Adult Enhanced Care Management (ECM) Comprehensive Assessment

This assessment is designed as a tool for you, as the ECM Lead Care Manager, to assess an Adult member's health needs and help the Adult member participate in the Enhanced Care Management benefit. Today and over the next 1-3 visits, you and the member will complete this assessment together, and from there develop goals and next steps that support the Adult member's overall health and wellness.

Indicate if you used any of the following, recently completed assessments or tools to complete/inform this assessment.

Indicate if you used any of the following, recently completed assessments or tools to complete/inform this assessment. The ECM Lead Care Manager should incorporate findings from all available assessments. Assessment do not replace this comprehensive assessment but should inform development of the care plan.

1. *ACEs *If no ACES completed: refer to PCP/SW for screening.*	☐ Yes Date Completed: MM/DD/YYYY	☐ No	☐ N/A
2. *Needs Evaluation Tool	☐ Yes Date Completed: MM/DD/YYYY	☐ No	☐ N/A
3. *(Pregnant/Postpartum) CSPSP Assessment	☐ Yes Date Completed: MM/DD/YYYY	☐ No	☐ N/A
4. *(Justice Involved) Health Risk Assessment	☐ Yes Date Completed: MM/DD/YYYY	☐ No	☐ N/A
5. *(Justice Involved) Re-entry Care Plan	☐ Yes Date Completed: MM/DD/YYYY	☐ No	☐ N/A

Question required to be completed

Other(s):	List with date completed: MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY

Section 1. Demographics

1. *Date Assessment Started:	**2. *Member's Full Name:**
3. *Member's Date of Birth:	**4. *Member's Medicaid ID:**

5. Full Name of Respondent (*(If different from member, i.e., parent, legal guardian, authorized representative) and relationship to member)*:

_____

6. *Population(s) of Focus (select all that apply):

- ☐ Adult- Individuals Experiencing Homelessness
- ☐ Adult-Families Experiencing Homelessness
- ☐ Adult- Avoidable Hospital or ED Utilization
- ☐ Adult-SMI or SUD
- ☐ Adults- Transitioning from Incarceration
- ☐ Adults- at risk for LTC Institutionalization
- ☐ Adults- NF Transitioning to Community
- ☐ Adult- Birth Equity

7. *Is anyone else in the family enrolled in ECM? ☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

If yes, list family member name(s), relationship(s) to member, and their ECM provider(s) below:

Family Member Name(s):	**Family Member's Relationship to Member:**

Question required to be completed

Section 1. Demographics

8. *Preferred name and /or pronouns:

9. *Gender Identification:

10. *Preferred written/spoken language:

11. *Interpreter needed: ☐ Yes ☐ No

If **yes**, language:

_____

12. *Nationality/tribe/ethnicity (Select all that apply):

- ☐ Hispanic or Latino
- ☐ Asian
- ☐ Pacific Islander / Native Hawaiian
- ☐ White
- ☐ Black / African American
- ☐ American Indian / Alaskan Native
- ☐ Other:

_____

13. *Where would you like to receive mail? *(include physical address and location type, e.g., home, friend's house, DPSS office, etc.)*

_____

14. *Home Phone(s):

15. *Cell Phone(s):

16. *In person contact? ☐ Yes ☐ No

If no, what is your preferred method of contact? Select all that apply. *(Reminder: ECM preferred contact is in person).*

- ☐ Phone
- ☐ Email
- ☐ Text

17. *Email Address(es):

_____

18. *Preferred location(s) of contact. *Are you comfortable meeting at your home? Where would you like to meet?*

***Question required to be completed**

Section 1. Demographics

_____

19. *Relationship Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Domestic partnership
- ☐ Widower
- ☐ Decline to answer
- ☐ Other: _____

20. *Opt-In to ECM Date: _____

- ☐ Verbal
- ☐ Written
- ☐ N/A-Grandfathered from HHP/WPC

21. *Is there a person or location that we can contact if we need to get in contact with you? (List relationship of person and contact info, or location address and description-e.g. shelter)

_____

22. *Veteran / Discharged from U.S Armed Forces?

