Comprehensive Needs Assessment

Member Name:
<First Name> <Last Name>

Member ID: <Member_ID>

Member Date of Birth:
<MM/DD/YYYY>

We would like to get to know you better. We will be asking you to provide some personal information, including race, ethnicity, gender, and language preferences. We collect this information to improve the quality of care for everyone we serve. We will protect your answers and keep them confidential. This questionnaire is completely voluntary. You may choose not to answer any or all of the questions. Your care and benefits will not change because of your answers or if you do not answer any or all of the questions.

1. **What is your ethnicity?**
   - ☐ Hispanic or Latino, or of Spanish origin
   - ☐ Not Hispanic or Latino, or of Spanish origin
   - ☐ I don't know
   - ☐ I choose not to answer

2. **What is your race? You may select more than one response.**
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or other, Pacific Islander
   - ☐ White
   - ☐ Other race. Please specify: _____
   - ☐ I don't know
   - ☐ I choose not to answer

3. **What is your sex assigned at birth?**
   - ☐ Female
   - ☐ Male
   - ☐ Intersex
   - ☐ I don't know
   - ☐ I choose not to answer

4. **What gender do you most identify with?**
   - ☐ Female
   - ☐ Male
   - ☐ Nonbinary/Genderqueer
   - ☐ Transgender male/trans man/female-to-male (FTM)
   - ☐ Transgender female/trans woman/male-to-female (MTF)
   - ☐ Other, please specify: _____
   - ☐ I choose not to answer

5. **In which language do you prefer to speak?**

   - ☐ English
   - ☐ Spanish
   - ☐ Portuguese – Brazilian
   - ☐ Portuguese – European
   - ☐ Vietnamese
   - ☐ Chinese – Cantonese
   - ☐ Chinese – Mandarin
   - ☐ French
   - ☐ Cape Verdean Creole
   - ☐ Haitian Creole
   - ☐ Arabic
   - ☐ Tagalog
   - ☐ Other – please specify: _____

6. **In which language do you prefer to read?**

   - ☐ English
   - ☐ Spanish
   - ☐ Portuguese – Brazilian
   - ☐ Portuguese – European
   - ☐ Vietnamese
   - ☐ Chinese – Cantonese
   - ☐ Chinese – Mandarin
   - ☐ French
   - ☐ Cape Verdean Creole
   - ☐ Haitian Creole
   - ☐ Arabic
   - ☐ Tagalog
   - ☐ Other – please specify: _____

7. In which language do you prefer to write in?

- ☐ English
- ☐ Spanish
- ☐ Portuguese – Brazilian
- ☐ Portuguese – European
- ☐ Vietnamese
- ☐ Chinese – Cantonese
- ☐ Chinese – Mandarin
- ☐ French
- ☐ Cape Verdean Creole
- ☐ Haitian Creole
- ☐ Arabic
- ☐ Tagalog
- ☐ Other – please specify: _____

8. Do you need written materials in an alternate format?

- ☐ Yes
- ☐ No
- ☐ If yes, which format?
  - ☐ Braille
  - ☐ Audio File
  - ☐ Large Print
  - ☐ Other _____

9. Which assistive devices or service communication do you use? (Check all that apply.)

- ☐ TTY
- ☐ Video Remote Interpreting (VRI)
- ☐ Video Relay Services (VRS)
- ☐ Interpreter services
- ☐ Screen reader software
- ☐ Other, please specify: _____
- ☐ None

10. What is the highest level of education that you have completed?

- ☐ Grade 1-6
- ☐ Grade 7-9
- ☐ Grade 10-12
- ☐ High School diploma
- ☐ Vocational certificate
- ☐ Some college (no degree)
- ☐ Associate degree, please specify: _____
- ☐ Bachelor's degree, please specify: _____
- ☐ Graduate degree, please specify: _____
- ☐ I choose not to answer

11. What is your housing situation today?

- ☐ I have a steady place to live
- ☐ I have a place to live today but am worried about losing it in the future
- ☐ I do not have a steady place to live (I am staying temporarily with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- ☐ I choose not to answer

12. What type of home do you live in?

- ☐ Single family home
- ☐ Apartment
- ☐ Mobile Home
- ☐ Senior, Retirement, or Assisted Living Facility
- ☐ Homeless
- ☐ Other, please specify: _____

