Enhanced Care Management (ECM)
Comprehensive Assessment (FORM C)

CenCal HEALTH
Local. Quality. Healthcare.

Member Information

Medi-Cal # CIN: (9 digits/letter) _____ Authorization #: _____

Last Name / *Apellido*: _____ First Name/ *Nombre:* _____

Birthdate / *Fecha de Nacimiento*: _____

Member's Phone Number / *Número de teléfono*: _____

Preferred written/spoken language / *Idioma preferido- escrito/hablado*: _____

Requires Interpreter / *Necesita Intérprete*: ☐ Yes / Sí ☐ No

Address / *Dirección*: _____

Homeless / *Sin vivienda*: ☐ Yes / Sí ☐ No

Highest Level of Education / *Nivel más alto de educación:*

☐ Less Than High School / *Menos que preparatoria* ☐ High School / *Preparatoria*

☐ More than High School/College / *Más que preparatoria/Universidad*

Primary or Emergency Contact (Name/Phone#) / *Contacto en caso de emergencia (Nombre/ teléfono):*

_____

Relationship / *Parentesco*: _____

Has An Authorized Representative (AR) / *Tiene un representante autorizado*: ☐ Yes / Sí ☐ No

Name (AR) / *Nombre*: _____

Relationship (AR) / *Parentesco*: _____ Phone (AR) / *teléfono*: _____

Name of Primary Care Provider (PCP) / *Nombre del Proveedor de Cuidado Primario*: _____

PCP Phone Number / *Número de teléfono del Proveedor de Cuidado Primario*: _____

ECM Provider Information

Lead Care Manager Name: _____ Phone Number: _____

Email Address: _____

Assessment Completed: ☐ In Person ☐ Over the Phone ☐ Both (In Person and on the Phone)

Assessment Type: ☐ Initial ☐ Reassessment Assessment Date: _____

ECM POPULATIONS OF FOCUS: *Select all that apply*

- ◯ Individuals & Families Experiencing Homelessness (POF 1)
- ◯ Adult at Risk for Avoidable Hospital and Emergency Department (ED) Utilization (POF 2)
- ◯ Adult with Severe Mental Illness/Substance Use Disorder Needs (POF 3)
- ◯ Adults Living in the Community at Risk for Institutionalization (POF 5)
- ◯ Adults who are Nursing Facility Residents Transitioning to the Community (POF 6)

ENGAGEMENT PURPOSE/MEANING AND STRENGTHS

Ask at least 3 or more of these engagement questions

◯ How strongly do you agree with this statement? I lead a purposeful and meaningful life?
¿Que tan de acuerdo está con esta oración? Llevo una vida plena y con propósito?

◯ Agree / *de acuerdo* ◯ Disagree / *No estoy de acuerdo* ◯ Don't know / *no sé*

◯ **Strengths / *Fortalezas*:** What is something that you are good at or proud of? / *¿Dígame algo que hace bien o de lo que está orgulloso/a?*

◯ **Self-Efficacy / *Autoeficacia*:** How confident are you in taking actions needed to maintain or improve your health? / *¿Cuánta confianza siente en tomar las medidas necesarias para mantener o mejorar su salud?*

◯ **Coping Skills / *Habilidades de afrontamiento*:** When you feel sad or worried, what helps you feel better? What do you do for fun or to relax? / *¿Cuando se siente triste o preocupado/a, ¿qué hace para sentirse mejor? ¿Qué hace para divertirse o relajarse?*

ENGAGEMENT PURPOSE/MEANING AND STRENGTHS (cont.)

