BROOKLYN HEALTH HOME

HEALTH HOME COMPREHENSIVE ASSESSMENT

Social Determinants of Health

1. In the last 12 months, did you eat less than you felt you should because there wasn't enough money for food?

☐ Yes ☐ No

2. In the last 12 months, has your utility company shut off your service for not paying your bills?

☐ Yes ☐ No

3. Are you worried, that in the next 12 months, you may not have stable housing?

☐ Yes ☐ No

3a.Where do you live now?

☐Own my home/apartment ☐Rent my home/apartment ☐Live in friend or relative's house

☐Shelter ☐Street homeless ☐Supportive housing ☐Other

3b. Specify (if other) _____

3c. Have you ever been evicted or homeless in the past?

☐ Yes ☐ No

4. Do problems getting child care make it difficult for you to work or study?

☐ Yes ☐ No

5. In the last 12 months, have you needed to see a doctor, but could not because of cost?

☐ Yes ☐ No

6. In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?

☐ Yes ☐ No

6a. Are there other needs you cannot meet because of transportation issues? If yes, answer 6b.

☐ Yes ☐ No

6b. Specify _____

7. Do you ever need help reading or understanding materials that you get from your doctor or other health care providers?

☐ Yes ☐ No

8. Are you afraid you might be hurt by another person in your apartment building, house, life, or community?

☐ Yes ☐ No

8a. Are there any other situations at home that make it hard for you to take care of yourself? If yes, answer 8b.

☐ Yes ☐ No

8b. Specify _____

**If 8a. or 8b are "yes", develop safety plan and report to supervisor*

Benefits

9. Do you receive any of the following benefits or subsidies?

☐SNAP ☐ PA/HASA/SSI/SSDI ☐Section 8 ☐FEPS ☐MRT ☐None ☐Other _____

10. Do you need any of the following benefits or subsidies?

☐SNAP ☐ PA/HASA/SSI/SSDI ☐Section 8 ☐FEPS ☐MRT ☐None ☐Other _____

Medical

11. Do you have any medical problems/issues/diagnoses?

☐ Yes ☐ No ☐Unknown

11a. What are your medical problems/issues/diagnoses?

☐Advanced Coronary Artery Disease ☐Alcohol and Liver Disease ☐Asthma
☐Cerebrovascular Disease ☐Chronic Alcohol Abuse ☐Chronic Obstructive Pulmonary Disease
☐Chronic Renal Failure ☐Cocaine Abuse ☐Congestive Heart Failure ☐Diabetes
☐Drug Abuse – Cannabis/NOS/NEC ☐Hepatitis C ☐HIV/AIDS ☐Hypertension
☐Kidney/Renal Disease ☐Obesity ☐Opioid Abuse ☐Other Significant Drug abuse
☐Peripheral Vascular Disease ☐Other

11b.Specify (if other) _____

12. Have you been to the emergency room or admitted to the hospital in the past year for medical reasons?

☐ Yes ☐ No

12a. If yes, how many times in the past year have you been to the ER? _____

12b. If yes, how many times in the past year have you been admitted to the hospital? _____

13. Do you have a primary care doctor?

☐ Yes ☐ No

If yes, include PCP details (name, address, phone, last/next appointment, etc.) and remember to update the care team and consent.

14. Do you see any medical specialists?

☐ Yes ☐ No

If yes, include specialist(s) details (name, address, phone, last/next appointment, etc.) and remember to update the care team and consent.

15. Are any of your medical issues bothering you especially/more than usual right now?

☐ Yes ☐ No

15a. If yes, please specify_____

16. Decisions about health and medical care can be so complicated. Is there someone in your life that you have identified or formally designated who would help you make decisions about your health care if you were unable to make those decisions for yourself? If no, answer 16b. If yes, remember to update consent and obtain copy of proxy or other paperwork.

☐ Yes ☐ No

16b. Is this something you would like to learn more about?

☐ Yes ☐ No

Behavioral Health

17. Do you have any behavioral/psychiatric problems/issues/diagnoses?

☐ Yes ☐ No

17a. If yes, what are your mental health/behavioral/psychiatric problems/issues/diagnoses?

☐Anxiety Disorder ☐Bi-Polar Disorder ☐Conduct, Impulse control, and Other Disruptive Behavior Disorders
☐Dementing Disease ☐Depressive and Other Psychoses ☐Eating Disorders
☐Major Personality Disorders ☐Post-Traumatic Stress Disorder (PTSD)
☐Psychiatric Disease (Except Schizophrenia) ☐Schizoaffective Disorder ☐Schizophrenia
☐Other

17b. If other, please specify_____

18. Have you been to the emergency room or admitted to the hospital in the past year for any of mental health reasons?

☐ Yes ☐ No

18a. How many times in the past year have you been to the ER?

_____

18b. How many times in the past year have you been admitted to the hospital? _____

19. Do you have a psychiatrist or psychiatric nurse practitioner?

☐ Yes ☐ No

If yes, include provider details (name, address, phone, last/next appointment, etc.) and remember to update the care team and consent.