13. If homeless, please describe your situation:

- ☐ Shelter, please specify: _____
- ☐ Staying with friends/family, please specify: _____
- ☐ Street, please specify: _____
- ☐ Crisis residence, please specify: _____
- ☐ Other, please specify: _____

14. Who do you currently live with?

- ☐ Alone
- ☐ Partner/significant other
- ☐ Family with children (under 18)
- ☐ Family with no children
- ☐ Roommates
- ☐ Friends
- ☐ Other, please specify: _____

15. Do you have children?

- ☐ Yes – over the age of 18
  - If yes, do they live with you?
    - ☐ Yes
    - ☐ No
- ☐ Yes – under the age of 18
  - If yes, do they live with you?
    - ☐ Yes
    - ☐ No
- ☐ No, I don't have children

16. Think about where you live. Do you have problems with any of the following? (Check all that apply).

- ☐ Mold
- ☐ Lead paint or paint
- ☐ Inadequate heat
- ☐ Oven or stove not working
- ☐ No smoke detectors OR smoke detectors not working
- ☐ Water leaks
- ☐ None of the above
- ☐ Other, please specify: _____

17. Do you have overdue rent or are pending eviction?

- ☐ Yes
- ☐ No

18. Indicate if there are any special needs in relation to housing placement:

- ☐ Wheelchair accessible
- ☐ Unable to climb stairs
- ☐ Legal restrictions
- ☐ Other, please specify: _____

19. Do you have a case manager/residential counselor assigned?

- ☐ Yes
- ☐ No

20. Do you receive a housing subsidy?

- ☐ Yes
- ☐ No

21. How long have you lived in your current housing?

- ☐ Less than 1 year
- ☐ 1-2 years
- ☐ Greater than 2 years

22. What are your sources of income? (Check all that apply)

- ☐ Paid employment
- ☐ Cash assistance: SNAP, WIC and or Unemployment
- ☐ Supplemental Security Income (SSI)
- ☐ Social Security Disability Insurance (SSDI)
- ☐ HIV/AIDS Services (HASA)
- ☐ Veteran's benefits
- ☐ Retirement Benefits/Pension Funds
- ☐ Other, please specify: _____

23. Is your income sufficient to meet your basic needs (e.g.: food, clothing, shelter?

- ☐ Yes
- ☐ No

24. Which of these statements best describes the food eaten in your household in the last 12 months?

- ☐ Enough of the kinds of foods I want to eat
- ☐ Enough, but not always the kinds of foods I want to eat
- ☐ Often not enough to eat
- ☐ I don't know
- ☐ I choose not to answer

25. If you do not have access to the food you need, what are the barriers?

- ☐ Finances
- ☐ Transportation
- ☐ Distance to the nearest food market
- ☐ Physically unable to shop
- ☐ Other, please specify: _____

26. In the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work or from getting the things you need for daily living?

- ☐ Yes
- ☐ No

27. Do you need assistance applying to and/or following up with additional benefits?

- ☐ Yes

  Additional benefits needed. (Check all that apply):

  - ☐ Medicaid
  - ☐ Cash assistance
  - ☐ Food stamps
  - ☐ Supplemental Security Income
  - ☐ HIV/AIDS Services Administration
  - ☐ Veteran's benefits
  - ☐ Fair hearing
  - ☐ Other, please specify: _____

- ☐ No

28. In general, how would you rate your health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

29. Have you been seen in the Emergency Room in the past 12 months?

☐ Yes

If yes, how many times:

☐ 1

☐ 2

☐ 3 or more

☐ No

30. Have you been hospitalized in the past 12 months?

☐ Yes

If yes, how many times:

☐ 1

☐ 2

☐ 3 or more

☐ No

31. Have you had any hospitalizations, major procedures and/or surgeries?

☐ Yes

Please specify:

_____

_____

☐ No

32. Do you have any significant past illnesses and/or treatment history?

☐ Yes

Please specify:

_____

_____

☐ No

33. Are you connected to a Primary Care Provider and/or Clinic?

☐ Yes

If yes, please provide the following information:
Name of Primary Care Provider and/or Clinic:

_____

Address of Primary Care Provider and/or Clinic:

_____

Phone number of Primary Care Provider and/or Clinic:

