

Comprehensive Assessment & Social History

Member Name:

Medicaid #:

Assessment Information

Assessment Date:

Previous Assessment Date:

Type of Assessment: Initial Annual Change in status update

The following sources were used to gather and develop my comprehensive assessment and social history (check all that are applicable): Member Caregiver Guardian Parent

Physician Provider Other

Assessment completed by: Health Home Provider Name MCO

Name, title, contact information for person completing this assessment:

Reason for referral:

Assessment/Screening Type	Date	Score/Results/Tier
Health Risk Screener		
Risk Stratification		
Other (list):		

Personal Information

Preferred Name	
Preferred Pronouns	
Date of Birth	
Address (Street, City, State Zip)	
Phone Number	
Email	
Parent Name (<i>if child</i>)/ Representative (<i>if adult, applicable</i>)	
Parent's Address (if different from the child's)	
Spouse Name (<i>if married</i>)	I want my spouse to be contacted regarding my care: <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:
Preferred method(s) of contact	<input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Mail
My preferred spoken language	
My preferred written language	
I am a veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, answer following questions:</i> Branch: Years of service: Honorable Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No

For **Children Only**

Member Name:
 Medicaid #:

Child resides with, (<i>If in a facility, note name of facility and address</i>)	
Parents' Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married
If parents are not living together, the following parent is the non-custodial parent	Name: Address:
There are sibling(s) living in the home with the child	<input type="checkbox"/> Yes <input type="checkbox"/> No
One or more siblings are receiving waiver/habilitation services	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:

My Strengths are:

My Preferences are:

Preferences should also include personal preferences for how case management and services are delivered (i.e. where/with who to live, when to go to bed, when and what to eat, whom to involve in care planning, which services and service providers to use).

I am currently accessing long-term services and supports waiver: Yes No Unsure
If yes, name of waiver:

I am on a waiting list for a long-term services and supports waiver: Yes No Unsure
If yes, I am pending for:

Communication & Language

I need support with reading and/or understanding written material (include guardian response if applicable)
 Yes No *If yes, what support is needed:*

I need support with understanding information about my condition, medicines, or doctor's instructions (include guardian response if applicable)
 Yes No *If yes, what support is needed:*

I describe my understanding of my needs and challenges (insight) as (select the most appropriate)

I am knowledgeable about my needs and I am able to help direct planning to address them.	<input type="checkbox"/> Yes
I am knowledgeable about my needs and participate in planning to address them.	<input type="checkbox"/> Yes
I am somewhat knowledgeable about my needs.	<input type="checkbox"/> Yes
I would rather not participate in plans to address my needs.	<input type="checkbox"/> Yes
I do not think that I have needs or challenges that need to be addressed at this time.	<input type="checkbox"/> Yes
Comments:	

Awareness and Memory

I describe my awareness & memory (cognitive status) as (select the most appropriate):

Fine with no concerns (alter and fully oriented)	<input type="checkbox"/> Yes
Alert and oriented with daily fluctuations in mood	<input type="checkbox"/> Yes
Generally oriented through use of assistive technologies (verbal prompts, schedules, uses of technology for reminders, etc.)	<input type="checkbox"/> Yes

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Difficulty with orientation (e.g. time/place, attention/concentration, perception, memory, reasoning)	<input type="checkbox"/> Yes
Exhibits mental status changes consistent with psychiatric disorder	<input type="checkbox"/> Yes
Comatose, but responsive	<input type="checkbox"/> Yes
Comatose, but unresponsive	<input type="checkbox"/> Yes
Other – Specify	<input type="checkbox"/> Yes

- I have the following awareness & memory needs

Hearing

I describe my hearing as (select the most appropriate):

Fine with no concerns	<input type="checkbox"/> Yes
Fine with use of assistive devices (e.g. hearing aids)	<input type="checkbox"/> Yes
Able to hear but not clearly	<input type="checkbox"/> Yes
Difficulty hearing in noisy environments	<input type="checkbox"/> Yes
Unable to hear	<input type="checkbox"/> Yes

- I have the following hearing needs

Vision

I describe my vision as (select the most appropriate):

Fine with no concerns	<input type="checkbox"/> Yes
Impairment, but managed through assistive devices (i.e. glasses/contacts)	<input type="checkbox"/> Yes
Vision is significantly impaired	<input type="checkbox"/> Yes

