**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 |