_____

☐ No

Please specify:

_____

34. Medical Diagnoses

Have you been diagnosed with any of the following conditions? Please check all that apply:

☐ Anxiety
☐ Asthma
☐ Bipolar Disorder
☐ Cancer
☐ COPD/Emphysema
☐ Heart Disease
☐ Dementia
☐ Diabetes
☐ Heart Failure
☐ Kidney Failure
☐ Low Back Pain
☐ Organ Transplant
☐ Obesity
☐ Schizophrenia
☐ Stroke
☐ Hypertension
☐ None
☐ Other, please specify:

_____

35. Have you been screened for diabetes in the past year?

☐ Yes

Please provide the date of the screening:

_____

☐ No

36. Are you experiencing any of the following?

☐ Increase in thirst
☐ Increase in urination
☐ None

37. If you have been diagnosed with diabetes, have you had an HbA1c test in the last year?

☐ Yes
If yes, please provide the following information:
Date of the last HbA1c test:
_____
Results of the last Hba1c test:
_____

☐ No – I have an appointment to have an HbA1c test
Date of appointment:
_____

☐ No – I do not have an appointment to have an HbA1c test
Please specify:
_____

38. Have you been screened for asthma or COPD in the past year?

☐ Yes
If yes, please provide the date of the screening:
_____

☐ No

39. Have you experienced any of the symptoms below within the past 4 months?

☐ Cough
☐ Wheezing
☐ Shortness of breath
☐ Excessive sputum
☐ None

40. Have you had a blood pressure screening in the past year?

☐ Yes
If yes, please provide the date of the screening:
_____

☐ No

41. Have you experienced any of the symptoms below within the past 4 months?

☐ Dizziness
☐ Palpitations
☐ Headaches
☐ Shortness of breath
☐ None

42. Cognitive Function: Do you ever miss important events like birthdays and appointments due to forgetfulness?

- ☐ Yes
- ☐ No

43. Do you, your friends or family have concerns about your memory?

- ☐ Yes
- ☐ No

44. Because of a physical, mental, or emotional problem, do you have serious difficulty remembering, concentrating, or making decisions?

- ☐ Yes
- ☐ No

45. Life Planning: Do you have any advance directives, such as a health care proxy, power of attorney for health care, or living will? (These are written documents concerning the medical care you would want if you were not able to speak for yourself?

- ☐ Yes

  If yes, which of the following do you have?

  - ☐ Power of Attorney
  - ☐ Living Will
  - ☐ DNR (Do Not Resuscitate)
  - ☐ Healthcare Proxy
  - ☐ MOLST
  - ☐ POLST
- ☐ No

46. Do you need assistance in obtaining any advance directives?

- ☐ Yes

  If yes, please specify: _____
- ☐ No

47. Is there anything that we should know about your culture, beliefs, or religious practices that would help us take better care of you?

- ☐ Yes

  If yes, please specify: _____
- ☐ No

48. Hearing, Visual and Dental Screenings: Do you have any hearing issues?

☐ Yes

Are you deaf or have serious difficulties when wearing hearing aids?

☐ Yes

☐ No

☐ No, I do not have hearing issues

49. Do you need assistance in obtaining hearing services?

☐ Yes

☐ No

50. Do you have any visual issues?

☐ Yes

Are you blind or have serious difficulty seeing, even when wearing glasses?

☐ Yes

☐ No

☐ No, I do not have visual issues

51. Do you need assistance in obtaining vision services?

☐ Yes

☐ No

52. Do you have any dental issues?

☐ Yes

☐ No

53. Do you need assistance in obtaining dental services?

☐ Yes

☐ No

54. Do you ever leak urine? (Check all that apply)

☐ Yes

Does it happen during the following?

☐ Standing

☐ Coughing

☐ Sudden urge

☐ Bending

☐ None

☐ No, I don't leak urine

55. If applicable, how many times per week do you leak urine?

- ☐ Occasionally
- ☐ Daily
- ☐ Several times a day
- ☐ Not applicable

56. If applicable, do you use a urinary catheter or any urinary device?

- ☐ Pads
- ☐ Briefs
- ☐ Catheter
- ☐ None
- ☐ Not applicable

57. Do you have trouble holding a bowel movement?

- ☐ Yes

  How many times per week or month does it happen?