- I have the following vision needs

Speech and Communication

I describe my **speech and communication** as (select the most appropriate):

Fine with no concerns	<input type="checkbox"/> Yes
Communicates with difficulty but can be understood	<input type="checkbox"/> Yes
Communicates with sign language, symbol board, written messages, gestures, and/or interpreter	<input type="checkbox"/> Yes

- I have the following speech and communication needs

Social, Cultural & Spiritual Preferences

Describe family involvement, relationships, include past & current (*Describe the member's immediate family, involvement through member's life, relationships such as very close, never sees them, etc. and how they would describe growing up*):

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Social

I communicate with friends, relatives and others (not paid helpers) as often as I want: Yes No

If no, explain:

If child, are there any people who the child is not to have contact with (list):

I am satisfied with my relationships: Yes No Support Needed:

I would like to have more of a support system: Yes No *If yes, explain:*

I feel that I lack companionship: Yes No *If yes, explain:*

My support system consists of (check all that apply):

- Family Members Friends Co-Workers
 Church Support Groups Other – Explain

I communicate with my support system by (check all that apply):

- Visiting in person Phone Texting
 Email Other, explain

My support system is supportive and/or involved in my treatment? Yes No *If no, explain:*

I have access to mass media (i.e. television, newspaper) and technology (cell phone, internet): Yes No
If no, explain:

Cultural

I identify myself as:

My family traditions/beliefs that I follow are:

I have the following cultural beliefs regarding healthcare or specific treatments:

I experience cultural stress regarding social norms, behaviors and attitudes (e.g. racism, negativity towards sexual orientation, gender identify and expression, and other forms of discrimination): Yes No

If yes, explain:

Spiritual

My religious/spiritual preference is:

I choose to practice a religion/spiritual belief: Yes No

I attend religious/spiritual services, as I want: Yes No

I choose to participate in my religion/spiritual beliefs as much as I want: Yes No

I have the following religious/spiritual beliefs regarding receiving healthcare or specific treatments:

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Leisure Activities

These are my hobbies, activities and things I do for fun:

I enjoy spending time with the following people in my free time:

Marital & Dating Status

My dating and marital status history is:

Is member able to understand consent: Yes No *If no, additional information:*

I am currently (*check all that apply*):

Never Married Married Single Divorced
 Legally Separated Widowed Dating Unknown NA- Minor

If not married, I would like to date: Yes No NA

I am sexually active: Yes No Prefer not to answer

I am taking the following precautions:

Developmental Milestones (Children Only)

My birth parents are:

My child's weight at birth:

Was the pregnancy full-term?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If no or unknown, explain:</i>
Were there any complications during or immediately following delivery?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If yes or unknown, explain:</i>
Was your child exposed to drugs or alcohol in utero?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If yes or unknown, explain:</i>
Did your child walk independently by 18 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If no or unknown, explain:</i>
Did your child use 2 to 4 word sentences by 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If no or unknown, describe:</i>
By age 4, was your child daytime toilet trained?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If no or unknown, describe:</i>

I have the following concerns regarding my child's development:

Gross motor (walking, running, physical activities)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, explain:</i>
Fine motor (use of pencil, manipulation of objects)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, explain:</i>
Independent functioning (eating, dressing self)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, explain:</i>

Comments:

I have the following additional concerns regarding my child's development:

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Is the home childproof (e.g. hazards such as detergents or medications are kept out of child's reach or are locked up; electrical outlets are covered, etc.): Yes No *If no, describe:*

Medical & Mental Health History

I am currently diagnosed with the following conditions:

Condition	Active	Past	Physician & Credentials	Year Diagnosed	Family History (mark if yes)	Family Member & Age of Diagnosis (i.e. parents, siblings, children, grandparents)
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Behavioral Health Diagnosis (Name and ICD-10 Code):	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Cancer Type:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Chronic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Diabetes Type 1 Last A1C date & number:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Diabetes Type 2 Last A1C date & number:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Pre-Diabetes Last A1C date & number:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
HIV	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Mental Health Diagnosis (Name and ICD-10 Code):	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Sickle Cell Disease (not trait)	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	