☐ Yes ☐ No ☐ Declined to Answer

Section 2. Culture

1. ***Do you have any cultural, religious and/or spiritual beliefs that are important to your family's health and wellness?**

☐ Yes ☐ No ☐ Declined to Answer

If **yes**, describe:

_____

Question required to be completed

Section 3. Physical Health/Preventative Care

Physical Health

1. ***In general, would you say your health is:**
   - ☐ Very Good
   - ☐ Good
   - ☐ Poor
   - ☐ Decline to answer

Please give me more information about why you chose this rating:

_____

1. ***Compared to one (1) year ago, is your health:**
   - ☐ Much Better
   - ☐ Somewhat better
   - ☐ About the same
   - ☐ Somewhat worse
   - ☐ Much worse now than one (1) year ago
   - ☐ Declined to Answer

Please give me more information about why you chose this rating:

_____

2. ***How many times have you been to the emergency room in the past 6 months?**
   - ☐ None
   - ☐ 1 time
   - ☐ 2 times
   - ☐ 3 times or more
   - ☐ Don't remember / Not sure
   - ☐ Decline to Answer

Please give me more information about why you chose this rating:

_____

Question required to be completed

Section 3. Physical Health/Preventative Care

3. ***How many times have you been a patient in the hospital in the past 6 months?**
   - ☐ None
   - ☐ 1 time
   - ☐ 2 times or more times
   - ☐ Don't remember/Not sure
   - ☐ Declined to Answer

Comments:

---

4. ***In the last 12 months, how many times have you been in a nursing home, rehab, and/or recuperative care?**
   - ☐ None
   - ☐ 1 time
   - ☐ 2 times or more times
   - ☐ Declined to Answer

Please give me more information about why you chose this rating (including which setting(s)):

---

5. ***Do you know who your regularly assigned health care providers are?**
   - ☐ Yes
   - ☐ No

If **yes**, enter Provider name(s)/clinic(s)/phone #(s):

If **yes**, when was the last time you saw your regular doctor?
   - ☐ Less than 3 months ago
   - ☐ Less than 6 months ago
   - ☐ 6-12 months ago
   - ☐ More than 1 year ago
   - ☐ Not sure

Question required to be completed

Section 3. Physical Health/Preventative Care

6. ***Do you have a provider for women's health**

☐ Yes ☐ No ☐ N/A

Provider name(s)/clinic(s)/phone #(s):

_____

7. ***Have you had a dental visit in the past 12 months?**

☐ Yes ☐ No ☐ Not Sure ☐ Decline

If **yes,** enter Dentist's name/phone #:

_____

8. ***Do you have any problems eating (for example, appetite, chewing or swallowing)?**

☐ Yes ☐ No

If **yes**, please provide details:

_____

9. ***Have you been told by a doctor or medical provider that you have any medical conditions?**

☐ Yes ☐ No

If **yes**, please include the date(s) (estimated) of diagnosis(es):

_____

If **yes,** please check all the diagnosis(es) that apply:

☐ Arthritis/chronic pain
☐ Asthma *(difficulty breathing)*
☐ Ankle/leg swelling
☐ Alzheimer's/dementia/memory loss
☐ Cancer
☐ COPD/emphysema/bronchitis *(breathing problems*)
☐ Congestive Heart Failure
☐ Circulation problems

Question required to be completed

Section 3. Physical Health/Preventative Care

- ☐ Diabetes, Type 1
- ☐ Diabetes, Type 2
- ☐ Pre-Diabetes
- ☐ Heart problems *(heart attack, chest pain)*
- ☐ HIV/AIDS
- ☐ Hepatitis *(liver problems)*
- ☐ High cholesterol
- ☐ Hypertension *(high blood pressure)*
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Physical disability/para/quadriplegic/amputation
- ☐ Recent fracture
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Transplant:

_____

- ☐ History of TB
- ☐ Urinary problems
- ☐ Other conditions not listed above (including a wound that needs care):

_____

Physical Health

10. *Do you have trouble with your vision?

☐ Yes ☐ No

If **yes**, describe:

_____

Other:

_____

Question required to be completed

Section 3. Physical Health/Preventative Care

11. *If you have diabetes, have you had a Diabetic Eye Exam done in the last year?

☐ Yes ☐ No ☐ N/A

12. *Do you have trouble with your hearing?

☐ Yes ☐ No

If **yes,** describe:

_____

Preventative Care

13. *Have you had any of the following vaccinations?

COVID-19

☐ Yes ☐ No ☐ Unsure

Date (if known): MM/DD/YYYY _____

Tetanus

☐ Yes ☐ No ☐ Unsure

Date (if known): MM/DD/YYYY _____

Flu

☐ Yes ☐ No ☐ Unsure

Date (if known): MM/DD/YYYY _____

Pneumonia

Shingles

☐ Yes ☐ No ☐ Unsure

Date (if known): MM/DD/YYYY _____

Question required to be completed

Section 3. Physical Health/Preventative Care

Others (list with dates, if know):

_____

14. *Do you have any questions or need support getting your vaccinations?