  - ☐ Occasionally
  - ☐ Daily
  - ☐ Several times a day

- ☐ No

58. If applicable, when you have trouble holding a bowel movement, is your stool typically:

- ☐ Loose
- ☐ Formed
- ☐ Not applicable

59. Activities of Daily Living (ADLs): Do you need assistance with any activities of daily living (such as grooming, dressing, walking, eating & drinking, etc.)?

☐ Yes

Which ADLs do you need assistance with? (Check all that apply)

☐ Grooming

☐ Dressing

☐ Bathing and showering

☐ Getting in/out of the bed/shower

☐ Walking

☐ Eating or drinking

☐ Toileting

☐ Climbing stairs

☐ No, I am fully independent

60. Instrumental Activities of Daily Living (IADLs): Do you need assistance with any instrumental activities of daily living (such as using the telephone, preparing meals, shopping, transportation, etc.)?

☐ Yes

Which IADLs do you need assistance with? (Check all that apply)

☐ Telephone

☐ Preparing meals

☐ Laundry

☐ Housekeeping

☐ Shopping

☐ Transportation

☐ No, I am fully independent

61. Caregiver support: Which statement describes you best?

☐ You are independent and do not need caregiver assistance

☐ You do not have a caregiver but would benefit from assistance

☐ You have a caregiver and support is adequate

Please provide the following information:

Caregiver's name: _____

Caregiver's contact number: _____

☐ You have a caregiver, but support is inadequate

Please provide the following information:

Caregiver's name: _____

Caregiver's contact number: _____

62. If applicable, does your current caregiver live with you?

☐ Yes

☐ No

☐ Not applicable

63. If applicable, what is your relationship to the caregiver?

☐ Family member

☐ Friend

☐ Neighbor

☐ Paid support

☐ Not applicable

64. If applicable, which of the following statements are true about your caregiver? (Check all that apply)

☐ Current caregiver is unable to continue caregiving activities (ex. due to decline in the caregiver's health, which makes it difficult to provide support.)

☐ Current caregiver is not satisfied with support received from family and friends (ex. other children of the member.)

☐ Current caregiver expresses feelings of emotional distress or anger

☐ Current caregiver can manage duties without any difficulties

☐ Not applicable

65. Long Term Support Services: Do you have any of the following long term supports in place? (Check all that apply)

☐ Personal Care Assistance

☐ Homemaker

☐ Laundry

☐ Grocery

☐ Transportation

☐ None

66. Do you have any of the following support services in place? (Check all that apply)

☐ Home Health Aide

☐ Adult Foster Care

☐ Group Adult Foster Care

☐ Visiting Nurse

☐ None

67. Would you benefit from any support services?

☐ Yes

If yes, what services could you benefit from?

_____

☐ No

68. Do you have other support systems or attend support groups (social, religious, self-help, etc.)?

☐ Yes

If yes, please specify?

_____

☐ No

69. Is there somebody who can help you to cope with any problems you might be having?

☐ Yes

☐ No

70. Do you have a condition that causes pain?

☐ Yes

If yes, on a scale of 1-10, what is the level of pain? (10 being the highest)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ No

71. If applicable, in the past week, how often have you experienced pain?

☐ Daily

☐ Some days

☐ Not at all

☐ Not applicable

72. If applicable, how do you treat your pain? (Check all that apply)

☐ Topical ointment/patch

☐ Over the counter medication

☐ Prescribed medication

☐ Heat/Cold therapy

☐ No treatment

☐ Other, please specify: _____

☐ Not applicable

73. If applicable, do the treatment(s) relieve your pain?

☐ Mostly, yes

☐ Often

☐ Sometimes

☐ No

☐ Not applicable

74. Have you lost or gained weight in the past 30 days?

☐ Lost weight
Please specify how many pounds (lbs.): _____

☐ Gained weight
Please specify how many pounds (lbs.): _____

☐ No, I did not lose or gain weight

75. Have you been diagnosed with any of the following conditions (Check all that apply)?

☐ Anxiety
☐ Bipolar Disorder
☐ Dementia
☐ Depression
☐ Other psychotic disorder, please specify: _____
☐ Post Traumatic Stress Disorder
☐ Schizophrenia
☐ Substance Use Disorder
☐ None