Member Name:
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Transplant Type:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
Any other chronic conditions:	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	

Summary of physical and mental health, including onset of diagnosis and symptoms:

I have the following physical and mental health concerns:

I have the following physical and mental health barriers to recovery:

Surgeries/Major Procedures

I have had the following surgeries/major procedures:

Hospital/Surgery Center	Surgery/Major Procedure	Dates Received

Significant Illnesses

I have had the following significant past illnesses:

Past Health Condition	Symptoms	Treatment History	Dates Received

In the **past 12 months**,

- I needed to see a doctor but could not because of the cost or lack of resources. Yes No
- I went without health care because I didn't have a way to get there. Yes No

Comments:

Dental

I describe my dental hygiene as

Fine, no concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have tooth pain	<input type="checkbox"/> Yes <input type="checkbox"/> No

Member Name:
Medicaid #:

I have no teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have dentures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

- I have the following dental needs

Fall History

I have a history of falls: Yes No *If yes, my last fall was:*

I have the following preventative measures in place to decrease my falls:

Behavioral Health/Mental Health

I would rate my overall mental health as: Excellent Good Fair Poor

Comment:

My current stressors are:

Today,

I have thoughts of harming myself or feelings of suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have thoughts of wanting to harm others	<input type="checkbox"/> Yes <input type="checkbox"/> No

- If yes, provide more details:*

In the **Past,**

I have had thoughts to harm myself or feelings of suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have had thoughts of wanting to harm others or have harmed others	<input type="checkbox"/> Yes <input type="checkbox"/> No

- If yes, provide more details:*

In the **past 2 weeks,** I have been bothered by the following,

Little interest or pleasure in doing things	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
Feeling down, depressed or hopeless	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day

In the **past 30 days,** I have

Seen or heard things that are not really there (hallucinations)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had feeling of paranoia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had irrational thoughts that weren't true (delusions)	<input type="checkbox"/> Yes <input type="checkbox"/> No

- If yes, provide more details:*

Hospitalization & Emergency Room Visit History

I am able to access emergency room assistance, as needed: Yes No

I need the following supports to access emergency room assistance:

In the **past year,**

Member Name:
 Medicaid #:

I have been hospitalized for mental health reasons	<input type="checkbox"/> None <input type="checkbox"/> 8+ times	<input type="checkbox"/> Once	<input type="checkbox"/> 2-4 times	<input type="checkbox"/> 5-7 times
I have been hospitalized for medical reasons	<input type="checkbox"/> None <input type="checkbox"/> 8+ times	<input type="checkbox"/> Once	<input type="checkbox"/> 2-4 times	<input type="checkbox"/> 5-7 times
I have been to the emergency room	<input type="checkbox"/> None <input type="checkbox"/> 8+ times	<input type="checkbox"/> Once	<input type="checkbox"/> 2-4 times	<input type="checkbox"/> 5-7 times

Psychiatric and/or Alcohol/Substance Use Hospitalizations

I have had the following psychiatric and/or alcohol/substance use hospitalizations:

Provider Name & Address	Reason for Inpatient Stay/Facility Stay	Successful/Helpful	Dates Received
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Medical Hospitalizations

I have had the following medical hospitalizations:

Provider Name & Address	Reason for Inpatient Stay/Facility Stay	Successful/Helpful	Dates Received
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Emergency Room Visits

I have had the following emergency room visits current and past:

Provider Name & Address	Reason for ED Visit	Dates Received

Preventative Visits

I have had the following health screenings

Preventative Measure	Completed	Date	Results
Flu Shot	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Member Name:
 Medicaid #:

Blood Pressure (systolic/diastolic)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
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For **Adults ONLY**

Preventative Measure	Completed	Date	Results
Cholesterol (Total)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Low Density Lipoprotein (LDL)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No		

For **Women ONLY**

Preventative Measure	Completed	Date
Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pap smear in last five years	<input type="checkbox"/> Yes <input type="checkbox"/> No	
I am pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Due Date: Name of Provider:
I have a prenatal doctor	<input type="checkbox"/> Yes <input type="checkbox"/> No	

For **Children ONLY**

My child is up-to-date on his/her immunizations: Yes No *If no, describe:*

Allergies

Allergy Type	Allergy	Type	Reaction
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Physical Health