☐ Yes ☐ No

15. *Have you had the following screenings/tests? Select all that apply.

- ☐ Colonoscopy (5 years)
- ☐ Mammogram (2 years)
- ☐ Pap smear (3-5 years)
- ☐ Bone density
- ☐ Blood sugar (HbA1C, 12 month)
- ☐ Kidney function
  Date: MM/DD/YYYY _____
- ☐ Eye exam
  Date: MM/DD/YYYY _____

Section 4: Medications

1. *Please tell me what medications (including birth control, over-the-counter medications, vitamins, etc.) you are currently taking:

Medication Name	How Often (Frequency)	How Administered (Route)	Dosage

Question required to be completed

Section 4: Medications

If you were not able to list all medications above, list the missing medications below:

_____

2. *Are you having any trouble getting or filling your medications?

☐ Yes ☐ No ☐ N/A

If **yes**, comments:

_____

3. *People sometimes miss taking their medications. Thinking over the past week, were there any days you did not take your medications as prescribed?

☐ Yes ☐ No

If **yes**, please describe what gets in the way:

_____

4. *Do you need help taking your medicines?

☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

Section 5: Activities of Daily Living (ADLs)

1. *Do you need help with any of the following actions?

Taking a bath or shower?

☐ Yes ☐ No

Comments:

_____

Eating?

Question required to be completed

Section 5: Activities of Daily Living (ADLs)

☐ Yes ☐ No

Comments:

Brushing teeth, brushing hair, shaving?

Comments:

Getting out of a bed or chair?

☐ Yes ☐ No

Comments:

Using the toilet?

☐ Yes ☐ No

Comments:

Washing dishes or clothes?

☐ Yes ☐ No

Comments:

Getting a ride to the doctor or to see your friends?

☐ Yes ☐ No

Comments:

Going out to visit family or friends?

☐ Yes ☐ No

***Question required to be completed**

Section 5: Activities of Daily Living (ADLs)

Comments:

Keeping track of appointments?

☐ Yes ☐ No

Comments:

Going upstairs?

☐ Yes ☐ No

Comments:

Getting dressed?

☐ Yes ☐ No

Comments:

Making meals or cooking?

☐ Yes ☐ No

Comments:

Shopping and getting food?

☐ Yes ☐ No

Comments:

Walking?

☐ Yes ☐ No

Comments:

***Question required to be completed**

Section 5: Activities of Daily Living (ADLs)

Writing checks or keeping track of money?

☐ Yes ☐ No

Comments:

Doing house or yard work?

☐ Yes ☐ No

Comments:

Using the phone?

☐ Yes ☐ No

Comments:

2. **If yes to any of the above, are you getting all the help you need with these actions?**

☐ Yes ☐ No

Comments:

3. ***Have you fallen the last month?**

☐ Yes ☐ No

Comments:

4. ***Are you afraid of falling?**

☐ Yes ☐ No

Question required to be completed

Section 5: Activities of Daily Living (ADLs)

Comments:

---

5. *Do friends or family members express concerns about your ability to care for yourself? *Note: if yes, consult with clinical consultant and supervisor.*

☐ Yes ☐ No

Comments:

---

6. *Do you use or need any of the following? Select all that apply.

Glasses	☐ Use	☐ Need
Cane	☐ Use	☐ Need
Walker	☐ Use	☐ Need
Hearing Device	☐ Use	☐ Need
TTY(Visual support)	☐ Use	☐ Need
Crutches	☐ Use	☐ Need
Grab Bars	☐ Use	☐ Need
Raised toilet	☐ Use	☐ Need
Feeding tube	☐ Use	☐ Need
Wheelchair	☐ Use	☐ Need
Food supplements	☐ Use	☐ Need
Hospital bed	☐ Use	☐ Need
Oxygen	☐ Use	☐ Need
Ostomy supplies	☐ Use	☐ Need
CPAP/BIPAP	☐ Use	☐ Need
Diabetes supplies	☐ Use	☐ Need
Large Print	☐ Use	☐ Need
Sideboard	☐ Use	☐ Need
Urinary catheter	☐ Use	☐ Need
IV infusion for meds	☐ Use	☐ Need
Incontinence supplies	☐ Use	☐ Need
Trach, suction supplies	☐ Use	☐ Need

Question required to be completed

Section 5: Activities of Daily Living (ADLs)

Lift device (for transferring)	☐ Use	☐ Need
Other	☐ Use	☐ Need

Comments:

_____

Section 6: Pain Management

1. **Do you experience pain?**

☐ Yes ☐ No ☐ N/A

If **yes**, answer below:

_____

2. ***During the past week, how much did pain interfere with your normal activities (including work outside the home and/or housework)?**
   - ☐ Not at all
   - ☐ A little bit
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely
   - ☐ Decline to Answer

Section 7: Pregnancy/Postpartum

☐ **N/A for Section 7. Pregnancy/Postpartum section** ***(e.g., not of child-bearing age, etc.)*** *(skip questions below & continue to Section 8: Behavioral Health)*

If this section is applicable to the member, the following questions **must be** completed.

