Member Name: _____
Medicaid #: _____

Comprehensive Assessment & Social History

Assessment Information

Assessment Date: _____
Previous Assessment Date: _____

Type of Assessment: ☐ Initial ☐ Annual ☐ Change in status update

The following sources were used to gather and develop my comprehensive assessment and social history *(check all that are applicable)*:
☐ Member ☐ Caregiver ☐ Guardian ☐ Parent
☐ Physician ☐ Provider ☐ Other

Assessment completed by: ☐ Health Home Provider Name ☐ MCO
Name, title, contact information for person completing this assessment: _____

Reason for referral: _____

Assessment / Screening Type	Date	Score/Results/Tier
Health Risk Screener		
Risk Stratification		
Other (list):		

Personal Information

Preferred Name	
Preferred Pronouns	
Date of Birth	
Address (Street, City, State Zip)	
Phone Number	
Email	
Parent Name (***if child)***/Representative ***(if adult, applicable)***	
Parent's Address (if different from the child's)	
Spouse Name ***(if married***)	I want my spouse to be contacted regarding my care: ☐ Yes ☐ No Comments:
Preferred method(s) of contact	☐ Phone ☐ Text ☐ Email ☐ Mail
My preferred spoken language	
My preferred written language	
I am a veteran	☐ Yes ☐ No *If yes*, answer following questions: Branch:

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

	Years of service: _____ Honorable Discharge: ☐ Yes ☐ No

For **Children Only**

Child resides with, (*If in a facility, note name of facility and address)*	
Parents' Marital Status	☐ Married ☐ Divorced ☐ Never Married
If parents are not living together, the following parent is the non-custodial parent	Name: _____ Address:
There are sibling(s) living in the home with the child	☐ Yes ☐ No
One or more siblings are receiving waiver/habilitation services	☐ Yes ☐ No If yes, describe:

My Strengths are: _____

My Preferences are: _____
Preferences should also include personal preferences for how case management and services are delivered (i.e. where/with who to live, when to go to bed, when and what to eat, whom to involve in care planning, which services and service providers to use).

I am currently accessing long-term services and supports waiver: ☐ Yes ☐ No ☐ Unsure
If yes, name of waiver: _____

I am on a waiting list for a long-term services and supports waiver: ☐ Yes ☐ No ☐ Unsure
If yes, I am pending for: _____

Communication & Language

I need support with reading and/or understanding written material (include guardian response if applicable)
☐ Yes ☐ No *If yes*, what support is needed: _____

I need support with understanding information about my condition, medicines, or doctor's instructions (include guardian response if applicable)
☐ Yes ☐ No *If yes*, what support is needed: _____

I describe my understanding of my needs and challenges (insight) as (select the most appropriate)

I am knowledgeable about my needs and I am able to help direct planning to address them.	☐ Yes
I am knowledgeable about my needs and participate in planning to address them.	☐ Yes
I am somewhat knowledgeable about my needs.	☐ Yes
I would rather not participate in plans to address my needs.	☐ Yes
I do not think that I have needs or challenges that need to be addressed at this time.	☐ Yes

Comments: _____

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Awareness and Memory

I describe my awareness & memory (cognitive status) as (select the most appropriate)

Fine with no concerns (alter and fully oriented)	☐ Yes
Alert and oriented with daily fluctuations in mood	☐ Yes
Generally oriented through use of assistive technologies (verbal prompts, schedules, uses of technology for reminders, etc.)	☐ Yes
Difficulty with orientation (e.g. time/place, attention/concentration, perception, memory, reasoning)	☐ Yes
Exhibits mental status changes consistent with psychiatric disorder	☐ Yes
Comatose, but responsive	☐ Yes
Comatose, but unresponsive	☐ Yes
Other - Specify	☐ Yes

- I have the following awareness & memory needs

Hearing

I describe my hearing as (select the most appropriate):

Fine with no concerns	☐ Yes
Fine with use of assistive devices (e.g. hearing aids)	☐ Yes
Able to hear but not clearly	☐ Yes
Difficulty hearing in noisy environments	☐ Yes
Unable to hear	☐ Yes

- I have the following hearing needs

Vision

I describe my vision as (select the most appropriate)

Fine with no concerns	☐ Yes
Impairment, but managed through assistive devices (i.e. glasses/contacts)	☐ Yes
Vision is significantly impaired	☐ Yes

- I have the following vision needs

Speech and Communication

I describe my **speech and/communication** as (select the most appropriate)

Fine with no concerns	☐ Yes
Communicates with difficulty but can be understood	☐ Yes
Communicates with sign language, symbol board, written messages, gestures, and/or interpreter	☐ Yes