I would rate my overall physical health as: Excellent Good Fair Poor

Comments:

My height (inches)	My weight (pounds)	My body mass index (BMI)
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Exercise Routine

I engage in moderate to strenuous exercise (like a brisk walk) # days per week	
I engage in # minutes of strenuous exercise per week	
I want to increase my activity level	<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments:

Nutrition

My appetite is	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
I follow a healthy diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have had unexplained weight loss or weight gain in the past year	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have concerns regarding my nutrition	<input type="checkbox"/> Yes <input type="checkbox"/> No
I am able access the local grocery store or farmers market, as needed	<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments:

Member Name:
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Toxin Exposure

I have had the following exposure to toxins (e.g. Radon, lead in drinking water, lead in paint, chemicals, in-utero drug or alcohol exposure including smoking, alcohol poisoning, etc. If none, indicate no known exposure.):

Toxin	Exposure (inhalation, ingestion, direct contact)	Dates	Effects

Domestic Violence, Physical, Emotional, Sexual Abuse & Trauma

I have been a victim of	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Psychological Abuse
	<input type="checkbox"/> Emotional Abuse	<input type="checkbox"/> Sexual Abuse	
I have been a perpetrator of	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Psychological Abuse
	<input type="checkbox"/> Emotional Abuse	<input type="checkbox"/> Sexual Abuse	
I have a history of trauma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
My trauma history includes			

Additional information regarding domestic violence, physical, emotional, sexual abuse (i.e. don't identify people by name but as friend, neighbor, family member, etc.):

Medications

In the **past year**,

I have had significant medication changes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments:
I have forgotten to refill medications on time	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments:

I store my medications in the following location(s):

I forget to take my prescribed medications:

Daily Weekly Once/ Twice a Month Infrequent Never

I remember to take my medications by (select all that apply):

Following directions Caregiver gives them to me Medication machine
 Timer Calendar Pill minder
 Nurse/Home Health set up Staff Other (note in comments)

Comments:

I am currently taking:

- Prescription medication Yes No
- Over the counter medications, including vitamins Yes No

Member Name:
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I know what medications I take and why I take them: Yes No

Comments:

I am able to self-administer my medications: Yes No

Comments:

I have the following additional medication needs or concerns:

Current Medications

My current medications (include prescription, over the counter & vitamins):

Medication Name	Dosage	Frequency	Prescriber	Reason/Purpose	Date Started

Past Relevant Medications

Past medications tried:

Medication Name	Dates	Reason Discontinued (e.g. specific side effect, insurance coverage, medication wasn't effective)

Member Name:
 Medicaid #:

Pharmacy

I have a pharmacy that I use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pharmacy Name		
Pharmacy Address		
Pharmacy Phone		
I am locked into a pharmacy	<input type="checkbox"/> Yes	<input type="checkbox"/> No

My Current Medical Support Team

Role	Name/ Agency	Address	Last Visit Date	Reason for Last Visit
Primary Care Practitioner (PCP)				
Dentist				
Eye Doctor				
Audiologist				
Therapist				
Psychiatrist				
Speech Therapy				
Physical Therapy				
Occupational Therapy				
Other Specialties (list)				

I currently need assistance to access or identify the following providers:

Supports & Services Received

I **currently** receive the following supports & services (i.e. Therapy (individual, group, family), Psychiatry services, Intensive Outpatient, Medication Management, HCBS waiver services, BHIS, Habilitation services, Transportation, In-Home Care, Durable Medical Equipment, Alcohol and/ or Substance use/ abuse services, etc.):

Service Type	Provider Name	Provider Address	Successful or Helpful	Dates of Service
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Comments:

My **past** supports & services I have accessed (i.e. Therapy (individual, group, family), Psychiatry services, Intensive Outpatient, Medication Management, HCBS waiver services, BHIS, Habilitation services, Transportation, In-Home Care, Durable Medical Equipment, Alcohol and/ or Substance use/abuse services, etc.):

Member Name:
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Service Type	Provider Name	Provider Address	Successful or Helpful	Dates of Service
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Comments:

I am satisfied with my current supports and services: Yes No

If no, explain:

I participate in support groups (e.g. NAMI, NA/AA, etc.): Yes No

If yes, explain (type/frequency):

I want to participate in support groups (e.g. NAMI, NA/AA, etc.): Yes No

If yes, explain (type/reason):

Substance Use or Abuse

I have a history of alcohol and/or substance use: Yes No

I live with or spend time with a person who has alcohol or substance abuse concerns, including misuse of prescription medication: Yes No *If yes, provide additional information:*

The following people in my life (e.g. spouse, partner, parents/guardian, friend, child, etc.) are concerned about my substance and/or tobacco use: Yes No *Describe:*

Alcohol Use

I consume alcoholic beverages	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, skip to caffeine use</i>
I drink alcohol	<input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 4 or more times a week
On a typical day, I consume this many alcohol drinks	<input type="checkbox"/> 1-2 drinks <input type="checkbox"/> 7-9 drinks <input type="checkbox"/> 3-4 drinks <input type="checkbox"/> 10 or more drinks
I drink 5 or more drinks on one occasion	<input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 4 or more times a week
In the past year, I have consumed, 5 or more drinks for men or 4 or more drinks for women, per day	<input type="checkbox"/> Yes <input type="checkbox"/> No
My choice of alcohol is	
I first used alcohol at age	
My longest sobriety was	

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Caffeine Use

In the past two weeks , I have consumed the following caffeinated beverages per day	<input type="checkbox"/> No coffee or caffeinated beverages <input type="checkbox"/> 1-2 cups of coffee or 1-4 caffeinated beverages <input type="checkbox"/> 3-6 cups of coffee or 5-9 caffeinated beverages <input type="checkbox"/> 7 or more cups of coffee or 10 or more caffeinated beverages
My preferred choice of caffeinated beverage is	

Illegal Substances

I have used illegal substances	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, skip to tobacco use</i>
I use illegal substances	<input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 4 or more times a week
In past year, I have used an illegal drug	<input type="checkbox"/> Yes <input type="checkbox"/> No
In past year, I have used prescription medication for non-medical reasons	<input type="checkbox"/> Yes <input type="checkbox"/> No
My preferred choice of illegal substance is	
I first used illegal substances at age	
I have tried the following illegal substances	

Tobacco Use

I currently smoke or use other forms of tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, skip to alcohol/substance abuse treatment</i>
My choice of tobacco is	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> E-cigarettes/Vape <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Other
I use tobacco	<input type="checkbox"/> Sometimes (few times a month) <input type="checkbox"/> Occasionally (few times a week) <input type="checkbox"/> Daily For cigarettes/cigars/vaping, answer the following: <input type="checkbox"/> Light cigarette smoker (1-9 cigs/day) <input type="checkbox"/> Moderate cigarette smoker (10-19 cigs/day) <input type="checkbox"/> Heavy cigarette smoker (20-39 cigs/day) <input type="checkbox"/> Very heavy smoker (40+cigs/day)
In past year, I have used tobacco	<input type="checkbox"/> Sometimes (few times a month) <input type="checkbox"/> Occasionally (few times a week) <input type="checkbox"/> Daily Type/Comments:
I first used tobacco at age	

Alcohol/Substance Abuse History

My family history of substance use, treatment and/or issues include:

Additional alcohol/substance use comments:

Gambling/Dependence

I have gambled money or goods in the past year: Yes No *If no, skip to Self-Care/ADLs/IDLs Section.*

In the **past 12 months**, I have

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Become restless, irritable, or anxious when trying to stop or cut down on gambling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tried to keep my family or friends from knowing how much I have gambled	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Had financial trouble as a result of my gambling, that I had to get help with living expenses from family, friends or other sources	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Self-Care/ADLs/IDLs

I need assistance with the following:

Activity	Independent	Supervision/ Verbal Prompts/ Cueing	Assistive Device	Physical Assistance	Total Dependence	Frequency of Assistance	
						Daily	Intermittent
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming and personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
House-keeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handling transportation (driving or navigating public transit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the telephone or other communication devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If assistance is needed to participate in an activity listed in the table above, include information about the type of supervision, physical assistance, and/or use of assistive devices or adaptive equipment needed:

Caregiver(s) Natural Supports

I have an unpaid caregiver(s)/natural support who assists with me with activities above: Yes No

