Health Home Comprehensive Assessment Tool

Client Name: 
DOB: 
Age: 

Client Address: 
Phone Number: 

Relationship Status: 
Gender: 
Sexual Orientation: 

Ethnicity: 
Race: 

Languages Spoken: 
Reading: 
Writing: 

Support Needed? 

Medicaid / Seq #: 
MCO: 
Verified? 

SS#: 
Can be reached by: 
Mail:  
Phone:  
Home Visit:  

Medical

1. Diagnoses
List all current conditions and the most recent test date and result, if applicable, associated with each condition. For example: Hypertension (BP/date measured); Diabetes (HbA1c/result date); Asthma; Hyperlipidemia (LDL-C/result date); Congestive Heart Failure; COPD; HIV/AIDS (CD4 count/result date); cancer; renal disease; liver disease; obesity; stroke history; vision/hearing impairment; neuropathy; incontinence, etc.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Latest Test Result/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Medications (Prescriptions and Adherence)
List all current medications, including over-the-counter medicines and vitamins. In the event of a home visit, please ask the member to gather all of the medications in order to obtain the most accurate medication history possible.

<table>
<thead>
<tr>
<th>Medication/Dosage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For Questions 2a – 2c, check the number next to the appropriate answer. Then add up the checked numbers to calculate a score.
2a. How often does the member (in his/her own perception) have difficulty taking medications on time? On time means no more than 2 hours before or 2 hours after the time that the doctor instructed.

☐ 4 Never [has difficulty taking medications on time]
☐ 3 Rarely [has difficulty taking medications on time]
☐ 2 Most of the time [has difficulty taking medications on time]
☐ 1 Always [has difficulty taking medications on time]

2b. On average, how many days PER WEEK does the member (in his/her own perception) miss at least one dose of medication?

☐ 1 Every day
☐ 2 4 – 6 days/week
☐ 3 2 – 3 days/week
☐ 4 Once a week
☐ 5 Less than once a week
☐ 6 Never

2c. When was the last time the member missed at least one dose of medication?

☐ 1 Within the past week
☐ 2 1 – 2 weeks ago
☐ 3 3 – 4 weeks ago
☐ 4 Between 1 and 3 months ago
☐ 5 More than 3 months ago
☐ 6 Never

SCORE: _______

>10 = Good adherence       ≤10 = Poor adherence

3. Medications (Health Literacy)

3a. Does the member understand the consequences of missing doses? ☐ Yes ☐ No

3b. Does the patient feel that they know enough about the medications they are taking? ☐ Yes ☐ No

4. Hospitalizations/Emergency Department (ED) Visits

Describe the member’s last visit to the ED/last hospitalization. Why did the member go to the ED? Why was the member admitted to the hospital?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
5. **Allergies**
List all medication and other (e.g. food, latex) allergies. Include the type of reaction (rash, difficulty breathing, etc.).

6. **Pain Assessment**
6a. Does the member have pain? □ Yes □ No [If no, SKIP to Question 7: General Health]

6b. Where is the pain?

6c. When did the pain start? How often does it occur? Has it gotten worse?

6d. What does the pain feel like (e.g. stabbing, throb, burning, aching, etc.)?

6e. How much pain does the member report currently, on a scale of 0 – 10 (with 0 being no pain, and 10 being the worst pain imaginable)?

6f. How bad is the pain, on a scale of 0 – 10, at its worst?

6g. How bad is the pain, on a scale of 0 – 10, at its best?

6h. What makes the pain better?

6i. What makes the pain worse?

6j. What has the member tried to relieve the pain? Was it effective?

6k. How does the pain affect physical and social functioning?

