IDAHO RYAN WHITE MEDICAL CASE MANAGEMENT ASSESSMENT

Client Name:_____ **Date**:_____/_____/_____ **URN:**_____

TRANSPORTATION EVALUATION

How do you get to your medical or support service visits?

- ☐ Public transportation
- ☐ Medicaid taxi
- ☐ Taxi (non-Medicaid)
- ☐ Own vehicle
- ☐ Ride from family member or friend
- ☐ Bike
- ☐ Walk
- ☐ Other _____

Do you have difficulty arranging transportation? ☐ No ☐ Yes

If yes, why? _____

Note any transportation barriers or concerns below:

When was your last dental appointment? _____

NUTRITION AND BASIC NEEDS EVALUATION

Tell me how you are meeting your nutritional needs. Do you need assistance with any of the following?

Obtaining enough nutritious food to eat? ☐ No ☐ Yes Preparing food/cooking? ☐ No ☐ Yes

Grocery shopping? ☐ No ☐ Yes Food storage? ☐ No ☐ Yes

Do you receive or use any of the following types of food assistance?

Food Assistance			
Assistance type	**Receive/Use?**	**How often?**	**From where?**
Food stamps	☐ No ☐ Yes		
Food pantry	☐ No ☐ Yes		
Home delivered meals	☐ No ☐ Yes		
Congregate meals	☐ No ☐ Yes		
Food voucher	☐ No ☐ Yes		
Other _____	☐ No ☐ Yes		

Do you have any dietary limitations or food allergies? ☐ No ☐ Yes

Do you have any problems eating due to medications? ☐ No ☐ Yes

Have you ever seen a nutritionist/registered dietician? ☐ No ☐ Yes

How is your appetite?

Do you need any assistance with "activities of daily living," e.g., bathing, dressing and bathroom, or eating? ☐ No ☐ Yes

Do you need assistance with housekeeping, shopping, remembering appointments, or using the telephone? ☐ No ☐ Yes

Do you have adequate clothing? ☐ No ☐ Yes Do you have any other basic needs? ☐ No ☐ Yes

Note any additional nutrition or basic needs concerns below:

Substance Abuse and Mental Illness Symptoms Screener (SAMISS)

For each question, please check only one box.

Substance Abuse	Mental Illness
1. How often do you have a drink containing alcohol? □ Never □ Monthly or less □ 2-4 times/mo. □ 2-3 times/wk. □ 4 or more times/wk.	**8. In the past year, when not high or intoxicated, did you ever feel extremely energetic or irritable and more talkative than usual?** □ Yes □ No
2. How many drinks do you have on a typical day when you are drinking? □ None □ 1- 2 □ 3- 4 □ 5-6 □ 7-9 □ 10 or more	**9. In the past, were you ever on medication or antidepressants for depression or nerve problems?** □ Yes □ No
3. How often do you have 4 or more drinks on 1 occasion? □ Never □ Less than Monthly □ Monthly □ Weekly □ Daily or Almost Daily	**10. In the past year, was there ever a time when you felt sad, blue, or depressed for more than 2 weeks in a row?** □ Yes □ No
4. In the past year, how often did you use nonprescription drugs to get high or to change the way you feel? □ Never □ Less than Monthly □ Monthly □ Weekly □ Daily or Almost Daily	**11. In the past year, was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work or activities that usually give you pleasure?** □ Yes □ No
5. In the past year, how often did you use drugs prescribed to you or to someone else to get high or change the ways you feel? □ Never □ Less than Monthly □ Monthly □ Weekly □ Daily or Almost Daily	**12. In the past year, did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious?** □ Yes □ No
6. In the past year, how often did you drink or use drugs more than you meant to? □ Never □ Less than Monthly □ Monthly □ Weekly □ Daily or Almost Daily	**13. In the past year, did you have a spell or an attack when all of a sudden you felt frightened, anxious or very uneasy when most people would not be afraid or anxious?** □ Yes □ No
7. How often did you feel you wanted or needed to cut down on your drinking or drug use in the past year, and were not able to? □ Never □ Less than Monthly □ Monthly □ Weekly □ Daily or Almost Daily	**14. In the past year, did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath? (If it was only when having a heart attack or due to physical causes, mark "no")** □ Yes □ No
	15. During your lifetime, as a child or adult, have you experienced or witnessed traumatic event(s) that involved harm to yourself or to others? □ Yes □ No **If yes: In the past year, have you been troubled by flashbacks, nightmares, or thoughts of the trauma?** □ Yes □ No
This questionnaire is based on the validated screening instrument developed by the University of North Carolina at Chapel Hill, Departments of Psychiatry, Medicine, Public Policy, and Community and Family Medicine; and the Health inequities Program of Duke University.	**16. In the past 3 months, have you experienced any event(s) or received information that was so upsetting it affected how you cope with everyday life?** □ Yes □ No

Have you ever engaged in Mental Health Services (counseling)?

If yes, with who: _____

HOMELESS PREVENTION SCREENING TOOL[1]

The following questions will help me to understand the stability of your housing situation. These questions can help to determine to what extent you are at risk of homelessness. Please answer each question honestly. You are not required to answer any of the questions.