- I have the following speech and communication needs

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Social, Cultural & Spiritual Preferences

Describe family involvement, relationships, include past & current (*Describe the member's immediate family, involvement through member's life, relationships such as very close, never sees them, etc. and how they would describe growing up):*

Social

I communicate with friends, relatives and others (not paid helpers) as often as I want: ☐ Yes ☐ No
If no, explain: _____
If child, are there any people who the child is not to have contact with (list):
_____

I am satisfied with my relationships: ☐ Yes ☐ No Support Needed:
_____

I would like to have more of a support system: ☐ Yes ☐ No *If yes,* explain:
_____

I feel that I lack companionship: ☐ Yes ☐ No *If yes,* explain:
_____

My support system consists of (check all that apply): ☐ Family Members ☐ Friends ☐ Co-Workers
☐ Church ☐ Support Groups ☐ Other – Explain _____

I communicate with my support system by (check all that apply): ☐ Visiting in person ☐ Phone ☐ Texting
☐ Email ☐ Other, explain _____

My support system is supportive and/or involved in my treatment? ☐ Yes ☐ No *If no*, explain:
_____

I have access to mass media (i.e. television, newspaper) and technology (cell phone, internet): ☐ Yes ☐ No
If no, explain: _____

Cultural

I identify myself as: _____

My family traditions/beliefs that I follow are: _____

I have the following cultural beliefs regarding healthcare or specific treatments:
_____

I experience cultural stress regarding social norms, behaviors and attitudes (e.g. racism, negativity towards sexual orientation, gender identify and expression, and other forms of discrimination): ☐ Yes ☐ No
If yes, explain: _____

Spiritual

My religious/spiritual preference is: _____

I choose to practice a religion/spiritual belief: ☐ Yes ☐ No

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

I attend religious/spiritual services, as I want: ☐ Yes ☐ No

I choose to participate in my religion/spiritual beliefs as much as I want: ☐ Yes ☐ No

I have the following religious/spiritual beliefs regarding receiving healthcare or specific treatments:

_____

Leisure Activities

These are my hobbies, activities and things I do for fun:

_____

I enjoy spending time with the following people in my free time:

_____

Marital & Dating Status

My dating and marital status history is:

Is member able to understand consent: ☐ Yes ☐ No *If no,* additional information:

_____

I am currently (*check all that apply*): ☐ Never Married ☐ Married ☐ Single ☐ Divorced
☐ Legally Separated ☐ Widowed ☐ Dating ☐ Unknown ☐ NA- Minor

If not married, I would like to date: ☐ Yes ☐ No ☐ NA

I am sexually active: ☐ Yes ☐ No ☐ Prefer not to answer I am taking the following precautions:

_____

Developmental Milestones (Children Only)

My birth parents are: _____

My child's weight at birth: _____

Was the pregnancy full-term?	☐ Yes ☐ No ☐ Unknown	*If no or unknown,* explain:
Were there any complications during or immediately following delivery?	☐ Yes ☐ No ☐ Unknown	*If yes or unknown,* explain:
Was your child exposed to drugs or alcohol in utero?	☐ Yes ☐ No ☐ Unknown	*If yes or unknown,* explain:
Did your child walk independently by 18 months?	☐ Yes ☐ No ☐ Unknown	*If no or unknown,* explain:
Did your child use 2-to-4-word sentences by 24 months?	☐ Yes ☐ No ☐ Unknown	*If no or unknown,* describe:
By age 4, was your child daytime toilet trained?	☐ Yes ☐ No ☐ Unknown	*If no or unknown,* describe:

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

I have the following concerns regarding my child's development:

Gross motor (walking, running, physical activities)	☐ Yes ☐ No	*If yes*, explain:
Fine motor (use of pencil, manipulation of objects)	☐ Yes ☐ No	*If yes*, explain:
Independent functioning (eating, dressing self)	☐ Yes ☐ No	*If yes*, explain:

Comments: _____

I have the following additional concerns regarding my child's development:

_____

Is the home childproof (e.g. hazards such as detergents or medications are kept out of child's reach or are locked up; electrical outlets are covered, etc.): ☐ Yes ☐ No *If no*, describe:

_____

Medical & Mental Health History

I am currently diagnosed with the following conditions:

Condition	**Active**	**Past**	**Physician & Credentials**	**Year Diagnosed**	**Family History** (mark if yes)	**Family Member & Age of Diagnosis** (i.e. parents, siblings, children, grandparents)
Arthritis	☐	☐			☐	
Asthma	☐	☐			☐	
Back Pain	☐	☐			☐	
Behavioral Health Diagnosis (Name and ICD-10 Code):	☐	☐			☐	
Cancer Type:	☐	☐			☐	
Chronic Kidney Disease	☐	☐			☐	
COPD / Emphysema	☐	☐			☐	
Diabetes Type 1 Last A1C date & number:	☐	☐			☐	
Diabetes Type 2 Last A1C date & number:	☐	☐			☐	
Pre-Diabetes Last A1C date & number:	☐	☐			☐	
Hepatitis	☐	☐			☐	
Heart Disease	☐	☐			☐	
High Blood Pressure	☐	☐			☐	
High Cholesterol	☐	☐			☐	
HIV	☐	☐			☐	
Learning Disability	☐	☐			☐	

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Mental Health Diagnosis (Name and ICD-10 Code):	☐	☐			☐	
Sickle Cell Disease (not trait)	☐	☐			☐	
Stroke	☐	☐			☐	
Transplant Type:	☐	☐			☐	
Any other chronic conditions:	☐	☐			☐	

Summary of physical and mental health, including onset of diagnosis and symptoms:

_____

I have the following physical and mental health concerns:

_____

I have the following physical and mental health barriers to recovery:

_____

Surgeries/Major Procedures

I have had the following surgeries / major procedures:

Hospital / Surgery Center	Surgery / Major Procedure	Dates Received

Significant Illnesses

I have had the following significant past illnesses:

Past Health Condition	Symptoms	Treatment History	Dates Received

In the **past 12 months**,

- I needed to see a doctor but could not because of the cost or lack of resources. ☐ Yes ☐ No
- I went without health care because I didn't have a way to get there. ☐ Yes ☐ No

Comments: _____

Dental

I describe my dental hygiene as:

Fine, no concerns	☐ Yes ☐ No
I have tooth pain	☐ Yes ☐ No
I have no teeth	☐ Yes ☐ No
I have dentures	☐ Yes ☐ No
Other	☐ Yes ☐ No

- I have the following dental needs

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Fall History

I have a history of falls: ☐ Yes ☐ No *If yes,* my last fall was:

_____

I have the following preventative measures in place to decrease my falls:

_____

Behavioral Health / Mental Health

I would rate my overall mental health as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Comment: _____

My current stressors are:

Today,

I have thoughts of harming myself or feelings of suicide	☐ Yes ☐ No
I have thoughts of wanting to harm others	☐ Yes ☐ No

- *If yes*, provide more details: _____

In the **Past**,

I have had thoughts to harm myself or feelings of suicide	☐ Yes ☐ No
I have had thoughts of wanting to harm others or have harmed others	☐ Yes ☐ No

- *If yes,* provide more details: _____

In the **past 2 weeks**, I have been bothered by the following,

Little interest or pleasure in doing things	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling down, depressed or hopeless	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

In the **past 30 days**, I have

Seen or heard things that are not really there (hallucinations)	☐ Yes ☐ No
Had feeling of paranoia	☐ Yes ☐ No
Had irrational thoughts that weren't true (delusions)	☐ Yes ☐ No

- *If yes,* provide more details: _____

Hospitalization & Emergency Room Visit History

I am able to access emergency room assistance, as needed: ☐ Yes ☐ No

I need the following supports to access emergency room assistance:

In the **past year**,

I have been hospitalized for mental health reasons	☐ None ☐ Once ☐ 2-4 times ☐ 5-7 times ☐ 8+ times

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

I have been hospitalized for medical reasons	☐ None ☐ Once ☐ 2-4 times ☐ 5-7 times ☐ 8+ times
I have been to the emergency room	☐ None ☐ Once ☐ 2-4 times ☐ 5-7 times ☐ 8+ times

Psychiatric and/or Alcohol / Substance Use Hospitalizations

I have had the following psychiatric and/or alcohol / substance use hospitalizations:

Provider Name & Address	Reason for Inpatient Stay/Facility Stay	Successful/Helpful	Dates Received
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Medical Hospitalizations

I have had the following medical hospitalizations:

Provider Name & Address	Reason for Stay	Successful/Helpful	Dates Received
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Emergency Room Visits

I have had the following emergency room visits current and past:

Provider Name & Address	Reason for ED Visit	Dates Received

Preventative Visits

I have had the following health screenings

Preventative Measure	Completed	Date	Results
Flu Shot	☐ Yes ☐ No		
Blood Pressure (systolic/diastolic)	☐ Yes ☐ No		

For **Adults ONLY**

Preventative Measure	Completed	Date	Results
Cholesterol (Total)	☐ Yes ☐ No		
Low Density Lipoprotein (LDL)	☐ Yes ☐ No		
Colonoscopy	☐ Yes ☐ No		

