Better Health for Northeast New York
A Partnership for Better Health

Alliance FOR BETTER HEALTH

Welcome. This screening tool is used to support you with your health goals. There are no wrong answers. Your responses are completely confidential and do not affect your benefits and services.

Note: The screening tool should not be completed if you filled one out in the last 3 months.

First Name: ____________________ Last Name: ______________________

Birthdate: ____/____/______ Gender: ☐ Male ☐ Female ☐ Prefer not to answer

Medicaid CIN: __________________________ Zip Code: ____________
(Homeless person – approx.)

Question	Yes	No
In the last 12 months, did you ever eat less than you felt because there wasn't enough money for food?	☐ Yes	☐ No
In the last 12 months, has your utility company shut off your service for not paying your bills?	☐ Yes	☐ No
Are you worried that in the next 2 months, you may not have stable housing?	☐ Yes	☐ No
Do problems getting child care make it difficult for you to work or study? (leave blank if you do not have children)	☐ Yes	☐ No
In the last 12 months, have you needed to see a doctor, but could not because of cost?	☐ Yes	☐ No
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
Do you ever need help reading hospital materials?	☐ Yes	☐ No
Are you afraid you might be hurt in your apartment building or house?	☐ Yes	☐ No
If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	☐ Yes	☐ No
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