HHUNY

HEALTH HOMES OF UPSTATE NEW YORK

Empowering you. Expanding possibilities.

Comprehensive Assessment

Member Name ____

Member NSID or CIN _______________________

Care Management Agency ____

Completed By ____

Date Started _______________________

Date Completed _______________________

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Eligibility

☐ Eligibility screening is completed, proof of diagnosis was obtained and member meets Health Home requirements

☐ DOH 5055 Health Home Patient Information Sharing Consent signed and uploaded into member's chart

Demographic Information

☐ Demographic Page and Survey completed

1. Are there any cultural considerations the member would like us to be aware of?

2. In what language and modality (letter, phone, etc.) does the member prefer to receive information?

3. Does the member need interpretation services?
   - ☐ No → Move to next section
   - ☐ Yes → Summarize need and move to next section

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Physical Health: Medical Health Care

1. Who is the member's Primary Care Provider?

Name ____________________ Organization ____________________

Address ____________________ Phone ____________________

____________________ Last Visit Date ____________________

Identified on DOH 5055? ☐ Yes ☐ No

What does the member like and not like about their PCP?

What preventive care services are provided by the Care Team and/or needed by the member?

☐ Member does not have a PCP and needs to link with one

When was the member last seen by any PCP? ____________________

Preferences

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2. Does the member have any observed, diagnosed or reported current physical health diagnoses or symptoms?

☐ No → Move to Question 3

☐ Yes → Complete Table and move to question 3

Diagnosis and/or Symptom		
Severity	**Status**	***If Member declined Care Manager assistance, why?**
☐Mild ☐Moderate ☐Severe ☐Incapacitating	☐ Uncontrolled; requests Care Team assistance ☐ Uncontrolled; declines Care Team assistance* ☐ Controlled; Care Team assistance still needed ☐ Controlled or Resolved; No assistance needed*	
Past Treatment		

Is the member prescribed medications to assist in managing diagnosis/symptom?

☐ No → Why not?

☐ Yes → Review in Medications section

Is the member prescribed any form of treatment/services to address diagnosis/symptom?

☐ No → In the box below, provide narrative about why not and move to next section

☐ Yes → In the box below, provide a narrative about type, duration, frequency, last visit dates, etc. Complete "**If Yes**" section

If Yes:

Who are the providers of the services? Include names and organizations

Are they adherent to and engaged in treatment or services related to their diagnosis or symptom?

☐ Yes → In the box below provide a narrative about satisfaction of services and what they do and don't like

☐ No → In the box below provide a narrative about why not and identify any barriers to care

☐ Does not agree to treatment/ services → In the box below, provide a narrative about why not

Complete **Addendum A for additional Diagnosis/ Symptoms**

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3. Are there any physical health diagnoses given to the member that they deny or disagree with?

- ☐ No → Move to question 5
- ☐ Yes → Write a narrative identifying the diagnosis and why the member disagrees or denies the presence of the diagnosis and move to question 5

4. Does the member have a historic or current presence of any additional Physical Health concerns, diagnosis or issues not captured above?

- ☐ No, all information is captured above → Move to question 6
- ☐ Yes → Write a narrative about information not captured above, including any barriers and needs

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HIV/AIDS

☐ HIV Assessment Screening completed

1. Is the Member HIV positive?

- ☐ No → Move to question 2
- ☐ Unknown / Declines to Answer → Move to Question 2
- ☐ Yes → Complete Table Below and move to Question 3

If HIV positive:

Diagnosis		
Severity	**Status**	***If Member declined Care Manager assistance, why?**
☐Mild ☐Moderate ☐Severe ☐Incapacitating	☐ Uncontrolled; requests Care Team assistance ☐ Uncontrolled; declines Care Team assistance* ☐ Controlled; Care Team assistance still needed ☐ Controlled or Resolved; No assistance needed*	
Provider and Organization		

A) Does member understand meaning of VL and T-cell Count and how to read lab results?	☐ Yes ☐ No
B) What type of treatment are they receiving? (if they are prescribed medications please state as part of their treatment but address medications in Medications section)	
C) How involved is the member in their treatment plan/services?	
D) Provide a narrative about any barriers the member faces specific to their HIV	☐ No Barriers Identified

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If HIV Negative or Unknown:

2. Does the member need PrEP or PEP?

☐ Member declines to answer

PrEP (pre-exposure prophylaxis) is only for people who have an ongoing, very high risk of HIV infection (injective substances, unprotected sex, etc.)