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

For **Women ONLY**

Preventative Measure	Completed	Date
Mammogram	☐ Yes ☐ No	
Pap smear in last five years	☐ Yes ☐ No	
I am pregnant	☐ Yes ☐ No	*If yes,* Due Date:
I have a prenatal doctor	☐ Yes ☐ No	Name of Provider:

For **Children ONLY**

My child is up-to-date on his/her immunizations: ☐ Yes ☐ No *If no*, describe:

Allergies

Allergy Type	Allergy	Type	Reaction
Food	☐ Yes ☐ No		
Medications	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

Physical Health

I would rate my overall physical health as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Comments:

My height (inches)		My weight (pounds)		My body mass index (BMI)	

Exercise Routine

I engage in moderate to strenuous exercise (like a brisk walk) # days per week	
I engage in # minutes of strenuous exercise per week	
I want to increase my activity level	☐ Yes ☐ No

Comments:

Nutrition

My appetite is	☐ Good ☐ Fair ☐ Poor
I follow a healthy diet	☐ Yes ☐ No
I have had unexplained weight loss or weight gain in the past year	☐ Yes ☐ No
I have concerns regarding my nutrition	☐ Yes ☐ No
I am able access the local grocery store or farmers market, as needed	☐ Yes ☐ No

Comments:

Toxin Exposure

I have had the following exposure to toxins (e.g. Radon, lead in drinking water, lead in paint, chemicals, in-utero drug or alcohol exposure including smoking, alcohol poisoning, etc. If none, indicate no known exposure.):

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Toxin	Exposure (inhalation, ingestion, direct contact)	Dates	Effects

Domestic Violence, Physical, Emotional, Sexual Abuse & Trauma

I have been a victim of	☐ Domestic Violence ☐ Physical Abuse ☐ Psychological Abuse ☐ Emotional Abuse ☐ Sexual Abuse
I have been a perpetrator of	☐ Domestic Violence ☐ Physical Abuse ☐ Psychological Abuse ☐ Emotional Abuse ☐ Sexual Abuse
I have a history of trauma	☐ Yes ☐ No
My trauma history includes	

Additional information regarding domestic violence, physical, emotional, sexual abuse (i.e. don't identify people by name but as friend, neighbor, family member, etc.):

_____

Medications

In the **past year**,

I have had significant medication changes	☐ Yes ☐ No	Comments:
I have forgotten to refill medications on time	☐ Yes ☐ No	Comments:

I store my medications in the following location(s): _____

I forget to take my prescribed medications:

☐ Daily ☐ Weekly ☐ Once/Twice a Month ☐ Infrequent ☐ Never

I remember to take my medications by (select all that apply):

☐ Following directions ☐ Caregiver gives me them ☐ Medication machine
☐ Timer ☐ Calendar ☐ Pill minder
☐ Nurse/Home Health set up ☐ Staff ☐ Other – note in Comments: _____

I am currently taking:

- Prescription medication ☐ Yes ☐ No
- Over-the-counter medications, including vitamins ☐ Yes ☐ No

I know what medications I take and why I take them: ☐ Yes ☐ No Comments: _____

I am able to self-administer my medications: ☐ Yes ☐ No Comments: _____

I have the following additional medication needs or concerns:

_____

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Current Medications

My current medications (include prescription, over-the-counter & vitamins):

Medication Name	Dosage	Frequency	Prescriber	Reason/Purpose	Date Started

Past Relevant Medications

Past medications tried:

Medication Name	Dates	**Reason Discontinued** (e.g. specific side effect, insurance coverage, medication wasn't effective)

Pharmacy

I have a pharmacy that I use	☐ Yes ☐ No
Pharmacy Name	
Pharmacy Address	
Pharmacy Phone	
I am locked into a pharmacy	☐ Yes ☐ No

My Current Medical Support Team

Role	Name/ Agency	Address		Last Visit Date	Reason for Last Visit
Primary Care Practitioner (PCP)					
Dentist					
Eye Doctor					
Audiologist					
Therapist					
Psychiatrist					

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Speech Therapy					
Physical Therapy					
Occupational Therapy					
Other Specialties (list)					

I currently need assistance to access or identify the following providers:

_____

Supports & Services Received

I **currently** receive the following supports & services (i.e. Therapy (individual, group, family), Psychiatry services, Intensive Outpatient, Medication Management, HCBS waiver services, BHIS, Habilitation services, Transportation, In-Home Care, Durable Medical Equipment, Alcohol and/ or Substance use/ abuse services, etc.):

Service Type	Provider Name	Provider Address	Successful or Helpful	Dates of Service
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Comments: _____

My **past** supports & services I have accessed (i.e. Therapy (individual, group, family), Psychiatry services, Intensive Outpatient, Medication Management, HCBS waiver services, BHIS, Habilitation services, Transportation, In-Home Care, Durable Medical Equipment, Alcohol and/ or Substance use / Abuse services, etc.):