20. Do you see a therapist?

☐ Yes ☐ No

If yes, include provider details (name, address, phone, last/next appointment, etc.) and remember to update the care team and consent.

21. Have you been ordered by court to attend a program? If yes, answer 21a.

☐ Yes ☐ No

21a. Specify program _____

22. **Patient Health Questionnaire: PHQ-9**
Over the past two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
☐ Not at all ☐Several days ☐More than half the days ☐Nearly every day

2. Feeling down, depressed, or hopeless
☐ Not at all ☐Several days ☐More than half the days ☐Nearly every day

3. Trouble falling asleep or staying asleep, or sleeping too much
☐ Not at all ☐Several days ☐More than half the days ☐Nearly every day

4. Feeling tired or having little energy
☐ Not at all ☐Several days ☐More than half the days ☐Nearly every day

5. Poor appetite or overeating
☐ Not at all ☐Several days ☐More than half the days ☐Nearly every day

6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down
☐ Not at all ☐Several days ☐More than half the days ☐Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television
☐ Not at all ☐Several days ☐More than half the days ☐Nearly every day

8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual
☐ Not at all ☐Several days ☐More than half the days ☐Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way (*If yes, develop safety plan and report to supervisor*)
☐ Not at all ☐Several days ☐More than half the days ☐Nearly every day

10. If you marked any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐ Not at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

23. Have you ever attempted suicide? If yes answer 23b.

☐ Yes ☐ No

23b. When was the most recent attempt?

☐ Less than a month ago ☐ Within the past year ☐ More than one year ago

24. What are your triggers; how do you know when you are upset? _____

_____

24a. When you are upset, what activities can you do to feel better? _____

Medications

25. Do you take any medications for your medical or mental health/psychiatric/behavioral diagnoses?

☐Yes, for medical conditions only ☐Yes, for behavioral health conditions only
☐Yes, for both medical and behavioral health conditions ☐No

26. Do you ever have problems taking or remembering to take those medications?

☐Yes, for medical conditions only ☐Yes, for behavioral health conditions only
☐Yes, for both medical and behavioral health conditions ☐No

27. Do you ever have trouble getting or paying for those medications from the pharmacy?

☐Yes, for medical conditions only ☐Yes, for behavioral health conditions only
☐Yes, for both medical and behavioral health conditions ☐No

Trauma

28. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that you have had nightmares/thought about it when you did not want to?

☐ Yes ☐ No ☐ Unknown

28a. Have you tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

☐ Yes ☐ No ☐ Unknown

28b. Were constantly on guard, watchful, or easily startled?

☐ Yes ☐ No ☐ Unknown

28c. Have you felt numb or detached from others or your surroundings?

☐ Yes ☐ No ☐ Unknown

28d. Have you ever had an experience like that ever in your life?

☐ Yes ☐ No ☐ Unknown

Substance Use

29. **Drug Abuse Screening Test: DAST-10**

These questions refer to the past 12 months

1. Have you used drugs other than those required for medical reasons?
☐ Yes ☐No

2. Do you abuse more than one drug at a time?
☐ Yes ☐No

3. Are you unable to stop using drugs when you want to?
☐ Yes ☐No

4. Have you ever had blackouts or flashbacks as a result of drug use?
☐ Yes ☐No

5. Do you ever feel bad or guilty about your drug use?
☐ Yes ☐No

6. Does your spouse (or parents) ever complain about your involvement with drugs?
☐ Yes ☐No

7. Have you neglected your family because of your use of drugs?
☐ Yes ☐No

8. Have you engaged in illegal activities in order to obtain drugs?
☐ Yes ☐No

9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
☐ Yes ☐No

10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?
☐ Yes ☐No

30. **Alcohol Use Disorders Identification Test: AUDIT-C**

1. How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

3. How often do you have six or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

31. Have you ever gone to anyone for help for a drug or alcohol issue? If yes, answer 31a.
☐ Yes ☐ No

31a. Specify who _____

32. Have you ever been in a hospital for medical issues related to your drug or alcohol use?
☐ Yes ☐ No

33. Are you currently involved in an outpatient treatment program specifically related to drug or alcohol use?
☐ Yes ☐ No

34. Have you, in the past, been treated for problems related to drug or alcohol abuse?
☐ Yes, crisis services – medically supervised withdrawal (detox) – inpatient
☐ Yes, inpatient treatment services (30 day rehab)
☐ Yes, methadone treatment – methadone clinic
☐ Yes, outpatient services – outpatient clinic
☐ Yes, outpatient services, outpatient rehabilitation
☐ Residential Services
☐ No

35. Do you smoke cigarettes or use other tobacco products? If yes, answer 35a.
☐ Yes ☐ No

35a. Would you like information about, or a referral for, smoking cessation?
☐ Yes ☐ No

Justice

36. In the last 12 months, have you had any interactions with the police or law enforcement?
☐ Yes, once ☐ Yes, more than once ☐ No

36a. Have you been incarcerated?
☐ Yes ☐ No

36b. Please enter the date of the most recent release _____

36c. Have you been detained by the police?
☐ Yes ☐ No

36d. Have you been arrested?

