating a safe area in the home.

    In case the abuser becomes violent, my child/ren and I will seek shelter in our until help arrives.

11. If the member and/or member's children are taking medication, obtain copies of prescriptions to keep in member's chart. This will assist in obtaining medications if the member needs to leave quickly.

**If the member refuses these options, counseling should be offered for the member and family. Consider the possibility of including the perpetrator if the member is comfortable.