Service Type	Provider Name	Provider Address	Successful or Helpful	Dates of Service
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Comments: _____

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

I am satisfied with my current supports and services: ☐ Yes ☐ No
If no, explain: _____

I participate in support groups (e.g. NAMI, NA/AA, etc.): ☐ Yes ☐ No
If yes, explain (type/frequency): _____

I want to participate in support groups (e.g. NAMI, NA/AA, etc.): ☐ Yes ☐ No
If yes, explain (type/reason): _____

Substance Use or Abuse

I have a history of alcohol and/or substance use: ☐ Yes ☐ No

I live with or spend time with a person who has alcohol or substance abuse concerns, including misuse of prescription medication: ☐ Yes ☐ No *If yes*, provide additional information:

_____

The following people in my life (e.g. spouse, partner, parents/guardian, friend, child, etc.) are concerned about my substance and/or tobacco use: ☐ Yes ☐ No Describe:

_____

Alcohol Use

I consume alcoholic beverages	☐ Yes ☐ No *If no,* skip to caffeine use
I drink alcohol	☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 4 or more times a week
On a typical day, I consume this many alcohol drinks	☐ 1-2 drinks ☐ 7-9 drinks ☐ 3-4 drinks ☐ 10 or more drinks
I drink 5 or more drinks on one occasion	☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
In the past year, I have consumed, 5 or more drinks for men or 4 or more drinks for women, per day	☐ Yes ☐ No
My choice of alcohol is	
I first used alcohol at age	
My longest sobriety was	

Caffeine Use

In the **past two weeks**, I have consumed the following caffeinated beverages per day	☐ No coffee or caffeinated beverages ☐ 1-2 cups of coffee or 1-4 caffeinated beverages ☐ 3-6 cups of coffee or 5-9 caffeinated beverages ☐ 7 or more cups of coffee or 10 or more caffeinated beverages
My preferred choice of caffeinated beverage is	

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Illegal Substances

I have used illegal substances	☐ Yes ☐ No *If no,* skip to tobacco use
I use illegal substances	☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 4 or more times a week
In past year, I have used an illegal drug	☐ Yes ☐ No
In past year, I have used prescription medication for non-medical reasons	☐ Yes ☐ No
My preferred choice of illegal substance is	
I first used illegal substances at age	
I have tried the following illegal substances	

Tobacco Use

I currently smoke or use other forms of tobacco	☐ Yes ☐ No *If no,* skip to alcohol/substance abuse treatment
My choice of tobacco is	☐ Cigarettes ☐ Cigars ☐ E-cigarettes/Vape ☐ Chewing Tobacco ☐ Other
I use tobacco	☐ Sometimes (few times a month) ☐ Occasionally (few times a week) ☐ Daily For cigarettes/cigars/vaping, answer the following: ☐ Light cigarette smoker (1-9 cigs/day) ☐ Moderate cigarette smoker (10-19 cigs/day) ☐ Heavy cigarette smoker (20-39 cigs/day) ☐ Very heavy smoker (40+cigs/day)
In past year, I have used tobacco	☐ Sometimes (few times a month) ☐ Occasionally (few times a week) ☐ Daily Type/Comments:
I first used tobacco at age	

Alcohol/Substance Abuse History

My family history of substance use, treatment and/or issues include:

_____

Additional alcohol / substance use comments:

_____

Gambling/Dependence

I have gambled money or goods in the past year: ☐ Yes ☐ No *If no,* skip to Self-Care/ADLs/IDLs Section.
In the **past 12 months**, I have

Become restless, irritable, or anxious when trying to stop or cut down on gambling	☐ Yes ☐ No
Tried to keep my family or friends from knowing how much I have gambled	☐ Yes ☐ No

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Had financial trouble as a result of my gambling that I had to get help with living expenses from family, friends or other sources	☐ Yes ☐ No

Self-Care/ADLs/IDLs

I **need assistance** with the following:

Activity	Independent	Supervision/ Verbal Prompts / Cueing	Assistive Device	Physical Assistance	Total Dependence	Frequency of Assistance	
						Daily	Intermittent
Eating	☐	☐	☐	☐	☐	☐	☐
Grooming and personal hygiene	☐	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐	☐
Mobility in bed	☐	☐	☐	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐	☐	☐
Preparing meals	☐	☐	☐	☐	☐	☐	☐
Housekeeping	☐	☐	☐	☐	☐	☐	☐
Managing finances	☐	☐	☐	☐	☐	☐	☐
Managing medications	☐	☐	☐	☐	☐	☐	☐
Handling transportation (driving or navigating public transit)	☐	☐	☐	☐	☐	☐	☐
Using the telephone or other communication devices	☐	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐	☐