1. Are you homeless right now? (If answered NO, skip to question #2) ☐ NO ☐ YES

a. How long have you been homeless? Days: _____ Weeks: _____ Months: ____ Years: _____

b. Which shelter are you staying at today?

_____

2. Do you have difficulty meeting your rent or utility needs? ☐ NO ☐ YES

3. Do you have housing problems? ☐ NO ☐ YES If yes, what are they?

_____

☐ Legal eviction notice within the past 30 days

☐ Did not pay last month's rent

☐ Did not pay utility bill(s)

☐ Building in bad condition (Windows, locks, plumbing, insects, rodents, hot/cold water, electricity, etc)

☐ Doubled up with family or friends

☐ Overcrowded living situations

☐ Threats of being kicked out

☐ Other:

4. In the past 30 days (or 30 days prior to hospitalization / incarceration, etc.) where did you live?

☐ Owned apartment, room or house	Number of Days: _____
☐ Rented apartment, room or house	Number of Days: _____
☐ Family of friend's home / apartment	Number of Days: _____
☐ Shelter	Number of Days: _____
☐ Hotel or SRO	Number of Days: _____
☐ Abandoned building, park, train station, car, streets	Number of Days: _____
☐ Institution (hospital, halfway house, nursing home)	Number of Days: _____
☐ Foster home or group home	Number of Days: _____
☐ Jail, prison or detention center	Number of Days: _____
☐ Other:	Number of Days: _____

5. Have you ever been homeless as an adult? ☐ NO ☐ YES

a. How many times have you been homeless in your life?

_____

b. In what year(s) were you homeless?

_____

c. What was the longest period of time you were homeless?

(including shelter days) Days: _____ Weeks: _____ Months: ____ Years:____

6. Have you ever been picked up or arrested by the police? ☐ NO ☐ YES

7. Have you ever spent time in jail, prison, or a juvenile detention center? ☐ NO ☐ YES

8. Are you currently suffering from a chronic illness or physical disability? If yes, what kind of illness or disability? _____ ☐ NO ☐ YES

[1] Developed by the Office of Mental Health – Homeless Action Committee

DOMESTIC VIOLENCE (The HITS Scale[2] (Hurts, Insults, Threatens & Screams Domestic Violence))

1. **HURT:** How often does your partner physically hurt you?

☐ **1 = Never** ☐ **2 = Rarely** ☐ **3 = Sometimes** ☐ **4 = Fairly Often** ☐ **5 = Frequently**

2. **INSULT:** How often does your partner insult or talk down to you?

☐ **1 = Never** ☐ **2 = Rarely** ☐ **3 = Sometimes** ☐ **4 = Fairly Often** ☐ **5 = Frequently**

3. **THREATEN:** How often does your partner threaten you with physical harm?

☐ **1 = Never** ☐ **2 = Rarely** ☐ **3 = Sometimes** ☐ **4 = Fairly Often** ☐ **5 = Frequently**

4. **SCREAM:** How often does your partner scream or curse at you?

☐ **1 = Never** ☐ **2 = Rarely** ☐ **3 = Sometimes** ☐ **4 = Fairly Often** ☐ **5 = Frequently**

RISK OF DOMESTIC VIOLENCE: Score ranges from 4 to a maximum of 20

Score:_____ ***(A score equal to or greater than 10 is considered diagnostic of abuse)***

MEDICATION KNOWLEDGE SURVEY

First column: Filled in by MCM

Next: Check all boxes patients can answer successfully and fill in the information they provide to you about each of their medications.

Medication	Name of Medication?	Why are you taking medication?	How much to take each time?	When to take the medication?	Effects to look out for		Where do you keep the medication?	When is the next refill? Record date.
					P	N		

P = Positive effects of taking medication, N = Negative effects of taking medication

[2] Kevin M. Sherin, MD, MPH; James M. Sinacore, PhD; Xiao-Qiang Li, MD; Robert E. Zitter, PhD; Amer Shakil, MD (1998). HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting. *Family Medicine* 30(7):508-12.

DUKE – UNC FUNCTIONAL SOCIAL SUPPORT QUESTIONNAIRE (FSSQ)					
	5	**4**	**3**	**2**	**1**
	As much as I would like	Almost as much as I would like	Some, but would like more	Less than I would like	Much less than I would like
1. I have people who care what happens to me.					
2. I get love and affection.					
3. I get chances to talk to someone about problems at work or with my housework.					
4. I get chances to talk to someone I trust about my personal or family problems.					
5. I get chances to talk about money matters.					
6. I get invitations to go out and do things with other people.					
7. I get useful advice about important things in life.					
8. I get help when I am sick in bed.					

FSSQ Scoring Instructions
1. All questions must be completed to score the FSSQ.
2. Add the numeric scores for all 8 questions.
3. Divide the total score by 8 to achieve an average score.
Scoring: As social support increases, the score should increase. If the number is low, please address on the Wellness Plan.

Medical Case Manager Signature

Date