☐ Yes ☐ No ☐ Already Prescribed

PEP (post-exposure prophylaxis) is an option for someone who thinks they've recently been exposed to HIV during activities such as sex, sharing needles or works to prepare drugs

☐ Yes ☐ No ☐ Already Prescribed

Complete for all members:

3. When was the last time they were tested?

_______________ ☐ Never Been Tested

4. Does the member have a history or current presence of any of the following risk behaviors? Provide a narrative for each current or present behavior selected

☐ Declines to Answer

Behavior	NA	Historic	Present	Narrative?
Unprotected Sex	☐	☐	☐	
STD/ STIs	☐	☐	☐	
Intravenous Drug Use	☐	☐	☐	
Other:	☐	☐	☐	

5. Are referrals needed for any of the following?

☐ Information ☐ Education ☐ STI/STD Testing ☐ HIV Testing

☐ Disease Management ☐ Risk/Harm Reduction ☐ IVDU ☐ None Needed

☐ Other _______________

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Physical Health Summary

Provide input from the care team regarding the member's physical health including feedback on needed preventive services

Strengths- what strengths or resources does the member bring to the table that will assist in addressing any of their physical health needs

Barriers- what stands between the member and their ideal outcome related to their physical health

Next steps and/or Referrals Needed including needs related to health promotion, education, information, additional resources or supports

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Behavioral Health: Mental Health

1. Does the member have any observed, diagnosed or reported current Mental Health diagnoses or symptoms?

☐ No → Move to Next Question 2
☐ Yes → Complete Table and move to question 2

Diagnosis and/or Symptom		
Severity	**Status**	***If Member declined Care Manager assistance, why?**
☐Mild ☐Moderate ☐Severe ☐Incapacitating	☐ Uncontrolled; requests Care Team assistance ☐ Uncontrolled; declines Care Team assistance* ☐ Controlled; Care Team assistance still needed ☐ Controlled or Resolved; No assistance needed*	
Past Treatment		

Is the member prescribed medications to assist in managing diagnosis/symptom?

☐ No → Why not?

☐ Yes → Review in Medications section

Is the member prescribed any form of treatment/services to address diagnosis/symptom?

☐ No → In the box below, provide narrative about why not and move to next section
☐ Yes → In the box below, provide a narrative about type, duration, frequency, last visit dates, etc. Complete "**If Yes**" section

If Yes:

Who are the providers of the services? Include names and organizations

Are they adherent to and engaged in treatment or services related to their diagnosis or symptom?

☐ Yes → In the box below provide a narrative about satisfaction of services and what they do and don't like
☐ No → In the box below provide a narrative about why not and identify any barriers to care
☐ Does not agree to treatment/ services → In the box below, provide a narrative about why not

Complete **Addendum A for additional Diagnosis/ Symptoms**

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2. What is their current functioning level as related to their mental health?

'Independent functioning' is described as the ability to engage in daily living tasks and responsibilities, maintain relationships with their friends/family and is generally accepted within their community. This may occur with or without treatment.

'**Limited ability to function independently**' or '**unable to function independently**' could be characterized by being socially isolated to any degree, inability to maintain relationships and/or unable to engage or follow through on responsibilities as a result of their mental health condition or symptoms.

☐ Able to function independently

☐ Able to function independently due to being engaged in treatment such as taking medications or attending therapy

☐ Able to function independently when engaged in treatment such as taking medications or attending therapy but **not currently linked**

☐ Limited ability to function independently

- What is the limitation and cause?

☐ Unable to function independently

- What is the limitation and cause?

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3. Is there a current presence or history of any of the following?