If assistance is needed to participate in an activity listed in the table above, include information about the type of supervision, physical assistance, and/or use of assistive devices or adaptive equipment needed:

_____

Caregiver(s) Natural Supports

I have an unpaid caregiver(s)/natural support who assists with me with activities above: ☐ Yes ☐ No
If yes, list caregiver name, assistance and frequency:

_____

My Caregiver(s)/natural support reports feelings of stress: ☐ Yes ☐ No

The caregiver(s)/natural support access the following supports, training, and resources:

_____

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

The caregiver(s)/natural support needs the following supports, training, and resources:

_____

Transportation

I am able to arrange my own transportation	☐ Yes ☐ No
I have a valid driver's license	☐ Yes ☐ No
I have a safe/reliable vehicle	☐ Yes ☐ No
I am able to use public transportation	☐ No help or supervision ☐ Need some help or occasional supervision ☐ Need a lot of help ☐ Need consistent help
I am able to get to the places I want (check all that apply)	☐ Walking ☐ Bicycle ☐ Drive ☐ Take a taxi/bus ☐ Family/friends drive ☐ Staff/Provider ☐ Other, describe

I have the following transportation needs or concerns, not identified above:

_____

Employment & Volunteering

I am currently working: ☐ Yes ☐ No ☐ I am under age 14 (skip to Educational History section)

If working:

I work _____hours a week doing the following: _____.

I like my current job: ☐ Yes ☐ No

I want to find a different job: ☐ Yes ☐ No *If yes*, I am interested in: _____

I have supports that assist me with maintaining my job: ☐ Yes ☐ No *If yes*, I am currently receiving the following supports (name, type of support & # of hours of support):

_____

If not working:

I want to obtain a job: ☐ Yes ☐ No

I am interested in (identify job interest, why and # of hours): _____

I need the following supports to be successful in obtaining a job: _____

I am currently working with Iowa Vocational Rehabilitation Services (IVRS): ☐ Yes ☐ No *If yes*, I began working with IVRS on the following date: _____

My IVRS counselor name, address & phone number is: _____

My **past** work history includes:

Employer	**Services/Supports Received, if applicable**	**Summary About Employment** *(Like/dislike job, quit/fired, etc.)*	**Employment Dates**

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

I am currently volunteering or interested in volunteering: ☐ Yes ☐ No
I volunteer at:_____ doing the following:_____
I volunteer these days:_____
I am interested in volunteering at or doing:_____

Additional employment / volunteering comments:_____

Educational History

I am currently in school: ☐ Yes ☐ No *If yes*, where:_____
If yes, are you in any extra-curricular activities: ☐ Yes ☐ No Explain*:*

_____
I attend school as scheduled (i.e. following attendance policy, are there truancy issues, etc.): ☐ Yes ☐ No
Comments:_____

The highest level of education I have completed is:
☒ I am currently in K – 12th grade ☐ GED / Hi-Set ☐ High School Diploma ☒ Technical School
☐ Certificate ☐ 2 year Degree ☐ 4 year Degree ☐ Master's
☐ Doctorate/PhD ☐ Did not complete high school ☐ Other

I have a degree(s)/certificate(s), post high school/GED/Hi-Set: ☐ Yes ☐ No *If yes*, explain date obtained and specialty obtained:_____

I would describe my school experience as:_____

I receive or received the following supports/services (e.g. AEA, special educations, etc.) in school:

_____
I am interested in furthering my education: ☐ Yes ☐ No *If no,* skip to Housing Situation section

I would like to go to school for:

_____
I need assistance or support in gaining access to educational services: ☐ Yes ☐ No *If yes*, explain type of assistance/support needed:

_____
Additional educational comments:

_____

Housing Situation

I currently live (check all applicable):
☐ Alone ☐ With Immediate Family ☐ With Relatives
☐ With Friends ☐ With Roommates ☐ Other, describe_____

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

I currently reside in:

☐ Own home ☐ Apartment ☐ Family/Friend Home
☐ Shelter ☐ Homeless ☐ Residential Care Facility (RCF)
☐ Psychiatric Medical Institute ☐ Other, describe _____

I feel safe in my home: ☐ Yes ☐ No *If no*, why: _____

The exits in my home/residence are easily accessible in case of an emergency: ☐ Yes ☐ No *If no*, describe plan to make accessible: _____

I feel safe in my neighborhood: ☐ Yes ☐ No *If no*, why: _____

I am able to access emergency assistance in case of an emergency by (check all applicable):