◯ **Motivation / *Motivación*:** What do you want to improve about your health? What will the benefits be if you improve that area of your health? / *¿Qué quiere mejorar en cuanto a su salud? ¿Cuál sería el beneficio de mejorar esa área de su salud?*

◯ **Problem-Solving Skills / *Habilidades para resolver problemas*:** When you had a difficult situation in the past, what did you do? / *¿Cuando ha tenido una situación difícil en el pasado, ¿qué hizo?*

CULTURE

Do you have any cultural, religious and/or spiritual beliefs that are important to your family's health and wellness? / *¿Tiene alguna creencia cultural, religiosa, o espiritual que es importante para la salud y bienestar de su familia?*

◯ Yes / Sí ◯ No

If yes, please explain/ *Por favor explíqueme*:

HEALTH LITERACY

I would like to ask you about how you think you are managing your health conditions / *Me gustaría preguntarle sobre cómo piensa usted que está controlando sus problemas de salud:*

Do you need help taking your medications / *¿Necesita ayuda para tomar sus medicamentos?*

◯ Yes / Sí ◯ No **(LTSS)**

Do you need help filling out health forms / *¿Necesita ayuda para completar formularios de salud?*

◯ Yes / Sí ◯ No **(LTSS)**

Do you need help answering questions during a doctor's visits / *¿Necesita ayuda para contestar preguntas durante sus citas con el doctor?* ◯ Yes / Sí ◯ No **(LTSS)**

How often do you have difficulty understanding written information your health care provider (like a doctor, nurse, nurse practitioner) gives you? / *¿Qué tan seguido se le dificulta entender la información escrita que le da su proveedor de salud (como su doctor, enfermera, enfermera de práctica avanzada)?*

◯ Always / *Siempre* ◯ Often / *Seguido* ◯ Sometimes / *A veces* ◯ Occasionally / *Ocasionalmente*

◯ Never / *Nunca*

Coordination of Care Needs and Referrals:

EMERGENCY DEPARTMENT VISITS OR HOSPITALIZATIONS

◯ Have you had any Emergency Department (ED) visit or hospitalizations (in the last 30 days)?
¿Ha tenido una visita al departamento de emergencias u hospitalizaciones en los últimos 30 días?
◯ Yes / Sí ◯ No

Reason for ED OR Hospital Admission / *Razón por la visita al departamento de emergencias u hospitalización*:

PREVENTATIVE CARE

Has had a physical with his primary care provider in the last 12 months / *Ha tenido un examen físico con su proveedor de cuidado primario en los últimos 12 meses:* ◯ Yes / Sí ◯ No

Member Indicates Blood Sugar has been checked in the last 12 months / *Miembro indica que le han revisado el nivel de azúcar en la sangre en los últimos 12 meses*: ◯ Yes / Sí ◯ No

Member Indicates they had their Cholesterol levels checked in the last 12 months / *Miembro indica que le han revisado los niveles de colesterol en los últimos 12 meses*: ◯ Yes / Sí ◯ No

COVID Vaccine / *Vacuna contra el Covid*: ◯ Yes / Sí ◯ No

Flu Vaccine / *Vacuna contra la gripe*: ◯ Yes / Sí ◯ No

Shingles Vaccine / *Vacuna contra la culebrilla (herpes zoster)*: ◯ Yes / Sí ◯ No

Pneumonia Vaccine / *Vacuna contra la neumonía*: ◯ Yes / Sí ◯ No

Recommendations based on PCP, Age, Risk Factors

◯ Colorectal Cancer Screening (+50) ◯ Breast Cancer Screening (+40) ◯ Bone Density (+65)

◯ Cervical Cancer Screening (+25) ◯ Prostate Exam (+50) ◯ Tuberculosis Screening

Coordination of Care Needs and Referrals:

PHYSICAL HEALTH

Problems with Vision / *Problemas con la vista*: ◯ Yes / Sí ◯ No

Problems with Hearing / *Problemas con el oído (de audición)*: ◯ Yes / Sí ◯ No

Poorly Fitting Dentures (partial or full) / Dentaduras que le quedan mal: ◯ Yes / Sí ◯ No

Oral Pain/Visible Decay / *Dolor oral/ deterioro visible*: ◯ Yes / Sí ◯ No

Other / *otro*:

Coordination of Care Needs and Referrals:

PHYSICAL HEALTH (cont.)