Category	Current	History	NA	Narrative
Harm to Self	☐	☐	☐	
Ideation of harming self	☐	☐	☐	
Harm to Others	☐	☐	☐	
Ideation of harming others	☐	☐	☐	
Trauma	☐	☐	☐	
Abuse	☐	☐	☐	
Domestic Violence	☐	☐	☐	
Child Protective Services	☐	☐	☐	
Adult Protective Services	☐	☐	☐	

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4. Are there any mental health diagnoses given to the member that they deny or disagree with?

- ☐ No → Move to question 6
- ☐ Yes → Write a narrative identifying the diagnosis and why the member disagrees or denies the presence of the diagnosis and move to question 6

5. Does the member have a historic or current presence of any additional Mental Health concerns, diagnosis or issues not captured above?

- ☐ No, all information is captured above → Move to question 6
- ☐ Yes → Write a narrative about information not captured above, including any barriers and needs

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Behavioral Health: Substance Use

☐ CAGE-AID Screening completed

1. Does the member have any current or historic substance use?

☐ No → Move to Question 7

☐ Yes → Complete Table for every substance currently or historically used and move to question 2

Substance			
Route	Frequency	Amount Used	
Start Date/ Time Period			
Currently Using?	☐ Yes per member ☐ No, per member and care team* ☐ No per member, Care Team identifies evidence of use*		
*If no, when and how does the member report they stopped using?			

Severity	Status	*If Member declined Care Manager assistance, why?
☐Mild ☐Moderate ☐Severe ☐Incapacitating	☐ Uncontrolled; requests Care Team assistance ☐ Uncontrolled; declines Care Team assistance* ☐ Controlled; Care Team assistance still needed ☐ Controlled or Resolved; No assistance needed*	

Past Treatment	

Is the member prescribed medications to assist in managing diagnosis/symptom?

☐ No → Why not?

☐ Yes → Review in Medications section

Is the member prescribed any form of treatment/services to address diagnosis/symptom?

☐ No → In the box below, provide narrative about why not and move to next section

☐ Yes → In the box below, provide a narrative about type, duration, frequency, last visit dates, etc. Complete "**If Yes**" section

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If Yes:

Who are the providers of the services? Include names and organizations

Are they adherent to and engaged in treatment or services related to their diagnosis or symptom?

- ☐ Yes → In the box below provide a narrative about satisfaction of services and what they do and don't like
- ☐ No → In the box below provide a narrative about why not and identify any barriers to care
- ☐ Does not agree to treatment/ services → In the box below, provide a narrative about why not

Complete Addendum B for additional Diagnosis/ Symptoms

If currently using or in recent recovery:

2. What is the member's current state of change?

☐	Pre-contemplation:	Not yet acknowledging that there is a problem behavior that needs to be changed
☐	Contemplation:	Acknowledging that there is a problem but not yet ready to make a change
☐	Preparation/Determination:	Getting ready to change
☐	Action/Willpower:	Changing behavior
☐	Maintenance:	Maintaining the behavior change

3. What does the member share regarding the reason they use substances? Do they understand the consequences of substance use?

4. What is the social context in which the members use?

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5. Indicate any area of daily living impacted by member's use of substances

Impacted	Not Impacted	Area of Daily Living	How is the area affected?
☐	☐	Relationships- Family	
☐	☐	Relationships- Social	
☐	☐	Employment	
☐	☐	Finances	
☐	☐	Education	
☐	☐	Legal	
☐	☐	Behavioral Problems	
☐	☐	Psychiatric Symptoms	
☐	☐	Activities of Daily Living	
☐	☐	Other	

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6. Are there any diagnoses related to substance use given to the member that they deny or disagree with?

☐ No → Move to question 8

☐ Yes → Write a narrative identifying the diagnosis and why the member disagrees or denies the presence of the diagnosis and move to question 8

7. Do they have any additional needs related to substance use that aren't currently being addressed?

☐ No → Move to next section

☐ Yes → Write a narrative about the member's additional needs and any barriers to linking to services and move to next section

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Behavioral Health Summary

Provide input from the care team regarding the member's behavioral health

Strengths- what strengths or resources does the member bring to the table that will assist in addressing any of their substance use or mental health needs

Barriers- what stands between the member and their ideal outcome related to their behavioral health

Next steps and/or Referrals Needed including needs related to health promotion, education, information, additional resources or supports

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Medications

☐ Medication listing obtained and uploaded into member's chart
☐ Medication listing requested and notes show evidence of continual attempts to obtain
☐ Not currently prescribed medications → Move to question 6

1. Who currently prescribes their medications?

   ☐ Unknown

2. Who historically prescribed their medications?

   ☐ Unknown

3. Is the member currently prescribed multiple medications for the same diagnosis?

   ☐ No
   ☐ Yes → Which diagnosis(es)

4. Provide a narrative about the members understanding of their medications, why they take them and how to take them as prescribed

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5. Does the member have any barriers or needs related to taking their medications as prescribed?

