**Consumer contact information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Consumer name: | | | | ID #: |
| Phone #: (     )      - | Gender: | | DOB:      /     / | |
| Best time to contact:  AM  PM  Mon.  Tues.  Wed.  Thurs.  Fri. | | | | |
| Emergency contact: | | Phone #: (     )      - | | |
| Interviewer: | | Date:      /     / | | |
| Case management program completed by:  Elder Services  Peer support | | | | |

**Reason for referral**

* Do you know why you were referred for case management services?
* How can we assist you?

**Living situation**

* Where are you living now?
* How long have you lived there?
* Does anyone live there with you?  Yes  No
  + If so, who:
* Do you have any pets that live with you?  Yes  No
* What do you like most about where you live?
* What don’t you like about where you are living, or what doesn’t work well for you?
* Do you feel safe where you are currently living?  Yes  No
  + If not, why?
* Would you like to receive any assistance with your housing situation?  Yes  No

**Relevant / recent medical conditions**

* Are you having any health concerns right now?  Yes  No
  + If yes, what?
* What health problem is bothering you the most?
* What impacts in your life are you experiencing due to your health problem(s)?
* Are you currently seeing a medical provider for your health problem(s)?  Yes  No
* Are you currently taking any medications?  Yes  No
  + If yes, are you taking them as prescribed?  Yes  No
* Would you like to receive assistance with your medical care?  Yes  No

**Mental health**

* Are you having any mental health concerns right now?  Yes  No
  + If yes, what?
* Do you have any struggles with substance use, such as alcohol, drugs, or tobacco?  Yes  No
* What mental health problem is bothering you the most?
* As part of our screening, we would like to check in on any current struggles with suicide or any history. Please answer the following questions:
  + In the last month –
    1. Have you wished you were dead or wished you could go to sleep and not wake up?  Yes  No
    2. Have you had any actual thoughts of killing yourself?  Yes  No
  + If YES to 2, ask questions 3, 4, 5, and 6. If NO, skip to question 6. –

3. Have you been thinking about how you might do this?  Yes  No

4. Have you had these thoughts and had some intention of acting on them?  
  Yes  No

5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?  Yes  No

6. Have you ever done anything, started to do anything, or prepared to do anything to end your left?  Yes  No

* + If YES, was this within the past 3 months?  Yes  No
* What impacts in your life are you experiencing due to your mental health problem(s)?
* Are you currently seeing a therapist for your health problem(s)?
* Would you like to receive any assistance with your mental health care?  Yes  No

**Activities of daily living**

* Are there areas in your life that you feel you need some assistance in managing?
  + Preparing meals -  Yes  No
  + Accessing foods suitable for dietary restrictions (diabetic, gluten free, vegetarian, lactose intolerant) -  Yes  No
  + Taking medications -  Yes  No
  + Attending appointments -  Yes  No
  + Personal hygiene -  Yes  No
  + Taking care of household chores -  Yes  No
  + Safely waking around -  Yes  No
  + Driving -  Yes  No
  + Accessing public transportation or ride assistance -  Yes  No
  + Using or accessing the telephone -  Yes  No
  + Mailing things -  Yes  No
  + Shopping -  Yes  No
  + Paying bills -  Yes  No
  + Managing money -  Yes  No
  + Caring for other family members -  Yes  No
  + Other -
* Would you like to receive any assistance with managing your daily needs?  Yes  No

**Social support**

* Does anyone visit or help you on a regular basis?  Yes  No -
* Do you have any hired or contracted help? Visiting nurse services? Homemaker?  Yes  No
* Are there any community, spiritual, or cultural activities that you participate in?  Yes  No
* What don’t you like about your current social support? What would you like to be different about it?
* Would you like to receive any assistance with improving your social support?  Yes  No

**Goals for services**

* What are your strengths?
* In order of most important and meaningful for you, what resources can we assist you with?

|  |  |  |
| --- | --- | --- |
| Food pantry | Cultural supports | Housing |
| In-home assistance | Transportation | Cell phone access |
| Financial assistance | Social support | Elder case management |
| Medical care | Life is Sacred | 2SLGBTQ+ support |
| Mental health therapy | Psychiatric medication management | A & D services |
| Gambling support | Smoking cessation | Peer support case management |