Member Name:
 Medicaid #:

If yes, list caregiver name, assistance and frequency:

My Caregiver(s)/natural support reports feelings of stress: Yes No

The caregiver(s)/natural support access the following supports, training, and resources:

The caregiver(s)/natural support needs the following supports, training, and resources:

Transportation

I am able to arrange my own transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have a valid driver's license	<input type="checkbox"/> Yes <input type="checkbox"/> No
I have a safe/reliable vehicle	<input type="checkbox"/> Yes <input type="checkbox"/> No
I am able to use public transportation	<input type="checkbox"/> No help or supervision <input type="checkbox"/> Need some help or occasional supervision <input type="checkbox"/> Need a lot of help <input type="checkbox"/> Need consistent help
I am able to get to the places I want (check all that apply)	<input type="checkbox"/> Walking <input type="checkbox"/> Bicycle <input type="checkbox"/> Drive <input type="checkbox"/> Take a taxi/bus <input type="checkbox"/> Family/friends drive <input type="checkbox"/> Staff/Provider <input type="checkbox"/> Other, describe

I have the following transportation needs or concerns, not identified above:

Employment & Volunteering

I am currently working: Yes No I am under age 14 (skip to Educational History section)

If working:

I work _____ hours a week doing the following: _____.

I like my current job: Yes No

I want to find a different job: Yes No *If yes, I am interested in:*

I have supports that assist me with maintaining my job: Yes No *If yes, I am currently receiving the following supports (name, type of support & # of hours of support):*

If not working:

I want to obtain a job: Yes No

I am interested in (identify job interest, why and # of hours):

I need the following supports to be successful in obtaining a job:

I am currently working with Iowa Vocational Rehabilitation Services (IVRS): Yes No

If yes, I began working with IVRS on the following date:

My IVRS counselor name, address & phone number is:

My past work history includes:

Employer	Services/Supports Received, if applicable	Summary About Employment (Like/dislike job, quit/fired, etc.)	Employment Dates

Member Name:
Medicaid #:

I am currently volunteering or interested in volunteering: Yes No

I volunteer at: _____ doing the following:

I volunteer these days:

I am interested in volunteering at or doing:

Additional employment/volunteering comments:

Educational History

I am currently in school: Yes No *If yes, where:*

If yes, are you in any extra-curricular activities: Yes No Explain:

I attend school as scheduled (i.e. following attendance policy, are there truancy issues, etc.): Yes No

Comments:

The highest level of education I have completed is:

- I am currently in K–12th grade GED/Hi-Set High School Diploma Technical School
 Certificate 2 year Degree 4 year Degree
 Master's Doctorate/PhD Did not complete high school
 Other

I have a degree(s)/certificate(s), post high school/GED/Hi-Set: Yes No *If yes, explain date obtained and specialty obtained:*

I would describe my school experience as:

I receive or received the following supports/services (e.g. AEA, special educations, etc.) in school:

I am interested in furthering my education: Yes No *If no, skip to Housing Situation section*

I would like to go to school for:

I need assistance or support in gaining access to educational services: Yes No *If yes, explain type of assistance/support needed:*

Additional educational comments:

Housing Situation

I currently live (check all applicable):

- Alone With Immediate Family With Relatives
 With Friends With Roommates Other, describe

I currently reside in:

- Own home Apartment Family/Friend Home
 Shelter Homeless Residential Care Facility (RCF) Psychiatric Medical Institute
 Other, describe

I feel safe in my home: Yes No *If no, why:*

Member Name:
Medicaid #:

The exits in my home/residence are easily accessible in case of an emergency: Yes No *If no, describe plan to make accessible:*

I feel safe in my neighborhood: Yes No *If no, why:*

I am able to access emergency assistance in case of an emergency by (check all applicable):

- Cell Phone Family Neighbor Personal Emergency Response System
 Staff/Provider Other, describe

In the **next 2 months**, I am worried that I may not have stable housing: Yes No

I have the following additional housing needs or concerns:

Financial

Representative Payee & Conservator

I have a representative payee: Yes No

Representative Payee Name:
Address (Street, City, State, Zip)
Phone: Email:

I have a conservator: Yes No

Conservator Name:
Address (Street, City, State, Zip)
Phone: Email:

Income and Resources

I receive the following income and monthly amounts (Social Security, work wages, etc.):

Income Type	Amount	Frequency (Monthly, weekly, etc.)
Social Security (SSDI/SDAC/SSI)		
Retirement		
Work Wages		
Other:		

I am able to manage my own finances (i.e. understands use of money, can pay for things, pay bills, and balances a checkbook):

- Needs no help or supervision Needs some help or occasional supervision
 Needs a lot of help or constant supervision Can't do it at all

Comments:

I need legal aid assistance: Yes No *If yes, explain:*

In the **last 3 months**, I ate less because there wasn't enough money for food:

Yes No

In the **last 6 months**, I have had my electric, gas, oil or water company threaten to shut off my service:

Yes No

Member Name:
Medicaid #:

I have problems getting child care & it makes it hard for me to work or study: Yes No

If yes, explain:

I have the following additional financial needs or concerns:

I currently

receive food stamps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
access the food pantry	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
receive housing assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:

Additional community resources I use or need:

Legal Information

Legal Guardian

I have a legal guardian: Yes No

Name	
Address (Street, City, State, Zip)	
Phone	
Email	

Advanced Directive

I have an advanced directive in place: Yes No

If no, I would like information on how to complete this: Yes No

The following information was provided to me:

Power of Attorney

I have a power of attorney: Yes No

Name	
Type of Power of Attorney	
Address (Street, City, State, Zip)	
Phone	
Email	

Mental Health Committal

I have a mental health committal: Yes No

Committal County	
Judicial Advocate Name	
Address (Street, City, State, Zip)	
Phone	
Email	

Substance Abuse Committal

I have a substance abuse committal: Yes No

Committal County	
------------------	--

Member Name:
Medicaid #:

Judicial Advocate Name	
Address (Street, City, State, Zip)	
Phone	
Email	

Probation or Parole

I am on probation or parole: Yes No

Probation/Parole Officer Name	
Judicial Advocate Name	
Address (Street, City, State, Zip)	
Phone	
Email	

Summary of arrest history:

I have a no contact order in place: Yes No Details:

I am on the child abuse registry: Yes No Summary:

I am on the sex offender registry: Yes No Summary:

For **Children ONLY**,

My child has the following in place:

Child in need of assistance (CINA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
Child protection order	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
Foster Care Placement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foster Parent Names:
Other court order	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:

Future Identified Goals & Needs

A typical day for me is (e.g. starting from when you get up until bed time, outline your basic routine)?

I would like to change the following, if anything, about my day:

I have the following urgent needs (e.g. I don't have food tonight, don't have a place to sleep):

I would like to receive assistance with those needs: Yes No

My overall goal for improving my health and life is:

The following describes how ready I am to change or take action on my goals:

- Not planning to take action within the near future
- Planning to take action within the next six months
- Planning to take action within the next month and have a plan of how to do this
- I've already made significant modifications in my way of life

Comment:

The most important thing for me to address is:

I am aware that this could require a personal change to address this need: Yes No

Member Name:
Medicaid #:

On a scale of 0 – 10, with 10 being extremely important, I would rate this as a
On a scale of 0 – 10, with 10 being extremely confident, I would rate my confidence in making this change
a

The second most important thing for me is:

I am aware that this could require a personal change to address this need: Yes No
On a scale of 0 – 10, with 10 being extremely important, I would rate this as a
On a scale of 0 – 10, with 10 being extremely confident, I would rate my confidence in making this change
a

The third most important thing for me is:

I am aware that this could require a personal change to address this need: Yes No
On a scale of 0 – 10, with 10 being extremely important, I would rate this as a
On a scale of 0 – 10, with 10 being extremely confident, I would rate my confidence in making this change
a

I need the following support to accomplish my goal(s):

Identified risks and needs by the Assessor

Using the information in this assessment, complete each area.

Cognitive functioning. *Considerations: Cognitive functions, including the member’s ability to communicate and understand instructions, process information about an illness, focus and shift attention, comprehend and recall direction independently:*

Choose an item.