☐ No

☐ Yes → Write a narrative about barriers and needs and move to next section

6. Is the member connected with a pharmacy?

☐ No → Why not? Do they have a preference of where they would like to be linked?

☐ Yes → Complete Table

Pharmacy Name	Phone	Address

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Hospitalizations

1. Did the member have any admissions (inpatient stays) or hospitalizations related to their physical or behavioral health within the last 12 months?
   - ☐ No → Move to next section
   - ☐ Yes → Complete a Table for each instance of admission

Reason for Admission ______________________________

Provide a narrative about outcome of hospitalization including any changes in treatment or diagnosis

Reason for Admission ______________________________

Provide a narrative about outcome of hospitalization including any changes in treatment or diagnosis

Reason for Admission ______________________________

Provide a narrative about outcome of hospitalization including any changes in treatment or diagnosis

Reason for Admission ______________________________

Provide a narrative about outcome of hospitalization including any changes in treatment or diagnosis

** Complete **Addendum C** for additional Admissions **

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Social Health: Independent Living Skills

1. Assess the members ability level for each section below:

Skill	Requires no assistance	Requires assistance- services in place	Assistance needed, services NOT in place	Describe type of assistance used or needed; Is it related to or caused by another diagnosis/symptom
Meal Prep/ Eating	☐	☐	☐	
House Keeping	☐	☐	☐	
Finances	☐	☐	☐	
Shopping	☐	☐	☐	
Managing Medications	☐	☐	☐	
Phone Use	☐	☐	☐	
Communication	☐	☐	☐	
Transportation	☐	☐	☐	
Dressing/ Bathing/ Toileting	☐	☐	☐	
Personal Hygiene	☐	☐	☐	
Positioning, transferring	☐	☐	☐	
Mobility	☐	☐	☐	
Memory/ Learning	☐	☐	☐	
Other	☐	☐	☐	

2. Are they interested in self-help, advocacy or peer empowerment activities?

- ☐ No → Move to next section
- ☐ Yes → Summarize interests and move to next section

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Social Health: Social Supports

Who does the member consider to be part of their social and/or family support network?						
☐ No supports identified → move to next section						
Name	Relationship	Address	Phone	What support do they give	Are they the:	Consent
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No
					☐Legal Guardian ☐Emergency Contact	☐Yes ☐No

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Social Health: Housing

1. How many times has the member moved in the last 12 months?

- ☐ Has not moved in the last 12 months
- ☐ Has moved ________ times in the last 12 months

2. Does the member currently consider themselves to be homeless?

- ☐ No → Complete Table for "**Member is NOT Homeless**" response
- ☐ Yes → Complete Table for "**Member IS Homeless**" response

MEMBER IS HOMELESS

1. What is the member's current living situation?

2. Do they want housing?

- ☐ No → Provide a narrative about why not and move to next section
- ☐ Yes → Provide a narrative about preferences, including type of housing, location, amenities, etc. then move to next section

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MEMBER IS NOT HOMELESS

1. What is the member's current living situation?

2. Do they receive any type of rental assistance such as a subsidy or live in income based housing?
   - ☐ No → Would they like assistance? Why or why not?
   - ☐ Yes → What assistance do they receive?