Have you been told by a doctor or medical provider that you have any of the following medical conditions?

Le ha dicho un doctor o proveedor médico que usted tiene alguno de los siguientes problemas de salud?

NEUROLOGICAL / *NEUROLÓGICOS*

◯ **No Concerns Noted / *No se observaron preocupaciones***

- ◯ Alzheimer's, Dementia, Memory Loss / *Enfermedad de Alzheimer, demencia, pérdida de memoria*
- ◯ Stroke / *Ataque cerebrovascular*
- ◯ Seizures / *Convulsiones*
- ◯ Parkinson's / *Enfermedad de Parkinson*
- ◯ Chronic Pain / *Dolor crónico*
- ◯ Muscular Dystrophy (MS) / *Distrofia muscular*
- ◯ Amyotrophic Lateral Sclerosis (ALS) / *Esclerosis lateral amiotrófica*
- ◯ Paralysis / *Parálisis*
- ◯ Traumatic Brian Injury / *Lesión cerebral traumática*
- ◯ Other / *Otro:*

RESPIRATORY / CARDIAC / *Respiratorio/Cardiaco*

◯ **No Concerns Noted / *No se observaron preocupaciones***

- ◯ Heart Failure / *Insuficiencia cardiaca*
- ◯ Cystic Fibrosis / *Fibrosis quística*
- ◯ Hypertension / *Hipertensión (alta presión)*
- ◯ Asthma, COPD, Emphysema / *Asma, Enfermedad pulmonar obstructiva crónica, enfisema*
- ◯ Other / *Otro:*

Select all that apply for home use / *Seleccione todo lo que aplica para uso doméstico:*

- ◯ Oxygen at Home / *Oxígeno en casa*
- ◯ Nebulizer / *Nebulizador*
- ◯ Tracheostomy / *Traqueotomía*
- ◯ Ventilator / *Ventilador artificial*
- ◯ CPAP / *aparato de presión positiva continua de las vías respiratorias (CPAP, por sus siglas en inglés)*
  BiPAP / *aparato de presión positiva de las vías respiratorias de dos niveles (Bi-PAP, por sus siglas en inglés)*
- ◯ Other / Otro:

ENDOCRINE / *Endocrino*

◯ **No Concerns Noted / *No se observaron preocupaciones***

- ◯ Diabetes Type I / *Diabetes Tipo I*
- ◯ Diabetes Type II / *Diabetes Tipo II*
- ◯ Other / *Otro:*

Coordination of Care Needs and Referrals:

PHYSICAL HEALTH (cont.)

Have you been told by a doctor or medical provider that you have any of the following medical conditions?

¿Alguna vez le ha dicho un doctor o un proveedor médico que usted tiene alguno de los siguientes problemas médicos?

GASTROINTESTINAL / *GENITOURINARY*

◯ **No Concerns Noted / *No se observaron preocupaciones***

- ◯ Kidney Disease / *Enfermedad renal/ de riñón*
- ◯ Dialysis / *Diálisis*
- ◯ Cirrhosis, Hepatitis (B & C) / *Cirrosis, Hepatitis B y C*
- ◯ Other / *Otro:*

Select all that apply for home use / *Seleccione todo lo que aplica para uso doméstico:*

- ◯ Feeding Tube / *Sonda de alimentación*
- ◯ NG Tube / *Sonda nasogástrica*
- ◯ PEG Tube / *Sonda de gastrostomía endoscópica percutánea*
- ◯ Indwelling Foley Catheter / *Sonda de Foley Permanente*
- ◯ Suprapubic Catheter / *Catéter suprapúbico*
- ◯ Ostomy / *Ostomía*