☐ Yes ☐ No

36e. Are you on probation or parole?

☐ Yes, probation ☐ Yes, parole ☐ No

36f. If yes, provide probation or parole officer's name and contact information and update the consent/

36g. Do you have an upcoming hearing or court date?

☐ Yes ☐ No

36h. If yes, specify the court type _____

36i. If yes, specify the date _____

36j. Are you a registered sex offender?

☐ Yes ☐ No

37. If you needed help in an emergency, would you call the police?

☐ Yes ☐ No

38. Have you ever had a case open with ACS, CPS, or APS?

☐ Yes, in the past ☐ Yes, currently ☐ No

38a. Please specify agency (and update consent) _____

Activities of Daily Living

39. In the past 7 days, did you need help from others to perform every day activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

☐Eating
☐Getting dressed
☐Grooming
☐Bathing
☐Walking
☐Using the toilet
☐Other
☐None

39a. If other, please specify _____

39b. Who helped you with the tasks checked above? (If relevant, obtain contact information and update consent)

☐Relative
☐Friend
☐Neighbor
☐Home Attendant
☐No one
☐Other

39c. If other, please specify _____

40. In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

☐Laundry and housekeeping
☐Banking
☐Shopping
☐Using the telephone
☐Food preparation

☐Transportation
☐Taking your own medication
☐Other
☐None

40a. If other, please specify _____

40b. Who helped you with the tasks checked above? (If relevant, obtain contact information and update consent)
☐Relative
☐Friend
☐Neighbor
☐Home Attendant
☐No one
☐Other

40c. If other, please specify _____

Social Support

In the past month, rate how often:
41. I have someone who understands my problems
☐Never ☐Rarely ☐Sometimes ☐Usually ☐Always

41a. I have someone who will listen to me when I need to talk or if I am upset
☐Never ☐Rarely ☐Sometimes ☐Usually ☐Always

41b. I have someone to talk to when I have a bad day
☐Never ☐Rarely ☐Sometimes ☐Usually ☐Always

41c. I have someone I trust to talk with about my problems and feelings
☐Never ☐Rarely ☐Sometimes ☐Usually ☐Always

41d. I can get helpful advice when dealing with a problem
☐Never ☐Rarely ☐Sometimes ☐Usually ☐Always

41e. I get invited to go out and do things with other people
☐Never ☐Rarely ☐Sometimes ☐Usually ☐Always

41f. I can find a friend when I need one
☐Never ☐Rarely ☐Sometimes ☐Usually ☐Always

41g. I feel close to my friends
☐Never ☐Rarely ☐Sometimes ☐Usually ☐Always

41h. I feel like I'm part of a group of friends
☐Never ☐Rarely ☐Sometimes ☐Usually ☐Always

41i. In questions 41 through 41h, are there three or more responses of either 'Never' or 'Rarely'?
☐ Yes ☐ No

42. Have you ever worked with a peer support specialist? (If Yes – currently, provide peer's name and contact information, and update consent)
☐Yes – in the past ☐Yes – currently ☐No

43. Do you live with anyone?

☐ Yes ☐ No

43a. If yes, who do you live with? _____

_____

44. When I need support or am having a crisis I can reach out to:

_____

45. In a natural disaster or other emergency I would contact:

_____

46. If an emergency prevents my regularly scheduled service provider(s) from seeing me, my backup plan is to reach out to:

_____

Education and Employment

47. What is the highest level of school you have completed?

☐Elementary school ☐High school ☐Some college ☐College ☐Graduate school

47a. Are you interested in completing any more school?

☐ Yes ☐ No

48. Are you currently employed?

☐ Yes ☐ No

48a. If no, are you interested in getting a job?

☐ Yes ☐ No

Motivation

49. I believe that I can make changes that will improve my physical health.

☐Totally agree ☐Agree a little ☐Disagree

50. I believe that I can make changes that will improve my mental health.

☐Totally agree ☐Agree a little ☐Disagree

51. I believe that I can make changes in my life that will increase my happiness and overall wellbeing.

☐Totally agree ☐Agree a little ☐Disagree

Safety Plan

52. Warning signs (thought, images, mood, situation, behavior) that a crisis may be developing _____

_____

53. Things I can do to take my mind off my problems without contacting another person _____

People whom I can ask for help

54. People whom I can ask for help (name and phone number) _____

54f. Professional agencies I can contact during a crisis: _____

55. Clinician name_____

56. Local Urgent Care Services (name, address, phone number) _____

57. Other (MCO nurse HELPLINE, suicide prevention hotline, NYC Well) _____

Beginning the Plan of Care

58. What do you feel are your strengths/resources? _____

59. What do you feel are your weaknesses/challenges/deficits?_____

60. Would you like to receive assistance in any of the areas we discussed today?

☐Yes ☐No ☐Maybe

61. Are any of your needs urgent (for example: I don't have food tonight, I don't have a place to sleep tonight)?

☐Yes ☐No ☐Maybe

**If yes, identify emergency resources and report to supervisor*