3. Is member at risk for eviction?
   - ☐ No → Move to question 4
   - ☐ Yes → Why?

4. Does the member need advocacy assistance with their landlord?
   - ☐ No → Move to next section
   - ☐ Yes → Explain

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Social Health: Benefits/ Entitlements

1. What type of medical insurance does the member have?

If they have managed care, who is their managed care provider?	
Are they on the DOH 5055?	☐ Yes ☐ No

2. Select any sources of income the member currently receives and list the amounts

☐ **Member does not wish to share financial information**

Type	Amount	Type	Amount	Type	Amount
☐ Employment		☐ Temporary Assistance		☐ Supplemental Security Income	
☐ Unemployment		☐ Retirement Benefits		☐ Social Security Disability	
☐ Child Support		☐ SNAP		☐ VA Benefits	
☐ Alimony		☐ Dividends/ Interest		☐ Other:	

3. Do they have a Rep Payee?

☐ Yes → Complete Contact Information

Agency/ Name	Address	Phone	Consent
			☐Yes ☐No
			☐Yes ☐No

☐ No → Do they need or want one?

- ☐ No → Move to next section
- ☐ Yes → Do they have any preferences of who? Why do they need or want a rep payee?

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Social Health: Community Resources

1. Does the member need any referrals to Community Resources?

Resource	Needed	Not Needed	Description of need/ Preferences
Clothing	☐	☐	
Additional Income Sources	☐	☐	
Household Supplies	☐	☐	
Food	☐	☐	
Personal Hygiene products	☐	☐	
Furniture	☐	☐	
Other:	☐	☐	

Social Health: Legal

1. Is member currently on probation or parole?

- ☐ Member declines to answer → Move to question 2
- ☐ No → Move to question 2
- ☐ Yes → Complete contact information and move to question 2

Parole/ Probation Officer	Discharge Date?	Phone	Consent
			☐Yes ☐No

2. Is member currently involved in any diversion programs?

- ☐ Member declines to answer → Move to question 3
- ☐ No → Move to question 3
- ☐ Yes → Complete contact information and move to question 3

For what?	Agency/ Name	Address	Phone	Consent
				☐Yes ☐No

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3. Is member currently linked with or receiving Legal Assistance?

☐ Member declines to answer → Move to question 4
☐ Yes → Complete table below

For what?	Agency/ Name	Address	Phone	Consent
				☐Yes ☐No
				☐Yes ☐No

If yes, does the member need Care Manager assistance: ☐ Yes ☐ No
☐ No → Complete questions below

If No → Do they need or want legal assistance?
☐ No → Move to question 4
☐ Yes → What for? Do they have any preferences of who provides assistance?

4. Does the member have a Health Care Proxy?

☐ Yes →
☐ Proxy uploaded into Member's chart –**or**– ☐ Complete contact information and move to question 5

Identified Proxy	Phone	Consent
		☐ Yes ☐ No
		☐ Yes ☐ No

☐ No → Do they want more information about having and identifying a Health Care Proxy?
☐ No
☐ Yes

5. Does the member have any other Advanced Directive in place?

☐ Yes → Is a copy in their chart?
☐ No
☐ Yes
☐ No → Do they want more information about Advanced Directives?
☐ No
☐ Yes

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Social Health: Vocational/ Educational Status

Education

1. What is the member's current level of education?

2. Are they interested in furthering their education?
   - ☐ No → Move to Employment section
   - ☐ Yes → Explain

Employment

1. What is the member's history of employment?

2. Are they currently employed?
   - ☐ No → Move to question 3
   - ☐ Yes → Where? Doing what? Complete and move to question 3

3. Are they interested in employment opportunities or programs?
   - ☐ No → Move to Volunteering
   - ☐ Yes → What opportunities/programs are they interested in? → Move to volunteering

Volunteering

1. Is the member linked with or interested in volunteer opportunities?
   - ☐ No → Move to next section
   - ☐ Yes → What opportunities/programs are they interested or participating in? Identify if Care Manager assistance is needed

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Social Health Summary

Provide input from the care team regarding the member's social health

Strengths- what strengths or resources does the member bring to the table that will assist in addressing any of their social health needs

Barriers- what stands between the member and their ideal outcome related to their social health

Next steps and/or Referrals Needed including needs related to education, information, additional resources or supports

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Other Providers

List any providers, community and social supports not yet identified

Role	Name and Agency	Address	Phone	Care Team	Consent
MCO				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No
				☐Yes ☐No	☐Yes ☐No

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