MUSCULO-SKELETAL / *MUSCO ESQUELÉTICO*

◯ **No Concerns Noted / *No se observaron preocupaciones***

- ◯ Osteoarthritis / *Osteoartritis*
- ◯ Rheumatoid Arthritis / *Artritis reumatoide*
- ◯ Recent Fracture or Amputation / *Fractura o amputación reciente*
- ◯ Are you wheelchair or bedbound? / *¿Está confinado/ a una silla de ruedas o cama?* ◯ Yes / Sí ◯ No
- ◯ Other / *Otro:*

OTHER MEDICAL CONDITION / *Otro Problema Médico*

◯ **No Concerns Noted / *No se observaron preocupaciones***

- ◯ HIV /AIDS / *VIH / SIDA*
- ◯ Organ Transplant (Recent Transplant or on Waitlist) / *Trasplante de algún órgano (Trasplante reciente o en lista de espera)*
- ◯ High Risk Pregnancy / *Embarazo de alto riesgo*
- ◯ Cancer, in Treatment? / *¿Cáncer, en tratamiento?* ◯ Yes / Sí ◯ No
- ◯ Traumatic Brain Injury / *Lesión cerebral traumática*

Coordination of Care Needs and Referrals:

MEDICATIONS

◯ **No Concerns Noted**

People sometimes miss taking their medications. Thinking over the past week, were there any days you did not take your medications as prescribed? / *A veces, a algunas personas, se les pasa tomarse sus medicamentos. Piense en esta última semana, ¿hubo algún día en el que no se tomó sus medicamentos como se le recetaron?*

☐ Yes / Sí ☐ No

If Yes, please describe what gets in the way / *Si contestó que sí, por favor describa por qué se le dificulta:*

PALLIATIVE CARE

Palliative Care

☐ Enrolled in Palliative Care Services

☐ Does not meet criteria for Palliative Care

☐ **Meets Criteria Needs Referral**

☐ **Meets Criteria (Declined Referral)**

1. The member is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.
2. The member has an advanced illness, as defined in section I.B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The member's death within a year would not be unexpected based on clinical status.
4. The member has either received appropriate patient-desired medical therapy or is an individual for whom patient-desired medical therapy is no longer effective. The member is not in reversible acute decompensation.
5. The member and, if applicable, the family/member-designated support person, agrees to:
   a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
   b. Participate in Advance Care Planning discussions.

Disease-Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF): Must meet (a) and (b)

a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher;10 and b. The member has an ejection fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease: Must meet (a) or (b)

a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or

b. The member has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)

a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia; and

b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy

c. (Chemotherapy or radiation therapy).

4. Liver Disease: Must meet (a) and (b) combined or (c) alone

a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3, and

b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal

c. Varices; or c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

◯ **No Concerns Noted / *No se observaron preocupaciones***

Has a healthcare or mental health provider ever told you that you have any of the following / *¿Alguna vez le ha dicho un proveedor de salud o de salud mental que usted tiene alguno de los siguientes problemas?:*

◯ Anxiety / *Ansiedad*

◯ Obsessive-Compulsive Disorder / *Trastorno obsesivo compulsivo*

◯ Bipolar Disorder / *Trastorno bipolar*

◯ Schizophrenia / *Esquizofrenia*

◯ Depression / *Depresión*

◯ ADHD / *Trastorno de déficit de atención con hiperactividad*

◯ PTSD / Trastorno de estrés postraumático

◯ Intellectual Disability / *Discapacidad Intelectual*

◯ Autism / *Autismo*

◯ Other / *Otro:*

Have you had any Emergency Department (ED) visits or inpatient stay the last 6 months due to your mental health condition? / *¿Ha tenido una visita al departamento de emergencias (ED) o ha estado internado/a en el hospital en los últimos 6 meses debido a su estado de salud mental?* ◯ Yes / Sí ◯ No

Coordination of Care Needs and Referrals:

SUBSTANCE USE

◯ **No Concerns Noted / *No se observaron preocupaciones***

Do you use substances (Alcohol, Street Drugs or Misuse Prescriptions)? / *¿Consume sustancias (¿alcohol, drogas o usa incorrectamente algúnos medicamentos recetados)?* ◯ Yes / Sí ◯ No