☐ Cell Phone ☐ Family ☐ Neighbor ☐ Personal Emergency Response System
☐ Staff/Provider ☐ Other, describe _____

In the **next 2 months**, I am worried that I may not have stable housing: ☐ Yes ☐ No

I have the following additional housing needs or concerns:

_____

Financial

Representative Payee & Conservator

I have a representative payee: ☐ Yes ☐ No

Representative Payee Name: _____
Address (Street, City, State, Zip) _____
Phone: _____ Email: _____

I have a conservator: ☐ Yes ☐ No

Conservator Name: _____
Address (Street, City, State, Zip) _____
Phone: _____ Email: _____

Income and Resources

I receive the following income and monthly amounts (Social Security, work wages, etc.):

Income Type	**Amount**	**Frequency** *(Monthly, weekly, etc.)*
Social Security (SSDI/SDAC/SSI)		
Retirement		
Work Wages		
Other:		

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

I am able to manage my own finances (i.e. understands use of money, can pay for things, pay bills, and balances a checkbook): ☐ Needs no help or supervision ☐ Needs some help or occasional supervision ☐ Needs a lot of help or constant supervision ☐ Can't do it at all
Comments: _____

I need legal aid assistance: ☐ Yes ☐ No *If yes*, explain:

_____
In the **last 3 months**, I ate less because there wasn't enough money for food:
☐ Yes ☐ No

In the **last 6 months**, I have had my electric, gas, oil or water company threaten to shut off my service:
☐ Yes ☐ No

I have problems getting childcare & it makes it hard for me to work or study: ☐ Yes ☐ No *If yes*, explain:

_____

I have the following additional financial needs or concerns:

_____
I currently

Receive food stamps	☐ Yes ☐ No	Comment:
Access the food pantry	☐ Yes ☐ No	Comment:
Receive housing assistance	☐ Yes ☐ No	Comment:

Additional community resources I use or need: _____

Legal Information

Legal Guardian

I have a legal guardian: ☐ Yes ☐ No

Name	
Address (Street, City, State, Zip)	
Phone	
Email	

Advanced Directive

I have an advanced directive in place: ☐ Yes ☐ No
If no, I would like information on how to complete this: ☐ Yes ☐ No
The following information was provided to me:

_____

Power of Attorney

I have a Power of Attorney: ☐ Yes ☐ No

Name	

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Type of Power of Attorney	
Address (Street, City, State, Zip)	
Phone	
Email	

Mental Health Committal

I have a mental health committal: ☐ Yes ☐ No

Committal County	
Judicial Advocate Name	
Address (Street, City, State, Zip)	
Phone	
Email	

Substance Abuse Committal

I have a substance abuse committal: ☐ Yes ☐ No

Committal County	
Judicial Advocate Name	
Address (Street, City, State, Zip)	
Phone	
Email	

Probation or Parole

I am on probation or parole: ☐ Yes ☐ No

Probation/Parole Officer Name	
Judicial Advocate Name	
Address (Street, City, State, Zip)	
Phone	
Email	

Summary of arrest history:

I have a no contact order in place: ☐ Yes ☐ No Details: _____

I am on the child abuse registry: ☐ Yes ☐ No Summary: _____

I am on the sex offender registry: ☐ Yes ☐ No Summary: _____

For **Children ONLY**,
My child has the following in place:

Child in need of assistance (CINA)	☐ Yes ☐ No	Details:
Child protection order	☐ Yes ☐ No	Details:
Foster Care Placement	☐ Yes ☐ No	Foster Parent Names:
Other court order	☐ Yes ☐ No	Details:

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Future Identified Goals & Needs

A typical day for me is (e.g. starting from when you get up until bed time, outline your basic routine)?

_____

I would like to change the following, if anything, about my day:

_____

I have the following urgent needs (e.g. I don't have food tonight, don't have a place to sleep): _____

I would like to receive assistance with those needs: ☐ Yes ☐ No

My overall goal for improving my health and life is:

_____

The following describes how ready I am to change or take action on my goals:

☐ Not planning to take action within the near future
☐ Planning to take action within the next six months
☐ Planning to take action within the next months and have a plan of how to do this
☐ I've already made significant modifications in my way of life

Comment: _____

The most important thing for me to address is:

I am aware that this could require a personal change to address this need: ☐ Yes ☐ No
On a scale of 0 – 10, with 10 being extremely important, I would rate this as a _____
On a scale of 0 – 10, with 10 being extremely confident, I would rate my confidence in making this change a _____

The second most important thing for me is:

I am aware that this could require a personal change to address this need: ☐ Yes ☐ No
On a scale of 0 – 10, with 10 being extremely important, I would rate this as a _____
On a scale of 0 – 10, with 10 being extremely confident, I would rate my confidence in making this change a _____

The third most important thing for me is:

I am aware that this could require a personal change to address this need: ☐ Yes ☐ No
On a scale of 0 – 10, with 10 being extremely important, I would rate this as a _____
On a scale of 0 – 10, with 10 being extremely confident, I would rate my confidence in making this change a _____

I need the following support to accomplish my goal(s): _____

Identified Risks and Needs by the Assessor

Using the information in this assessment, complete each area.