1. ***Are you currently pregnant?**

☐ Yes ☐ No ☐ Declined to Answer

Question required to be completed

Section 7: Pregnancy/Postpartum

Comments:

---

2. ***Have you given birth in the last 12 months?** *Includes live or still birth delivery; miscarriage (SAB -spontaneous abortion); or an abortion induced for medical reasons (TAB - therapeutic abortion)*

☐ Yes ☐ No ☐ Declined to Answer

Comments:

---

3. ***Are you planning to become pregnant?**

☐ Yes ☐ No ☐ Not Sure ☐ Declined to Answer

Comments:

If **yes** to currently pregnant question, the following questions **must be** completed. Skip the following if **No** or **Declined to Answer** to currently pregnant question.

4. ***How many months pregnant are you?**

Months: ☐ Not Sure ☐ Declined to Answer

5. ***Due Date?**

Date: ☐ Not Sure ☐ Declined to Answer

6. ***Have you been told you are carrying more than one baby?**

☐ No ☐ Yes ☐ Not Sure ☐ Declined to Answer

Comments:

---

7. ***Do you have the following plans for pregnancy and labor and delivery?**

Birth Plan:

☐ Have ☐ Don't have, but want ☐ Don't have and don't want

Delivery Wishes:

☐ Vaginal

☐ Natural (unmedicated/no epidural)

Question required to be completed

Section 7: Pregnancy/Postpartum

- ☐ C-Section
- ☐ Vaginal Birth after C-Section (VBAC)

Delivery Location:

Birthing Classes:

☐ Have ☐ Don't have, but want ☐ Don't have and don't want

Labor support person(s) (including doulas):

☐ Have ☐ Don't have, but want ☐ Don't have and don't want

Comments:

Going into labor: when to call someone and/or go to your birthing location:

- ☐ I Know what to do
- ☐ I need help with this

Goals/plan for transportation to hospital:

- ☐ Have
- ☐ Don't have, but want
- ☐ Don't have and don't want

Childcare goal/plans for other kids:

- ☐ Have
- ☐ Don't have, but want
- ☐ Don't have and don't want
- ☐ N/A

Breastfeeding plans:

- ☐ Have
- ☐ Don't have, but want
- ☐ Don't have and don't want

Comments:

***Question required to be completed**

Section 7: Pregnancy/Postpartum

If **yes** to *Have you given birth in the last 12 months?* question, the following questions **must be** completed. Skip the following if **No** or **Declined to Answer** to *Have you given birth in the last 12 months?* question.

Questions below include live or still birth delivery; miscarriage (SAB - spontaneous abortion); or an abortion induced for medical reasons (TAB - therapeutic abortion)

8. *Did you have any issues with delivery?

☐ Yes ☐ No ☐ Declined to Answer

Comments:

_____

9. *Does your baby (babies) have any special health care needs?

☐ Yes ☐ No ☐ Unsure ☐ N/A (e.g. stillbirth, SAB, TAB

Comments:

_____

10. *Do you need any mental health support as a result of your birthing experience?

☐ Yes ☐ No ☐ Declined to Answer

Comments:

_____

Note: Consider needed connections for baby, such as CCS, or ECM services.

11. *What do you enjoy most about, your new baby?

_____

☐ N/A

☐ Declined to Answer

12. *What is most challenging?

_____

Question required to be completed

Section 7: Pregnancy/Postpartum

☐ N/A
☐ Declined to Answer

13. *Are your family members adjusting to the baby?

☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

Comments:

_____

14. *Are you breastfeeding?

☐ Yes ☐ No ☐ N/A ☐ Decline to Answer

15. If **no**, would you like to, or do you plan to?

☐ Yes ☐ No ☐ Unsure ☐ Decline to Answer

If **yes** to either:

Do you feel like you need help with breastfeeding?

☐ Yes ☐ No ☐ Decline to Answer

Do you need a breast pump?

☐ Yes ☐ No ☐ Decline to Answer

16. *Do you have any concerns about your baby's feeding (breastfeeding, bottle feeding)?

☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

If **yes**, provide details:

_____

If yes to either Are you currently pregnant? or Have you given birth in the last 12 months? questions, complete questions below.

☐ N/A. Select this if not applicable (*e.g., pregnancy resulted in still birth, SAB, or TAB, or only ask applicable questions).* Skip section and continue to ***Section 8: Behavioral Health.***

☐ Yes. Select this if **yes** was selected for either Are you currently pregnant? or have you given birth in the last 12 months? questions. Continue with the rest of the questions.

17. *When was your most recent prenatal or postpartum appointment?

_____

Question required to be completed

Section 7: Pregnancy/Postpartum

☐ Not Sure
☐ Declined to Answer
☐ Have not gone to an appointment

Comments:

---

18. *Has the doctor told you that there are health issues that need follow-up?

☐ Yes ☐ No ☐ Not Sure

If **yes**, do you need support in following up with those issues?

☐ Yes ☐ No ☐ Not Sure

Comments:

---

20. *Do you feel supported in your pregnancy/during your postpartum period?

Based on response, consult with a clinical consultant and supervisor if needed for any follow up support.

☐ Yes ☐ No ☐ Unsure ☐ Declined to Answer

Comments:

---

21. *Are there people that smoke around you and/or your baby?

☐ Yes ☐ No ☐ Declined to Answer

If **yes**, have you discussed this with your provider?

☐ Yes ☐ No ☐ Not Sure ☐ Declined to Answer

Comments:

---

22. *Do you need any of the following during your pregnancy or postpartum care? Select all that apply.

☐ Education/resources on pregnancy/post-pregnancy (body changes, baby growth, postpartum discomforts, self-care after pregnancy, etc.)

Question required to be completed

Section 7: Pregnancy/Postpartum

- ☐ Education/resources on family planning/birth control
- ☐ Education/resources on infant health (nutrition, developmental milestones, safe sleeping)
- ☐ Education/resources on immunizations for self and baby
- ☐ Education/resources on parenting skills/parenting classes
- ☐ Essential baby supplies (crib, diapers, formula, bottles, breast pump, clothing, blankets, and other supplies)
- ☐ Car seat
- ☐ Finding childcare or assistance paying for childcare
- ☐ Other: _____
- ☐ Declined to Answer

23. *Do you have a doctor for your baby?

☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

If **yes**, provider name/phone:

_____

24. *When (day and or month) did you most recently take your baby to the doctor? _____

- ☐ Not Sure
- ☐ N/A
- ☐ Declined to Answer

25. Has the doctor told you that there are health issues with your baby that need follow up?

☐ Yes ☐ No ☐ Not Sure

If **yes**, do you need support in following up with any of those issues?

☐ Yes ☐ No ☐ Not Sure

26. *Do you have a dentist for your baby?

☐ Yes ☐ No ☐ N/A *(no teeth present and less than 1 year of age)* ☐ Declined to Answer

If **yes**, provider name/phone:

Question required to be completed

Section 7: Pregnancy/Postpartum

Date of Last Visit (if known, or an approximate date):

27. Edinburgh Postnatal Depression Scale (EPDS) Screener

☐ Member declined to complete (and reason, if provided below). Skip to ***Section 8: Behavioral Health***.

☐ Complete the EPDS screener with the member here:
https://www.mcpapformoms.org/Docs/EdinbPostDepScale%20english%20no%20numbers.pdf

Scoring:

☐ Score of 9 and above: consult with clinical consultant and supervisor.

☐ Score of 13 and above: consult with clinical consultant and supervisor *and* initiate referral for behavioral health

☐ Positive score (1, 2, or 3) on question 10: immediate discussion required: consult with clinical consultant and supervisor *and* initiate referral for behavioral health.

Section 8: Behavioral Health

Mental Health History

1. ***Has a healthcare or mental health provider ever told you that you have a mental health diagnosis (including postpartum depression or postpartum anxiety)?**

☐ Yes ☐ No ☐ Unsure ☐ Declined to Answer

Comments:

If **yes**, what diagnosis have you been given? Select all that apply.

Question required to be completed

Section 8: Behavioral Health

- ☐ Depression
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Anxiety
- ☐ PTSD
- ☐ Other(s):

_____

☐ Declined to Answer

Comments:

_____

If **yes**, have you had a psychiatric hospitalization?

☐ Yes ☐ No ☐ Unsure ☐ Declined to Answer

If **yes**, list date(s), reason(s), outcome(s), location(s):

_____

If **yes**, have you received outpatient treatment?