If Yes, have you experience any negative consequences from your use? / ***Si contestó que sí**, ¿ha sufrido alguna consecuencia negativa como resultado de su consumo?* ◯ Yes / Sí ◯ No

Did you previously use substances and stopped? / *¿Anteriormente había consumido sustancias, pero ya las ha dejado?* ◯ Yes / Sí ◯ No

What substance(s) have you found to be a problem / *¿Cuáles sustancias han sido un problema para usted?*

Do you smoke, vape or chew tobacco? / *¿Fuma, vapea, o masca tabaco?* ◯ Yes / Sí ◯ No

Have you ever felt you ought to cut down on your drinking or drug use? / *¿Alguna vez ha sentido que debe de reducir su consumo de bebida o de drogas?* ◯ Yes / Sí ◯ No

If Yes, go to next question / ***En caso afirmativo**, pase a la siguiente pregunta.*

SUBSTANCE USE (cont.)

Would you like to talk with someone about your substance use, especially if you are thinking of quitting or cutting back? / *¿Le gustaría hablar con alguien sobre su consumo de sustancias, especialmente si está pensando en dejarlo o reducirlo?* ☐ Yes / Sí ☐ No

Coordination of Care Needs and Referrals:

COGNITIVE FUNCTION

☐ **No Concerns Noted / *No se observaron preocupaciones***

Have you had any changes in thinking, remembering, or making decisions? / *¿Ha tenido algún cambio en su manera de pensar, recordar, o tomar decisiones?* ☐ **Yes / Sí** ☐ **No** ***(LTSS)***

In the past month, have you felt worried, scared, or confused that something may be wrong with your mind or memory? / *En el último mes, ¿ha sentido preocupación, miedo, o confusión que puede tener algún problema con su mente o memoria?* ☐ Yes / Sí ☐ No

Coordination of Care Needs and Referrals:

SAFTEY

☐ **No Concerns Noted / *No se observaron preocupaciones***

Are you afraid of anyone or is anyone hurting you? / *¿Tiene miedo que alguien le está haciendo daño?*

☐ **Yes / Sí** ☐ **No** **(LTSS)**

If yes, please explain/ *Si contestó que sí, por favor explíqueme cómo*:

Is anyone using your money without your ok? / *¿Alguien está usando su dinero sin que usted le haya dado permiso?* ☐ **Yes / Sí** ☐ **No** **(LTSS)**

If yes, please explain / *Si contestó que sí, por favor explíqueme cómo:*

ACTIVITIES OF DAILY LIVING

☐ **No Concerns Noted / *No se observaron preocupaciones***

Limitations/Functional Capacity Risk Factors

Do you need help with any of these activities? (LTSS) (answer Yes or No to each individual activity) / *¿Necesita usted ayuda con cualquiera de estas actividades? (Responda Sí o No a cada actividad individual)*

Taking a Bath or Shower / *Bañarse en tina o regadera*	☐ Yes/Sí ☐ No
Using a Toilet / *Usar el escusado*	☐ Yes/Sí ☐ No
Getting Dressed / *Vestirse*	☐ Yes/Sí ☐ No
Brushing Teeth, Brushing Hair, Shaving / *Lavarse los dientes, peinarse, afeitarse*	☐ Yes/Sí ☐ No
Walking / *Caminar*	☐ Yes/Sí ☐ No
Getting out of Bed or a Chair / *Levantarse de la cama o una silla*	☐ Yes/Sí ☐ No
Going Up Stairs / *Subir escaleras*	☐ Yes/Sí ☐ No
Eating / *Comer*	☐ Yes/Sí ☐ No
Making Meals or Cooking / *Preparar las comidas o cocinar*	☐ Yes/Sí ☐ No
Shopping and Getting Food / *Hacer las compras o conseguir comida*	☐ Yes/Sí ☐ No
Writing Checks or Keeping Track of Money / Hacer cheques o llevar la cuenta de su dinero	☐ Yes/Sí ☐ No
Keeping Track of Appointments / *Llevar la cuenta de sus citas*	☐ Yes/Sí ☐ No
Using the Phone / Usar el teléfono	☐ Yes/Sí ☐ No
Doing Housework or Yard Work / *Hacer los quehaceres de la casa o el jardín*	☐ Yes/Sí ☐ No
Washing Dishes or Laundry / *Lavar los platos o la ropa*	☐ Yes/Sí ☐ No
Going out to Visit Family or Friends / *Salir a visitar a su familia o amistades*	☐ Yes/Sí ☐ No
Getting a Ride to the Doctor or to See your Friends / *Conseguir que alguien lo/a lleve al doctor o a ver a sus amistades*	☐ Yes/Sí ☐ No