Visual and hearing needs, preferences or limitations. *Considerations: Member’s vision and hearing, and the impact on member’s case management plan and barriers to effective communication or care. Examples include visual impairment and need for/use of visual aids, hearing impairment and need for/use of hearing aids or other supports or devices:*

Choose an item.

Social functioning. *Considerations: Social functioning refers to an ability to interact easily and successfully with other people. Examples include engagement with family and friends, social isolation, employment status:*

Choose an item.

Cultural and linguistic needs, preferences or limitations. *Considerations: Member’s cultural health beliefs/practices/needs, preferred languages and needs, and the impact of culture and language on communication, care, or acceptability of specific treatments:*

Choose an item.

Health status, including condition-specific issues. *Considerations: Active diagnoses, physical health conditions, co-morbidities, self-reported health status, current medications (including dosages and schedule):*

Choose an item.

Behavioral health status. *Considerations: Behavioral health status, including mental health conditions and substance use disorders (examples: substance use disorders, suicidal ideation, depression, psychosis):*

Choose an item.

Member Name:
Medicaid #:

Available benefits within the organization. *Considerations: Adequacy of the member's health insurance benefits in relation to the needs of the case management plan. Examples include benefits covered by the organization and providers, services carved out by the purchaser, services that supplement those the organization is contracted to provide such as community mental health/subsidized housing/palliative care programs:*

Choose an item.

Activities of daily living, including use of supports. *Considerations: ADL examples include grooming, dressing, bathing, toileting, eating, transferring, continence, walking; supports including assistive technology and human assistance:*

Choose an item.

Instrumental activities of daily living, including use of supports. *Considerations: IADL examples include managing finances, shopping, preparing meals, managing medications, housework and basic home maintenance, handling transportation, using telephone and other communication devices; supports including assistive technology and human assistance:*

Choose an item.

Paid and unpaid caregiver resources, involvement and needs. *Considerations: Adequacy of caregiver resources. For example, family involvement in the case management plan and carrying it out, availability/skills/capacity of caregivers to provide support of requested ADL/IADL, undue burden on caregiver, caregiver support needs:*

Choose an item.

Community resources. *Considerations: Member's eligibility for community resources and the availability of those resources. Examples include community mental health, vocational programs, volunteer companion services, government aid, senior centers, adult day care, support groups, poverty outreach groups, housing resources, legal aid, and palliative care programs:*

Choose an item.

Social determinants of health. *Considerations: Social determinants of health refer to the economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include current housing and housing security, access to local food markets, exposure to crime/violence/social disorder, residential segregation and other forms of discrimination, access to mass media and emerging technologies, social support/norms/attitudes, access to transportation, and financial barriers to obtaining treatment:*

Choose an item.

Health beliefs and behaviors. *Considerations: Health beliefs and behaviors may reflect cultural and social beliefs about health problems, perceived benefits of action, and barriers to action. Examples include optimism, self-efficacy, and physical activity, smoking, alcohol use, medication adherence, beliefs and concerns about the condition or services the member is receiving:*

Choose an item.

Physical environment for risk. *Considerations: Member's physical environment and risks. Examples include fall risks, medication risks, accessibility of exits, and access to emergency assistance:*

Choose an item.

Member Name:
Medicaid #:

Habilitation Eligibility (only complete if applying or accessing habilitation)

Risk Factor – meets at least 1 of the following

- A history of inpatient, partial hospitalization, or emergency psychiatric treatment more than once in the individual's life; or
- The individual has a history of continuous professional psychiatric supportive care other than hospitalization; or
- The individual has a history of involvement with the criminal justice system; or Services available in the individual's community have not been able to meet the individual's needs; or
- The individual has a history of unemployment or employment in a sheltered setting or poor work history; or
- The individual has a history of homelessness or is at risk of homelessness

Need for Assistance – meet at least 2 of the following on a continuing or intermittent basis for at least 12 months

- The individual needs assistance to obtain and/or maintain employment.
- The individual needs financial assistance to reside independently in the community.
- The individual needs significant assistance to establish or maintain a personal social support system.
- The individual needs assistance with at least one activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to reside independently in the community.
- The individual needs assistance with management and intervention of maladaptive or antisocial behaviors to ensure the safety of the individual and/or others.

SIGNATURE

Name, Credentials

Date

Member/Guardian

Date

Title:

Date

Title:

Date