Bassett Health Home

Intake Assessment

Must be completed within 6o days of HH Enrollment and Annually as part of Comprehensive Assessments

Staff Name:	Today's Date:
Was Referral Source notified of Member's HH Enrollment: ☐ Yes ☐ No ☐ N/A, DOH Assignment	

Member Demographic Information

Name:_____ Gender: ☐ Male ☐ Female ☐ Transgender

CIN: _____ Are you a Veteran? ☐ Yes ☐ No

DOB: _____ Marital Status: ☐ Married ☐ Divorced/Separated ☐ Living as Married/Domestic Partner ☐ Single

Street Address, City, Zip Code: _____

Phone: _____ Alt. Phone: _____ Okay to leave a message? ☐ Yes ☐ No

Email: _____ Preferred method of contact: ☐ Phone ☐ Text ☐ Email ☐ Mail

Emergency Contact: _____ Relation: _____ Phone: _____
(Be sure to obtain consent via the DOH 5055 for emergency contact)

Insurance: ☐ Excellus ☐ Fidelis ☐ United Healthcare ☐ CDPHP ☐ Fee For Service ☐ Unknown
☐ Other, specify: _____
(Include VA benefits and any other potential insurance sources)

Language / Culture Information

Primary Language: _____

Prefer materials/communication in another language?: ☐ No ☐ Yes, specify: _____

Are you able to read in your primary language? ☐ Yes ☐ No

If no, do you have someone to assist you with reading? ☐ Yes ☐ No

Do you have any cultural beliefs or customs that you would like to share? _____

_____

_____

_____

Basic Needs

1. Are you able to afford food for you / your dependents each month? ☐ Always ☐ Sometimes ☐ Never

   a. Do you receive support or assistance from: ☐ Meals on Wheels ☐ Food Pantry ☐ None
   ☐ Other: _____

2. Are you able to pay for utilities / other financial obligations each month? ☐ Always ☐ Sometimes ☐ Never

3. Do you have stable housing? ☐ Yes, stable (renting, homeowner)
   ☐ Somewhat, at risk (rent late, threat of eviction)
   ☐ Imminent risk (losing home within 14 days, guested homeless)
   ☐ No, literally homeless (emergency shelter, uninhabitable)

4. Who else lives in your household?

Name	Relationship	Age

Be sure to obtain DOH-5055 consent for any persons that will be social supports

5. Do you have childcare in place? ☐ Yes ☐ No ☐ N/A, no children in need of childcare

6. Are you connected with any community supports? *(Check all that apply)*
   ☐ Peer Supports ☐ Self Help ☐ Religious Organizations ☐ None
   ☐ Other: _____

7. Do you have your own transportation? ☐ Yes ☐ No

8. What do you typically rely on for transportation? *(Check all that apply)*
   ☐ Friends/Family ☐ CDTA Public Bus ☐ Taxi ☐ MAS/Starbus
   ☐ Other: _____

9. What are your interests / hobbies? _____
_____
_____

Healthcare Information

10. What are your current diagnoses, medical or mental health?

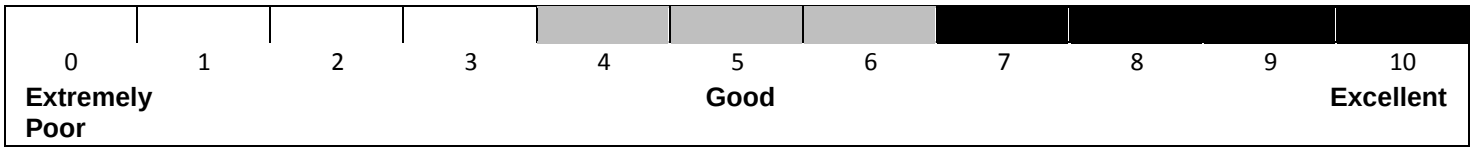
1.
2.
3.
4.
5.
6.
7.
8.