7. **General Health**
7a. Are there important things the member wants to share about his/her health? How do these things affect the member socially?
7b. When did the member last see his/her...
Primary Care Provider (PCP):
Psychiatrist:
Pain Management Physician:

Mental Health

8. Diagnoses and Medications
8a. Is the member being treated for – or has the member been diagnosed with – any of the following conditions (check all that apply):
☐ Bipolar Disorder
☐ Schizophrenia
☐ Severe Depression
☐ Schizoaffective Disorder
☐ None of the above [If none, SKIP to Question 9: Hospitalizations]

For the condition(s) checked off above, please indicate:
8b. The type of treatment received (e.g., outpatient clinic; PROS; private provider, partial hospitalization, inpatient setting).

8c. Names, phone numbers, and addresses of providers (include title: therapist; psychiatrist, etc.).

8d. How often does the member see the providers listed above?

8e. What medications are prescribed for the conditions listed above?
   Medication/Dosage:
   Medication/Dosage:
   Medication/Dosage:
   Medication/Dosage:
   Medication/Dosage:

8f. What, if anything, makes it difficult for the member to take their medications as prescribed? (Check all that apply)
☐ Confusion about when/how to take medications.
☐ Medication instructions are not written in the member’s native language.
☐ Difficulty paying for medications.
☐ The medication has unpleasant side effects.
☐ Lack of understanding about why to take the medications.
☐ Difficulty remembering to take medications.
☐ Other barrier(s) – Please describe.
8g. How does the member feel when taking his/her medication?

........................................................................................................................................................................
........................................................................................................................................................................

8h. How does the member feel when not taking his/her medication?

........................................................................................................................................................................
........................................................................................................................................................................
........................................................................................................................................................................
........................................................................................................................................................................

8i. Does the member have any allergies to psychiatric medications? What are the reactions?

........................................................................................................................................................................
........................................................................................................................................................................
........................................................................................................................................................................
........................................................................................................................................................................

9. Hospitalizations
9a. How many times has the member been to the ED for psychiatric reasons in the past year?
........................................................................................................................................................................

9b. Date of most recent visit/reason:
........................................................................................................................................................................
........................................................................................................................................................................

9c. How many times has the member been admitted to an inpatient psychiatric unit in a hospital in the past year?
........................................................................................................................................................................

9d. Date of most recent admission/reason:
........................................................................................................................................................................
........................................................................................................................................................................

9e. Age of onset of symptoms and first psychiatric hospitalization:
........................................................................................................................................................................
........................................................................................................................................................................
........................................................................................................................................................................

9f. Other details of psychiatric history:
........................................................................................................................................................................
........................................................................................................................................................................
........................................................................................................................................................................
........................................................................................................................................................................

10. Safety Risk (Appendix A)
11. Depression Screening (Appendix B)
12. Trauma Screening

12a. Has the member ever experienced trauma, abuse, or domestic violence? □ Yes □ No [If no, SKIP to Question 13: Substance Use]
........................................................................................................................................................................
........................................................................................................................................................................
........................................................................................................................................................................

12b. Has the member received help for coping with this experience? □ Yes □ No
........................................................................................................................................................................

12c. Does the member wish to be referred for help at this time? □ Yes □ No
........................................................................................................................................................................
13. Substance Use
13a. Diagnosis
Is the member (currently or previously) in treatment for drug or alcohol use (specify)? □ Yes □ No [If no, SKIP to Question 14: History of use and hospitalizations]

13b. What type of treatment does the member receive (Crisis; Detox; Inpatient Treatment; Outpatient Treatment or Outpatient Rehab; SU Residential Treatment; Methadone Maintenance Program, etc.)?

13c. List names, titles, phone numbers, and addresses of providers:

13d. How often does the member see the provider(s) listed above?

14. History of Use and Hospitalizations
14a. How many times has the member been to the ED or admitted for detox treatment in the past year?

14b. Date of most recent visit/admission and reason/treatment modality:

14c. How many times has the member been admitted to a rehab facility in the past year?

14d. Date of most recent rehab admission and reason/treatment modality:

14e. Age of first use of alcohol or other substance:

14f. If sober, duration of sobriety:

14g. What treatment modalities have been effective?

14h. What are the member’s alcohol/substance use triggers (e.g. people, places, circumstances, etc.)?