☐ Yes ☐ No ☐ Unsure ☐ Declined to Answer

If **yes**, list date(s), reason(s), outcome(s), location(s):

_____

If **yes**, have you received any other types of treatment?

☐ Yes ☐ No ☐ Unsure ☐ Declined to Answer

If **yes**, list date(s), reason(s), outcome(s), location(s):

_____

Question required to be completed

Section 8: Behavioral Health

2. ***Can you provide the contact information of your current or past mental health provider? Check one.**

☐ Yes ☐ No ☐ Unsure ☐ Declined to Answer

Provider:	**Contact Number:**
_____	_____

3. ***Over the past month (30 days), how many days have you felt lonely?**
   - ☐ Non-I Never feel lonely
   - ☐ Less than 5 days
   - ☐ More than half the days (more than 15)
   - ☐ Most days- I always feel lonely
   - ☐ Declined to Answer

Depression

The following are questions from the Patient Health Questionnaire [PHQ] - #1, #2, and #9.

☐ Not completed because the EPDS was completed above. Skip to ***Anxiety Section***.

☐ Yes. Select this if completing the **PHQ** with the member.

If yes was selected continue:

4. ***Over the last two weeks, how often have you been bothered by any of the following?** *If "several days" or more to any of these, consult with a clinical consultant and supervisor.*

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

   b. **Feeling down, depressed, or hopeless?**
      - ☐ Not at all
      - ☐ Several days
      - ☐ More than half the days

Question required to be completed

Section 8: Behavioral Health

☐ Nearly every day

c. Thoughts that you would be better off dead or of hurting yourself

☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

Anxiety

The following are questions from the Generalized Anxiety Disorder 2-item [GAD-2]

5. *Over the last two weeks, how often have you been bothered by the following problems? *If "several days" or more to any of these, consult with a clinical consultant and supervisor*

a. Feeling nervous, anxious, or on edge?

☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

b. Not being able to stop or control worrying?

☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

Trauma and Stressors

6. *Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic, that leave an impact on our day-to-day life. Are you interested in getting support with this (e.g., referral MH professional, support groups, coping skills, etc.)? *If the patient checks yes to either box, consult with the clinical consultant and supervisor*

☐ Yes ☐ No ☐ Declined to Answer

Comments:

_____

Question required to be completed

Section 8: Behavioral Health

Cognitive Functioning

7. ***Have you had any changes in thinking, remembering, or making decisions?**

☐ Yes ☐ No

Comments:

---

8. ***In the past month, have you felt worried, scared or confused that something may be wrong with your mind or memory?**

☐ Yes ☐ No

Comments:

Scoring: If the patient checks yes to either box, consult with the clinical consultant and supervisor

Section 9: Substance Use

☐ Member declined to complete. Skip section and continue to ***Section 10: Developmental Factors.***

Comments:

☐ Yes. This member wants to proceed with ***Section 9: Substance Use.***

I have some questions about your experience with alcohol, nicotine products, marijuana and other substances. Some of the substances we will talk about are prescribed by a doctor, but I will only be focusing on whether you have taken them for reasons other than prescribed or in doses other than prescribed.

1. ***In the past 6 months, how often have you used the following: Never, 1-2 times, Monthly, Weekly, or Daily.**

Alcohol

☐ Never ☐ 1-2 Times ☐ Monthly ☐ Weekly ☐ Daily

***Question required to be completed**

Nicotine Products (cigarettes, vaping, chewing tobacco)

☐ Never ☐ 1-2 Times ☐ Monthly ☐ Weekly ☐ Daily

Using Prescription drugs not as prescribed (circle any relevant):
Pain medicines, ADHD medicines, Sleeping pills, others

☐ Never ☐ 1-2 Times ☐ Monthly ☐ Weekly ☐ Daily

Marijuana or products with THC

☐ Never ☐ 1-2 Times ☐ Monthly ☐ Weekly ☐ Daily

Other substances: For example,
cocaine, meth, heroin, hallucinogens, inhalants, designer drugs

☐ Never ☐ 1-2 Times ☐ Monthly ☐ Weekly ☐ Daily

2. *Have you ever felt you ought to cut down on your drinking or drug use?

☐ Yes ☐ No ☐ N/A ☐ Unsure ☐ Declined to Answer

3. *Would you like to talk with someone about your substance use, especially if you are thinking of quitting or cutting back?

☐ Yes ☐ No ☐ N/A ☐ Unsure ☐ Declined to Answer

4. *Are you currently or have you received treatment for substance use?