Other please explain / *Otro- por favor explíqueme*:

If yes, are you getting all the help you need with these activities? / *Si contestó que sí, ¿está recibiendo toda la ayuda que necesita con estas actividades?* ☐ Yes/Sí ☐ No **(LTSS)**

Do you have family members or others willing and able to help you when you need it? / *¿Tiene usted familia u otras personas que están dispuestos y quieren ayudarle cuándo usted lo necesita?* ☐ Yes/Sí ☐ No **(LTSS)**

Do you ever think your caregiver has a hard time giving you all the help you need? / *¿Alguna vez ha pensado que a su cuidador se le dificulta darle toda la ayuda que usted necesita?* ☐ Yes/Sí ☐ No **(LTSS)**

Do friends or family members express concerns about your ability to care for yourself? / *¿Su familia o amistades han expresado alguna inquietud sobre su capacidad de cuidarse usted mismo/a?* ☐ Yes/Sí ☐ No

Coordination of Care Needs and Referrals:

HOUSING ENVIROMENT

☐ **No Concerns Noted / *No se observaron preocupaciones***

Can you safely and easily move around your home? / *¿Puede usted moverse fácilmente y con seguridad alrededor de su casa?* ☐ Yes/Sí ☐ No **(LTSS)**

If No, does the place that you live have / *Si contestó que no, ¿el lugar dónde vive tiene:*

(answer Yes or No to each individual item)

Good Lighting / *Buena iluminación*	☐ Yes/Sí ☐ No
Good Heating / *Buena calefacción*	☐ Yes/Sí ☐ No
Good Cooling / *Buen enfriamiento*	☐ Yes/Sí ☐ No
Rails for any Stairs or Ramps / *Barandales para cualquier escalera o rampa*	☐ Yes/Sí ☐ No
Hot Water / *Agua caliente*	☐ Yes/Sí ☐ No
Indoor Toilet / *Escusado interior*	☐ Yes/Sí ☐ No
A door to the outside that locks / *Puerta al exterior que cierra con llave*	☐ Yes/Sí ☐ No
Elevator / *Elevador*	☐ Yes/Sí ☐ No
Space to use a wheelchair / *Espacio para usar una silla de ruedas*	☐ Yes/Sí ☐ No
Clear Ways to Exit Home / *Salidas sin obstrucción para salir de la casa*	☐ Yes/Sí ☐ No
Stairs to get into your home or stairs inside your home / *Escalones para entrar a su casa o escalones dentro de su casa*	☐ Yes/Sí ☐ No

Coordination of Care Needs and Referrals:

FALL RISK

☐ **No Concerns Noted / *No se observaron preocupaciones***

Are you afraid of falling? / *¿Tiene miedo de caerse?*	☐ Yes/Sí ☐ No **(LTSS)**
Have you fallen in the last month? / *¿Se ha caído en el último mes?*	☐ Yes/Sí ☐ No **(LTSS)**

Coordination of Care Needs and Referrals:

MEDICAL EQUIPMENT

◯ **No Concerns Noted / *No se observaron preocupaciones***

Glasses / *Lentes*	◯ Use	◯ Need
Walker / *Andadera*	◯ Use	◯ Need
Grab Bars / *Barandales*	◯ Use	◯ Need
Raised Toilet Seat/Chair / *Asiento Elevado/ Silla del Baño*	◯ Use	◯ Need
Cane / *Bastón*	◯ Use	◯ Need
Lift / *Aparato de grúa*	◯ Use	◯ Need
Shower Chair / *Silla para la regadera*	◯ Use	◯ Need

Other / *Otro*:

Coordination of Care Needs and Referrals:

SOCIAL DETERMINANTS OF HEALTH

HOUSING ◯ No Concerns Noted

Where do they live?

◯ Live alone in my home/apartment

◯ Live with Family or other person's home/apartment

◯ Residential treatment center

◯ Board and care facility

◯ Assisted Living Nursing Home

◯ Protective housing

◯ Homeless

If Homeless, staying at ◯ Recuperative care ◯ In a motel ◯ Vehicle ◯ Shelter or with friend ◯ Streets

Comment:

Are you at risk for eviction / *¿Tiene usted riesgo de que lo/a desalojen?* ◯ Yes/Sí ◯ No

If Yes, please explain / *por favor explique:*

Is anyone helping with housing support? (e.g. Housing Navigator, Case Management, Adult Protective Services) / *¿Alguien le está ayudando con apoyo de vivienda? (Navegador de vivienda, Administración de casos, Servicios de Protección para Adultos)* ◯ Yes/Sí ◯ No

Are you on a housing waitlist / *¿Está en lista de espera para vivienda?* ◯ Yes/Sí ◯ No

If Yes: ◯ County ◯ City ◯ Other:

FINANCIAL INSECURITY ◯ No Concerns Noted / *No se observaron preocupaciones*

What is your monthly income / *¿Cuáles son sus ingresos mensuales?* $

Source of Income / *Fuente de los ingresos:*

◯ Employment ◯ SSI (Supplemental Security Income) ◯ SSDI (Social Security Disability Insurance)

Do you sometimes run out of money to pay for food, rent, bills and medications? / *¿De vez en cuando se le acaba el dinero y no puede pagar la renta, las cuentas, y medicamentos?* ◯ **Yes/Sí** ◯ **No (LTSS)**

FOOD INSECURITY ◯ No Concerns Noted / *No se observaron preocupaciones*

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? / *En los últimos 12 meses, ¿usted u otro adulto en su casa han recortado el tamaño de sus comidas o han dejado de comer una comida por falta de dinero para la comida?* ◯ Yes/Sí ◯ No

How often are you hungry or do not eat because there is not enough food in the house? / ¿Qué tan seguido pasa usted hambre o no come porque no hay suficiente comida en casa? ◯ Often ◯ Not Often

Do you eat less than you feel you should because there is not enough food? / ¿Come usted menos de lo que piensa que debe comer porque no hay suficiente comida? ◯ Yes/Sí ◯ No

Coordination of Care Needs and Referrals:

ISOLATION

◯ **No Concerns Noted / *No se observaron preocupaciones***

Over the past month (30 days), how many days have you felt lonely? / En el último mes (30 días), ¿cuántos días se ha sentido solo/a? (**LTSS)** *Check one*

◯ None – I never feel lonely / *Ninguno- nunca me siento solo/a*

◯ Less than 5 days / *Menos de 5 días*

◯ More than half the days (more than 15) / *Más de la mitad de los días (más de 15)*

◯ Most days – I always feel lonely / La mayoría de los días- siempre me siento solo/a

Coordination of Care Needs and Referrals:

SOCIAL SUPPORT (select all that apply)

◯ Family ◯ Adult Day Care ◯ Friendship Line ◯ TCRC ◯ Friendly Visitor ◯ Caregiver

◯ Religious/Spiritual ◯ Congregate Meal Services ◯ Support Group ◯ None

◯ Other:

LEGAL INVOLVEMENT

◯ **No Concerns Noted**

Involvement with the following in the last 12 months:

◯ Court Ordered Services

◯ On Probation

◯ On Parole

◯ Re-entry Program

◯ Immigration “e.g., Refugee”

◯ DUI/restricted License

◯ Child Welfare Services

◯ Adult Protective Services

◯ Other:

END-OF-LIFE-PLANNING

Do you have a life-planning document or advance directive in place? / *¿Tiene en pie un documento de planificación de vida o una directiva anticipada?* ☐ Yes/Sí ☐ No

Do you want information on these topics? / ¿Quiere información sobre estos temas? ☐ Yes/Sí ☐ No

COMMUNITY AND LTSS SERVICES

Select Agencies or Services Member is connected with:

- ☐ ***Multi-Senior Services Program(MSSP)**
- ☐ ***Home and Community Based Alternatives Waiver (HCBA)**
- ☐ ***Assisted Living Waiver (ALW)**
- ☐ ***HIV/AIDS Waiver**
- ☐ ***HCBA Waiver for Individuals with Developmental Disabilities**
- ☐ ***Self-Determination Program for Individuals with I/D**
- ☐ ***CenCal Health Complex Case Management**
- ☐ ∞Hospice
- ☐ Respite Services
- ☐ Meals on Wheels
- ☐ In Home Support Services
- ☐ Veterans Administration
- ☐ California Children's Services (CCS)
- ☐ Community Based Adult Services (CBAS)
- ☐ CalFresh Benefits
- ☐ County Specialty Mental Health
- ☐ Non-Medical Transportation
- ☐ Subsidized Housing
- ☐ Independent Living Resource Center
- ☐ Energy Assistance Program
- ☐ Free Government Phone
- ☐ TCRC (Tri County Regional Center)
- ☐ Other:

*** Member can be enrolled in ECM or these programs, not in both at the same time.**

∞ Excluded for ECM enrollment

Coordination of Care Needs and Referrals:

MEMBER PRIORITIES

What is one thing you would like to do right now to improve your health (such as cutting back sugary drinks or initiating daily walks? – provide an example of one personal goal). / *¿Cuál es una cosa que le gustaría hacer inmediatamente para mejorar su salud? (tal como reducir las bebidas con azúcar o empezar a caminar todos los días - proporcione un ejemplo de una meta personal)*

1)

What would you like to achieve from our work and time together? / *¿Qué le gustaría lograr con nuestro trabajo y durante nuestro tiempo juntos?*

From our meeting today what comes to mind as your top 2-3 goals for your health, mental wellness and social and/or living situation for the next 3-6 months? / *¿Como resultado de nuestra reunión el día de hoy, que piensa que son sus 2-3 metas principales para su salud, bienestar mental y social y/o su situación de vivienda para los siguientes 3-6 meses?*

1.

2.

3.

High Acuity, Recommended minimum one contact per week if any of the below apply

- ◯ Emergency Department (ED) visit or hospitalization (in the last 30 days).
- ◯ New diagnosis or new initiation of treatment (in last 30 days).
- ◯ Documented or known non-adherence (medication, treatment, or appointments).
- ◯ Little or no identified social support.
- ◯ Homeless or recently secured permanent housing (within the last 90 days).

Moderate Acuity, Recommended minimum (3x/month) contact if any of the below apply

- ◯ ED visit or hospitalization within the last two to six months.
- ◯ Newly sustained treatment adherence (medications, appointments).
- ◯ Newly integrated social support.
- ◯ Secured permanent housing within last three-six months.
- ◯ At risk of homelessness.

Low Acuity, Recommended minimum one contact per month if any of the below apply

- ◯ No ED visit or hospitalization (in the last six months).
- ◯ Ongoing treatment adherence (medications, appointments).
- ◯ Strong family/social support.
- ◯ Stable housing.

Narrative Summary (Include Primary Needs identified from Assessment)

Assessor's Printed Name: **Signature/Credentials** **Date:**