14i. How does the member protect him/herself (e.g. clean needles, safe environment when using, etc.)?
14j. In the member’s perception, what is good about his/her substance use?

14k. In the member’s perception, what is not good about his/her substance use?

14l. Other details of alcohol/substance use history and patterns/trends:

15. Tobacco Screening
15a. Does the member currently use tobacco products (specify)? □ Yes □ No [If no, SKIP to 15c]

15b. How often does the member use tobacco products/how many cigarettes smoked per day?

15c. Does the member currently use e-cigarettes? □ Yes □ No
15d. Has the member ever completed a smoking cessation program? □ Yes □ No
15e. Is the member interested in being referred to a smoking cessation program or receiving support services to reduce smoking? □ Yes □ No
   Referral made? □ Yes □ No

16. Substance Abuse Screening (Appendix C – administer if history of substance abuse is present)

Financial

17. What is the member’s monthly income?

18. What is the source(s) of the member’s income?

19. How many people reside in the member’s household?

20. How many of the people residing in the member’s household are financial dependents of the member?

21. What is the monthly cost of the member’s rent?

22. What is the member’s status regarding the following entitlements?

<table>
<thead>
<tr>
<th></th>
<th>Receives/Amount</th>
<th>Needs/Needs Recertification (list recertification date if applicable)</th>
<th>Stable/No Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNAP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA/HASA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
23. What are the member’s needs regarding the following financial elements?

<table>
<thead>
<tr>
<th>Assistance Needed (Describe)</th>
<th>Stable/No Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilities</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
</tr>
<tr>
<td>Financial Management</td>
<td></td>
</tr>
<tr>
<td>Debt Management</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

24. Where is the member currently living (check one)?

- House/Apartment
  - _____ Private _____ Public _____ NYCHA
  - Is the lease or mortgage in the member’s name? [Yes] [No]
  - Is the placement in the house/apartment stable? [Yes] [No]

- Friend’s/Relative’s Home _____
  - How long may the member remain? _____

- Parent/Immediate Family Guardian
  - How long may the member remain? _____

- Respite Care
  - How long may the member remain? _____

- Half-Way House
  - How long may the member remain? _____

- Homeless/in the street

- Homeless/Doubled Up living with others
  - How long may the member remain? _____

- Homeless/registered in shelter
  - Name of Shelter_____

- Supportive/Supported Housing _______
  - Agency Affiliation _______

25. Does the member give consent to the care manager to speak with his/her caseworker, landlord, and/or building management? [Yes] [No]

26. Does the member receive any of the following housing subsidies?

<table>
<thead>
<tr>
<th></th>
<th>Receives (Details, Including Case #)</th>
<th>Pending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEPS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HASA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
27. How long has the member been residing at his/her current location?

28. Does the member have any serious concerns related to their current living situation (describe)? □ Yes □ No

29. Is the member at risk of losing his/her current housing? □ Yes □ No [If no, SKIP to next section: Domestic Violence]

29a. Why is the member at risk of losing his/her current housing?
□ Rent Arrears (Specify Amount)
□ Loss of housing subsidy
□ Landlord issue
□ Other (Specify)

29b. Has the member received a vacate notice from a City Marshall? □ Yes □ No
29c. What steps, if any, has the member taken to address the loss of housing, or the threat of the loss of housing?

29d. Is the member in court for eviction proceedings? □ Yes □ No
29e. Is the member working with an attorney? □ Yes □ No
   Does the member give consent for the care manager to speak with the attorney? □ Yes □ No
29f. Is Adult Protective Services (APS) involved with the case? □ Yes □ No
29g. Does the member have any other housing options (describe)? □ Yes □ No

29h. Is the member willing to accept a referral to a shelter? □ Yes □ No

Domestic Violence

30. List all the people who reside with the member, and their relationship to the member.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31. Does the member feel safe in his/her relationships with the people listed above? □ Yes □ No
   If no, please explain:

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
32. Are there any relationships with people with whom the member does not reside, in which s/he does not feel safe?  □ Yes  □ No
If yes, please explain:

33. Does the member feel s/he is a victim of domestic violence?  □ Yes  □ No
If yes, please explain:

34. Does the member feel that his/her life is in danger?  □ Yes  □ No

35. Does the member understand what domestic violence is?  □ Yes  □ No (care manager should be able to educate the member if appropriate)

36. Ask the member, “Sometimes one person in a relationship makes the other person feel afraid or scared, either by intimidating them, threatening to hurt them or someone they care about, or by their physical actions. Has someone in your life done anything like this to you?”
□ Yes  □ No
If yes, please explain:

“Have you done anything like this to someone in your life?”
□ Yes  □ No
If yes, please explain:

37. Ask the member, “What happens when you and the person/people mentioned above disagree?”

38. Has there been any physical fighting such as hitting, pushing etc. in the relationship (describe, including any injuries)?  □ Yes  □ No

39. Has the member ever had police involvement related to a domestic incident?  □ Yes  □ No

40. Is there (or has there been) an order of protection against the member or the identified abuser?  □ Yes  □ No

[If psychological abuse is suspected, ask questions 41-43]
41. Ask the member, “In some relationships, one person tries to make the other feel bad about themselves or puts them down a lot, for example by calling them names, constantly criticizing them, or telling them they’re stupid. Has someone in your life done anything like this to you?”
   □ Yes □ No
   If yes, please explain:

42. Have the member ever been threatened with punishment or institutionalization? □ Yes □ No
   If yes, please explain:

43. Have the member ever been isolated from everyday living? □ Yes □ No
   If yes, please explain:

[If sexual abuse is suspected, ask questions 44-45]

44. Ask the member if s/he has ever felt coerced or obligated to have sex with the identified abuser.
   □ Yes □ No
   If yes, please explain:

45. Ask the member if s/he has ever been touched in a sexual way without permission.
   □ Yes □ No
   If yes, please explain:

[If financial abuse is suspected, ask questions 46-48]

46. Is the member’s money being controlled, stolen or used inappropriately by someone other than him/herself?
   □ Yes □ No
   If yes, please explain:

47. Has the member been forced to make financial decisions against his/her wishes?
   □ Yes □ No
   If yes, please explain:
48. Has the member been forced to sign any important document(s) against his/her wishes?
   ☐ Yes  ☐ No
   If yes, please explain:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

   **If any abuse is suspected, the care manager should initiate a safety plan (Appendix D).**

*Legal*

Answer the applicable questions below to provide a legal history and summary of ongoing and exigent legal needs.

49. Income supports and insurance (e.g. benefits, entitlements, denials, appeals, etc.)
   Exigent Needs
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   Ongoing Legal Activity
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   Legal History
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

50. Housing and Utilities
   Exigent Needs
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   Ongoing Legal Activity
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   Legal History
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

51. Legal status (e.g. immigration)
   Exigent Needs
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   Ongoing Legal Activity
52. **Personal and family stability (e.g. custody, guardianship, ACS, restraining orders/orders of protection, criminal justice, advance care planning/advance directives, etc.)**

Exigent Needs

Ongoing Legal Activity

Legal History

53. **Criminal Background**

53a. Is the member a registered sex offender? □ Yes □ No [If no, SKIP to Question 53b]

If yes, please explain:

State:

City:

County:

53b. Has the member ever been incarcerated? □ Yes □ No

If yes, please explain:

53c. Parole (if applicable)

Name of Officer:

Number:

Length of Time:
Consent for care manager to speak with Parole Officer? □ Yes □ No

53d. Probation (if applicable)
Name of Officer:

Number:

Length of Time:

Consent for care manager to speak with Probation Officer? □ Yes □ No

53e. Upcoming Court Dates (if applicable)
Date/Details:
Date/Details:
Date/Details:
Date/Details:

53f. Does the member have an attorney? □ Yes □ No
If yes:
Attorney Name and Contact Number

Consent for care manager to speak with Attorney? □ Yes □ No

53g. Does the client need a referral for legal services? □ Yes □ No

53h. Are there court ordered services (e.g. AOT)? □ Yes □ No
If yes, please explain:

53i. Does the member need assistance with transportation to appointments with attorney/caseworker/parole officer/probation officer or to court appearances? □ Yes □ No

General

Notes:

Signature: Date:
Appendix A: Safety Risk Assessment

Ask the member the following questions.

a. Have you ever had thoughts of hurting yourself or others?
   □ Yes □ No

b. Have you ever acted on thoughts to hurt yourself or others?
   □ Yes □ No

c. What are ways you or others around you can tell that you are not feeling well and may need help (triggers, symptoms/behaviors of client)


d. Do you have thoughts of harming yourself or ending your life?
   □ Yes □ No

e. Do you have a plan on how you would end your life?
   □ Yes □ No

f. Do you feel that you may now or in the near future act on that plan?
   □ Yes □ No

g. Have you ever attempted suicide before?
   □ Yes □ No

h. Has anyone in your family ever committed suicide?
   □ Yes □ No

i. Would you tell me if you felt like harming yourself or ending your life?
   □ Yes □ No
j. Do you hear voices telling you to harm or kill yourself?
   □ Yes □ No

k. Do you feel that you might act on those voices?
   □ Yes □ No
Appendix B: Depression Screening

Complete the Patient Health Questionnaire (PHQ-2) below. If an answer in the PHQ-2 is positive, complete the PHQ-9.

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems:</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
### Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)

**Directions:** The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. There are no right or wrong answers. Please check the box for the answer that best fits for you. Try to be as honest as you can be. Filling out this form will give us information to provide you with the services, care or treatment that best meet your specific needs.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the last six months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, cocaine, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1b Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Have you felt that you use too much alcohol or other drugs? (Other drugs also include prescription or over-the-counter medication more than recommended.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Have you tried to cut down or quit drinking or using alcohol or other Drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Have you had any health problems? Please check the following list, if you have:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had blackouts or other periods of memory loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injured your head after drinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had convulsions, delirium tremens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had hepatitis or other liver problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt sick, shaky, or depressed when you stopped</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt “coke bugs” or a crawling feeling under the skin after you stopped using drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Been injured after drinking or using</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used needles to shoot drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For question #5, the total possible score is 1. If no items are checked score is 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Score for #5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Has drinking or other drug use caused problems between you and your family or friends?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Has your drinking or other drug use caused problems at school or at work?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>---</td>
<td>----------</td>
<td>-----</td>
</tr>
<tr>
<td>9)</td>
<td>Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?</td>
<td>☐ Yes (1)</td>
</tr>
<tr>
<td>10)</td>
<td>Are you needing to drink or use drugs more and more to get the effect you want?</td>
<td>☐ Yes (1)</td>
</tr>
<tr>
<td>11)</td>
<td>Do you spend a lot of time thinking about or trying to get alcohol or other drugs?</td>
<td>☐ Yes (1)</td>
</tr>
<tr>
<td>12)</td>
<td>When drinking or using drugs, are you more likely to do something you wouldn’t normally do, such as break rules, break laws, sell things that are important to you, or have unprotected sex with someone?</td>
<td>☐ Yes (1)</td>
</tr>
<tr>
<td>13)</td>
<td>Do you feel bad or guilty about your drinking or drug use?</td>
<td>☐ Yes (1)</td>
</tr>
</tbody>
</table>

**The next questions are about your lifetime experiences.**

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>14)</td>
<td>Have you ever had a drinking or other drug problem?</td>
<td>☐ Yes (1)</td>
<td>☐ No (0)</td>
</tr>
<tr>
<td>15)</td>
<td>Have any of your family members ever had a drinking or drug problem?</td>
<td>☐ Yes (1)</td>
<td>☐ No (0)</td>
</tr>
<tr>
<td>16)</td>
<td>Do you feel that you have a drinking or drug problem now?</td>
<td>☐ Yes (1)</td>
<td>☐ No (0)</td>
</tr>
</tbody>
</table>