☐ Yes ☐ No ☐ N/A ☐ Unsure ☐ Declined to Answer

If **yes**, can you describe the treatment you received (e.g., residential treatment, outpatient treatment, or Medication Assisted Treatment such as Vivitrol, Suboxone, Naltrexone, Methadone, Subutex, etc.):
Comments:

_____

Can you provide contact information of where you are receiving treatment?

Provider:	**Contact Number:**
_____	_____

Member is:

☐ Currently receiving treatment
☐ Previously receiving treatment

5. *Please share any additional information about your past substance use (e.g., longer than the past 6 months, family history):

***Question required to be completed**

Comments:

Note: If any safety concerns for member or their family, consult with clinical consultant and supervisor

6. *** Additional Comments:**

Section 10: Developmental Factors

1. ***Has a healthcare provider ever told you or your family that when you were a child or adult that you had a developmental delay, disability or brain injury that impacted your ability to think clearly (for example, traumatic brain injury, autism spectrum disorder, ADHD, learning disability)?**

☐ Yes ☐ No ☐ Unsure ☐ Declined to Answer

Comments:

Section 11: Health Literacy

I would like to ask you about how you think you are managing your health conditions

1. ***Do you need help filling out health forms?**

☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

2. ***Do you need help answering questions during a doctor's visit?**

☐ Yes ☐ No ☐ N/A ☐ Declined to Answer

***Question required to be completed**

Section 12: Social Determinants of Health (SDOH)

Housing

1. ***What is your current housing condition?**
   - ☐ Stable and safe
   - ☐ Motel
   - ☐ Garage or portion of a living space
   - ☐ Staying with friends
   - ☐ Car
   - ☐ Transitional housing
   - ☐ Temporary shelter
   - ☐ Frequent migration
   - ☐ Other:

   _____

   - ☐ Declined to Answer

Comments:

_____

2. ***Are you worried about losing your housing?**

☐ Yes ☐ No ☐ Declined to answer

If **yes**, please explain:

_____

3. ***What concerns you the most about your housing situation?**

_____

4. ***Is anyone currently helping you with your housing support (for example, Housing Navigator, case management, or tenants' rights)?**

☐ Yes ☐ No ☐ N/A

Housing Environment

5. ***Can you live safely and easily around your home?**

☐ Yes ☐ No ☐ Declined to Answer

Question required to be completed

If **no**, does the place where you live have:

Good Lighting	☐ Yes	☐ No
Good Heating	☐ Yes	☐ No
Good Cooling	☐ Yes	☐ No
Rails for any stairs/ramps	☐ Yes	☐ No
Hot water	☐ Yes	☐ No
Indoor toilet	☐ Yes	☐ No
A door to the outside that locks	☐ Yes	☐ No
Stairs to get into your home or stairs inside your home	☐ Yes	☐ No
Elevator	☐ Yes	☐ No
Space to use a wheelchair	☐ Yes	☐ No
Clear ways to exit your home	☐ Yes	☐ No

Comments:

Safety

6. ***Do you feel physically and emotionally safe where you currently live?**
Note: if no, consult with clinical consultant and supervisor.

☐ Yes ☐ No

If **no**, please describe:

7. ***Is anyone staying in your home without your permission?** *Note: If yes, consult with clinical consultant and supervisor.*

☐ Yes ☐ No

***Question required to be completed**

If **yes**, please describe:

---

8. ***Are you afraid of anyone or is anyone hurting you?** *Note: If yes, consult with clinical consultant and supervisor.*

☐ Yes ☐ No

If **yes**, please explain:

---

9. ***Is anyone using your money without yours, OK?** *Note: If yes, consult with clinical consultant and supervisor.*

☐ Yes ☐ No

If **yes**, please explain:

Food Security

10. ***In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there was not enough money for food?**

☐ Yes ☐ No ☐ Declined to Answer

11. ***How often are you hungry or do you not eat because there is not enough food in the house?**

☐ Often ☐ Not Often ☐ N/A ☐ Declined to Answer

12. ***Do you eat less than you feel you should because there is not enough food?**

☐ Yes ☐ No ☐ Declined to Answer

13. **Comments:**

Social Connection/Support

14. ***Who do you live with?**

☐Live alone

Question required to be completed

☐Live with spouse or significant other. If checked, please list more information of relationship(s) and age(s):

_____

☐Live with children or other relatives or friends. If checked, please list more information of relationship(s) and age(s):

_____

☐Live with caregiver. If checked, please list more information of relationship(s) and age(s):

_____

☐Live with other residents in my facility/program.
☐Declined to Answer

15. *Do you have any children not already listed above (including ages)?

