HEALTHY ALLIANCE IPA

COMMUNITY SOLUTIONS FOR BETTER HEALTH

This screening tool is used to support you with your health goals. Your responses will not affect your benefits and services and should <u>not</u> be completed if you filled one out in the last 6 months.

First Name: _____

Last Name: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Birthdate: ___/___/_____

Sex: ☐ Female ☐ Male

OR Uninsured: ☐

Medicaid CIN: _____

Primary Phone #: _____

Screening and Targeted Health Questions	Yes, client plans to self-resolve	Yes, client agreeable to referral	No
1. In the last 12 months, did you ever eat less than you felt you should because there was not enough money for food?	☐	☐	☐
2. In the last 12 months, has your utility company shut off your service for not paying your bills?	☐	☐	☐
3. Are you worried that in the next 2 months you may not have stable housing?	☐	☐	☐
4. Do problems getting childcare make it difficult for you to work or study? (If No children, please select N/A)	☐	☐	☐ N/A
5. In the last 12 months, have you needed to see a doctor, but could not because of cost?	☐	☐	☐
6. In the last 12 months, have you ever had to go without health care because you did not have a way to get there?	☐	☐	☐
7. Do you ever need help reading hospital materials?	☐	☐	☐
8. Are you afraid you might be hurt in your apartment building or house?	☐	☐	☐
9. Have you seen a primary care provider in the last 12 months?	☐	☐	☐
10. Are you currently enrolled in a Medicaid Managed Care Plan with an “active” status?	☐	☐	☐
11. Do you require assistance accessing your prescriptions?	☐	☐	☐

Completed by CHW/Worker Name:_____ Screening Date:_____

Organization Name:_____