**Total SCORE for items 1-16**

**If total score is 4 or more, it indicates need for further assessment and member should be referred for further Substance Abuse Assessment. If member is currently in Substance Abuse treatment, no actions necessary.**
Appendix D: Safety Plan

Sometimes a victim has difficulty developing a safety plan. Use the following questions to assist in developing a plan with the victim. Consider safety in the home, at work, and in the community.

1. Would you like to leave the perpetrator?
   □ Yes □ No
   If yes, start immediate intervention call 911 or Safe Horizon Domestic violence Hotline 800-621-Hope (4673). If the member wants to make plans to leave, assist in developing a plan.

2. Do you have an order of protection?
   □ Yes □ No
   If no, ask if the member would like assistance in obtaining one and locate a safe place to keep it in the home. Instruct the member to always keep the order on or near them.

   I will keep my order of protection in my ____________________________.

3. Are there children involved?
   □ Yes □ No
   If yes, care manager must report to supervisor immediately.
   Ask the member if they would like the situation reported to the school guidance counselor.

4. Are the children being abused?
   □ Yes □ No

5. Have they ever been abused?
   □ Yes □ No

6. Ask the member if there is a safe way to leave the apartment/house/room, in the event a decision to leave is made?
   □ Yes □ No
   If no, practice how to get out safely. What doors, window or stairwells can the member use?

   I will leave my home by using the following exit
   ________________________________________________________________

7. Is there a family member/friend/neighbor that the member trusts and with whom s/he can leave copies of important documents?
   □ Yes □ No
   If no, the care manager should make copies and keep in the member’s file at the office.

   Copies of my important document will be kept with __________________________ at their __________________________.
8. Is there a safe place or person with whom the member can leave clothing for him/herself and any child/ren?
   □ Yes □ No
   If no, assist member in finding a safe place in the home or speak to your supervisor about leaving the clothes at your office.

   **If I leave my home I will contact _________________________________.**

9. Do the member’s children know how to dial 911 and give their address?
   □ Yes □ No
   If no, you may want to take the time to practice with the member and her children. Use the space below to write the directions.

10. Is there a safe place in the home where the member and his/her child/ren can hide until help arrives?
    □ Yes □ No
    If no, assist the family in locating a safe area in the home.

    **In case the abuser becomes violent, my child/ren and I will seek shelter in our_______________________ until help arrives.**

11. If the member and/or member’s children are taking medication, obtain copies of prescriptions to keep in member’s chart. This will assist in obtaining medications if the member needs to leave quickly.

    **If the member refuses these options, counseling should be offered for the member and family. Consider the possibility of including the perpetrator if the member is comfortable.**
**Safety Resources**

NYPD
911

National Domestic Violence Hotline
800-799-SAFE(7233)

Safe Horizon Domestic Violence Hotline
800-621-HOPE(4673)

CAMBA Victim Services
718) 282-5575

**Important Numbers**

Family/Friend/Neighbor

_______________________________

School Counselor

_______________________________

Employment

_______________________________

**An emergency bag should be prepared only if it is safe to do so. If it is not safe, the care manager can explore with the member the feasibility of leaving copies of documents with family or friends. The care management agency may also keep copies of important documents.**

**Emergency Bag:**

Items that you may want to put in the bag and keep in a safe place:

- Identification
- Order of Protection
- Social Security Card-for all family members
- Medicaid Card
- Passport/Green Card-for all family members
- Bank Card/Checkbook/Credit Card/Cash
- Children Information (school and vaccination papers)
- Birth Certificates-for all family members
- Baby Items (Food, Diapers, Medication)
- Important Legal Documents
- Medical Records- for all family members
- Medications-for all family members
- Clothing
- House Keys/Car keys