11. What providers are you currently working with currently? *(This list should match DOH 5055 consent.)*
If the Member does not need a listed provider, select "N/A."
If the Member has a need for a provider, but is not connected to a provider, select "Provider Needed."

Name of Practice/Provider	Phone Number	Last App't	Next App't	N/A	Provider Needed
PCP:				☐	☐
Pharmacy:				☐	☐
Dental:				☐	☐
Optical:				☐	☐
OB/GYN:				☐	☐
Preferred Hospital:				☐	☐
Parole/Probation:				☐	☐
CPS:				☐	☐
APS:				☐	☐
Veteran's Affairs:				☐	☐
Cardiologist:				☐	☐
Pulmonary:				☐	☐
Endocrinologist:				☐	☐
MH/BH Counselors:				☐	☐
Substance Abuse Counselor:				☐	☐
Psychiatrist:				☐	☐
Neurology:				☐	☐
Pain Management:				☐	☐

Name of Practice/Provider	Phone Number	Last App't	Next App't	N/A	Provider Needed
Dialysis:				☐	☐
Podiatry:				☐	☐
GI:				☐	☐
Housing (OMH, RSS, MO):				☐	☐
Home Care Agency (HHA or LTC):				☐	☐
Other: _____				☐	☐
Other: _____				☐	☐
Other: _____				☐	☐
Other: _____				☐	☐
Other: _____				☐	☐

12. On a scale of 1 to 10, with 1 being "Extremely Poor" and 10 being "Excellent," how would you rate your health in the last 30 days?



13. During the **past year,** how often did you visit your primary care provider?
    ☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times ☐ N/A, no PCP

14. During the **past three months,** how often did you visit the Emergency Room?
    ☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times

    a. What was the reason for the visit(s)? *(Check all that apply)*
       ☐ Medical ☐ Mental Health ☐ Substance Use

15. During the **past three months,** how many times were you admitted to the hospital?
    ☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times

    a. What was the reason for the admission(s)? *(Check all that apply)*
       ☐ Medical ☐ Mental Health ☐ Substance Use

16. What are your barriers to managing your healthcare needs?

☐ Forget appointments	☐ Forget Medication	☐ Don't agree with treatment
☐ Transportation	☐ Anxiety	☐ Not educated on diagnoses
☐ Other: _____	☐ Other: _____	☐ None identified

Legal

17. Do you have any pending charges at this time? ☐ Yes ☐ No

    a. If yes, please explain: _____
    _____
    _____

18. Are you currently on: Probation? ☐ Yes ☐ No
    Parole? ☐ Yes ☐ No
    (Be sure to obtain consent via the DOH 5055 if Member is willing to provide.)

19. Do you have an open case with: Child Protective Services ☐ Yes ☐ No
    Adult Protective Services ☐ Yes ☐ No
    (Be sure to obtain consent via the DOH 5055 if Member is willing to provide.)

20. Do you have a history of criminal justice involvement, such as arrests or convictions? ☐ Yes ☐ No

    a. If yes, please explain: _____
    _____
    _____

21. Do you have a history of incarceration? ☐ Yes ☐ No

    a. If yes, what is your most recent release date? _____

Care Coordination / Outreach Specialist Use Only

To be eligible for Health Home services, the individual must meet diagnostic criteria and must have significant risk factors that deem them appropriate.

22. Identify the risk factors that make the individual appropriate for Health Home services. *(Check all that apply)*

☐ Lack of or inadequate social / family / housing support
☐ Learning or cognition issues
☐ Lack of or inadequate connectivity with healthcare system
☐ Deficits in activities of daily living (e.g., dressing, eating)
☐ Non-adherence to or difficulty managing treatment(s) or medication(s)
☐ Repeated recent hospitalizations or ER visits for preventable conditions
☐ Probable clinical risk or adverse event (e.g., death, disability, inpatient, nursing home admission)
☐ Recent release from incarceration or psychiatric hospitalization
☐ None (If none, the person is not appropriate/eligible for HH services)