_____

16. *How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

☐ Less than once a week
☐ 1 or 2 times a week
☐ 3 to 5 times a week
☐ 5 or more times a week
☐ Decline to Answer

17. *Are you caring for anyone and/or any pets?

☐ Yes ☐ No

*If **yes**, describe:

_____

Question required to be completed

Family Member/Individual Supports (Including Caregiver Resources and Involvement)

18. *Do you have family members, friends or others willing to help you when you need it?

☐ Yes ☐ No ☐ Declined to Answer

Comments:

_____

19. * Do you have a caregiver assisting you?

☐ Yes

☐ No

☐ Declined to Answer

Name/contact info (phone/email):

_____

20. *Do you ever think your caregiver has a hard time giving you all the help you need?

☐ Yes ☐ No ☐ N/A

If **yes**, please explain:

_____

21. *Do you have an In-Home Supportive Services (IHSS) worker?

☐ Yes ☐ No ☐ Declined to Answer

If **yes**, how many IHSS hours are you receiving?

_____

Name of IHSS worker:	**Contact Number:**
_____	_____

22. *Comments:

Question required to be completed

Section 13: Benefits and Other Services

1. *Funding/benefit source/services:
   - ☐ WIC (list site):

     _____
   - ☐ CalFresh benefits (SNAP)
   - ☐ TANF recipient
   - ☐ SSI recipient
   - ☐ SSDI recipient
   - ☐ SSA (retirement) recipient
   - ☐ Other retirement income
   - ☐ Employed
   - ☐ VA Benefits
   - ☐ General Relief
   - ☐ CalWorks
   - ☐ Home Visiting Program (list):

     _____
   - ☐ Others:

     _____
   - ☐ None

2. ***Do you sometimes run out of money to pay for food, rent, bills and medicine?**

☐ Yes ☐ No ☐ Declined to Answer

3. ***What is your current work situation?**
   - ☐ Declined to Answer
   - ☐ Part-time

Question required to be completed

☐ Full-time
☐ Student
☐ Retired
☐ Other

_____

☐ Unpredictable (i.e. day labor)

4. ***Are there any concerns or challenges with your job?**

☐ Yes ☐ No ☐ Declined to Answer

If **yes**, please describe:

_____

5. ***Are you receiving any services from any of the programs below?**

☐ Long-term care and support (SNF, Rehab Center)
☐ Family PACT
☐ Community-Based Adult Services
☐ Veterans Administration
☐ Palliative care programs
☐ Regional Center
☐ California Children's Services
☐ Others:

_____

☐ None

Section 14: Legal Involvement

1. ***In the past 12 months, have you been involved with the following:**

☐ Court ordered services
☐ On probation
☐ On parole
☐ Re-entry program
☐ DUI/restricted license

Question required to be completed

☐ Adult Protective Services (APS)
☐ Child Protective Services (CPS)
☐ Community Legal Services
☐ None
☐ Declined to Answer
☐ Other (list):

Comments:

2. **Contact information as applicable (name, number, organization):**

3. ***In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?**

☐ Yes ☐ No ☐ Declined to Answer

If **yes**, I would like to coordinate with anyone you are working with related to your stay in :

so, we can work together to support you and your goals. May I contact that person with you?"

4. ***Have you ever associated with members of a gang or been involved in one?**

☐ Yes ☐ No ☐ Declined to Answer

Question required to be completed

If **yes**, what is your status?

Section 15: Advance Care Planning

Life planning is an important aspect to one's holistic health and planning needs.

1. ***Do you have a life-planning document or advance directive in place?**

☐ Yes ☐ No ☐ Declined to Answer

2. ***Do you have an authorized representative to speak on your behalf about issues?**

☐ Yes ☐ No ☐ Declined to Answer

Name and Relationship:

3. ***Do you want information on these topics?**

☐ Yes ☐ No ☐ Declined to Answer

Section 16: Member Priorities

1. ***What concerns you most about your physical or mental health?**

2. ***What is one thing you would like to do right now to improve your health (such as cutting back on caffeinated or sugary drinks? –** *provide easy, harm reduction examples***)**

3. ***What would you like to achieve from our work and time together?**

***Question required to be completed**

4. ***From our meeting today what comes to mind as your top 2-3 goals for your health, wellness and social and/or living situation for the next 3-6 months?**

Goal #1

Goal #2

Goal #3

Narrative Summary

Include Primary Needs identified from Assessment:

Next Steps	Person Responsible
1.	
2.	
3.	

Next Appointment/ Location:

End of ECM Adult Comprehensive Assessment

***Question required to be completed**