76. Do you have a history of substance use?

☐ Yes

If yes, please check all that apply:

☐ Alcohol
☐ Tobacco
☐ Marijuana
☐ Cocaine
☐ Opioids
☐ Crack
☐ Heroin
☐ Hallucinogenic
☐ Methamphetamine
☐ Prescriptions drugs
☐ Other, please specify: _____

☐ No

77. If applicable, please specify your preferred mode of substance administration (Check all that apply)

☐ Oral
☐ Injection
☐ Inhalation/Smoking
☐ Snorting
☐ Other, please specify: _____
☐ Not applicable

78. How would you describe your alcohol consumption frequency?

- ☐ Never
- ☐ Monthly or less
- ☐ 2 to 4 times a month
- ☐ 2 to 3 times a week
- ☐ 4 or more times a week

79. Have you consumed more than 5 drinks on any single occasion during the last year?

- ☐ Yes
- ☐ No
- ☐ Does not apply (I do not drink alcohol)

80. Have you thought about or tried reducing the amount of alcohol or drugs used during the last year?

- ☐ Yes
- ☐ No
- ☐ Does not apply

81. If applicable, select the treatment you've received for alcohol and drug use (Check all that apply)

- ☐ AA/ NA/ Self Help
- ☐ Recovery Readiness
- ☐ Methadone Maintenance
- ☐ Harm reduction/ Need Exchange
- ☐ Detox (Inpatient or ambulatory)
- ☐ Does not apply
- ☐ Inpatient Substance/ Alcohol (Rehab)
- ☐ Outpatient Alcohol
- ☐ Residential
- ☐ Other, please specify: _____

82. Over the last 2 weeks, how often have you been bothered by any of the following problems? ** *If you need someone to talk to or have any thoughts of hurting yourself or others, please dial 988 for the national 24-hour helpline***

- ☐ Little interest or pleasure in doing things
  How often:
  - ☐ Not at all
  - ☐ Several days
  - ☐ More than half the days
  - ☐ Nearly everyday
- ☐ Feeling down, depressed, or hopeless
  How often:
  - ☐ Not at all
  - ☐ Several days
  - ☐ More than half the days
  - ☐ Nearly everyday

83. Do you have a mental health provider?

☐ Yes

Provider's name: _____

Provider type: _____

Provider's address:

_____

_____

_____

☐ No

84. Have you had an appointment with a mental health provider?

☐ Yes

When was the appointment? _____

☐ No

85. Do you have another appointment scheduled with your mental health provider?

☐ Yes

When is the appointment? _____

☐ No

86. Do you regularly attend your mental health appointments?

☐ Yes

☐ No

☐ Not applicable

87. Do you feel safe at home?

☐ Yes

☐ No

If no, please explain: _____

88. Are you currently working with any state agencies?

☐ Yes

If yes, please specify: _____

☐ No

89. Do you take any prescription medications, vitamins, and supplements?

☐ Yes

☐ No

Medication, vitamin, or supplement name	Dose	Frequency	Prescriber

90. If applicable, do you take your medications as prescribed?

- ☐ Yes
- ☐ No

  If no, please check all that apply:

  - ☐ Unable to pay for medications
  - ☐ Disbelief that the treatment is necessary or helping me
  - ☐ Difficulty keeping up with multiple medications and complex dosing schedules
  - ☐ Confused about how and when to take medication(s)
  - ☐ Side effects or fear of side effects
  - ☐ Issues with transportation
  - ☐ Missed appointments
- ☐ Not applicable

91. Do you get side effects from your prescribed medication(s)?

- ☐ Yes
- ☐ No
- ☐ Does not apply

92. Do you understand your medication(s)?

- ☐ Yes
- ☐ No

  If no, please explain: _____
- ☐ Does not apply

93. Have you ever had to stop a medication because of an allergy or side effect?

- ☐ Yes

  Please list the medication and reasons for discontinuation:

  _____
- ☐ No
- ☐ Does not apply

94. Do you have a primary pharmacy where you fill your prescriptions?

☐ Yes

Pharmacy name: _____

Pharmacy phone: _____

Pharmacy address:

_____

_____

_____

☐ No

95. Are you interested in participating in an annual care plan review?

☐ Yes

☐ No

END OF FORM