Cognitive functioning. *Considerations: Cognitive functions, including the member's ability to communicate and understand instructions, process information about an illness, focus and shift attention, comprehend and recall direction independently*: Choose an item.

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Visual and hearing needs, preferences or limitations. *Considerations: Member's vision and hearing, and the impact on member's case management plan and barriers to effective communication or care. Examples include visual impairment and need for/use of visual aids, hearing impairment and need for/use of hearing aids or other supports or devices*: Choose an item.

Social functioning. *Considerations: Social functioning refers to an ability to interact easily and successfully with other people. Examples include engagement with family and friends, social isolation, employment status*:
Choose an item.

Cultural and linguistic needs, preferences or limitations. *Considerations: Member's cultural health beliefs/practices/needs, preferred languages and needs, and the impact of culture and language on communication, care, or acceptability of specific treatments*: Choose an item.

Health status, including condition-specific issues. *Considerations: Active diagnoses, physical health conditions, co-morbidities, self-reported health status, current medications (including dosages and schedule):*
Choose an item.

Behavioral health status. *Considerations: Behavioral health status, including mental health conditions and substance use disorders (examples: substance use disorders, suicidal ideation, depression, psychosis)*:
Choose an item.

Available benefits within the organization. *Considerations: Adequacy of the member's health insurance benefits in relation to the needs of the case management plan. Examples include benefits covered by the organization and providers, services carved out by the purchaser, services that supplement those the organization is contracted to provide such as community mental health/subsidized housing/palliative care programs*: Choose an item.

Activities of daily living, including use of supports. *Considerations: ADL examples include grooming, dressing, bathing, toileting, eating, transferring, continence, walking; supports including assistive technology and human assistance*: Choose an item.

Instrumental activities of daily living, including use of supports. *Considerations: IADL examples include managing finances, shopping, preparing meals, managing medications, housework and basic home*

Comprehensive Assessment & Social History

maintenance, handling transportation, using telephone and other communication devices; supports including assistive technology and human assistance: Choose an item.

Paid and unpaid caregiver resources, involvement and needs. *Considerations: Adequacy of caregiver resources. For example, family involvement in the case management plan and carrying it out, availability/skills/capacity of caregivers to provide support of requested ADL/IADL, undue burden on caregiver, caregiver support needs*: Choose an item.

Community resources. *Considerations: Member's eligibility for community resources and the availability of those resources. Examples include community mental health, vocational programs, volunteer companion services, government aid, senior centers, adult day care, support groups, poverty outreach groups, housing resources, legal aid, and palliative care programs*: Choose an item.

Social determinants of health. *Considerations: Social determinants of health refer to the economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include current housing and housing security, access to local food markets, exposure to crime/violence/social disorder, residential segregation and other forms of discrimination, access to mass media and emerging technologies, social support/norms/attitudes, access to transportation, and financial barriers to obtaining treatment:* Choose an item.

Health beliefs and behaviors. *Considerations: Health beliefs and behaviors may reflect cultural and social beliefs about health problems, perceived benefits of action, and barriers to action. Examples include optimism, self-efficacy, and physical activity, smoking, alcohol use, medication adherence, beliefs and concerns about the condition or services the member is receiving:* Choose an item.

Physical environment for risk. *Considerations: Member's physical environment and risks. Examples include fall risks, medication risks, accessibility of exits, and access to emergency assistance*: Choose an item.

Habilitation Eligibility (only complete if applying or accessing habilitation)

Risk Factor – must at least meet 1 of the following

☐ Has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care more than once in the member's life OR

☐ Has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization

Member Name:
Medicaid #:

Comprehensive Assessment & Social History

Need for Assistance – meet at least 2 of the following on continuing or intermittent basis for 2 years

- ☐ Is unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
- ☐ Requires financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
- ☐ Shows severe inability to establish or maintain a personal social support system.
- ☐ Requires help in basic living skills such as self-care, money management, housekeeping, cooking, or medication management.
- ☐ Exhibits inappropriate social behavior that results in demand for intervention.

SIGNATURE

_____	_____
Name, Credentials	Date
_____	_____
Member / Guardian	Date
_____	_____
Title:	Date
_____	_____
Title:	Date