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|  | Public Health DivisionHIV Community Services Program |  |
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**Care Coordination Triage**

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| Client name: |       |  | Date: |    /    /      |

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| If you received this in the mail, please complete the following questions and return in the enclosed envelope. This will help us address the needs you have at this time. | The Care Coordinator will follow-up on any “Yes” or “Unsure” checked boxes in this column  |
| 1. Have you had any problems or delays in getting medication?
 | [ ]  No [ ]  Yes |
| 1. In the last six months, did you miss any of your last scheduled medical appointments?
 | [ ]  No [ ]  Yes |
| 1. Do you have any concerns about your housing?
 | [ ]  No [ ]  Yes |
| 1. Have you been unable to pay for your rent, utilities, transportation, or food?
 | [ ]  No [ ]  Yes |
| **Within the past 12 months:**1. Were you worried whether your food would run out before you got money to buy more?

[ ]  Often [ ]  Sometimes [ ]  Never1. The food you bought just didn’t last and you didn’t have money to get more?

[ ]  Often [ ]  Sometimes [ ]  Never | # 5 or # 6 answered “Often” or “Sometimes”?[ ]  No [ ]  Yes |
| 1. Are you receiving SNAP benefits? [ ]  No [ ]  Yes
 | If “No”, qualifies for SNAP?[ ]  No [ ]  Yes[ ]  Unsure |
| 1. Are you uninsured?
 | [ ]  No [ ]  Yes |
| 1. Do you have unpaid medical bills within the last 12 months that are not in collection?
 | [ ]  No [ ]  Yes |
| 1. If you use/chew tobacco or smoke cigarettes, would you like to quit?
 | [ ]  No [ ]  Yes [ ]  N/A |
| 1. Would you like assistance obtaining employment or volunteering?
 | [ ]  No [ ]  Yes |
| **During the past two weeks:**1. Have you had little interest or pleasure in doing things? [ ]  No [ ]  Yes
2. Have you felt down, depressed, or hopeless? [ ]  No [ ]  Yes
3. If yes to #12 or #13 above, are you regularly seeing a mental health professional? [ ]  No [ ]  Yes
 |   |
| 1. If you are not regularly seeing a mental health professional, do you want a referral or help connecting with your mental health professional?
 | [ ]  No [ ]  Yes [ ]  N/A |
| 1. If you are regularly seeing a mental health professional, have you missed any mental health appointments in the last month?
 | [ ]  No [ ]  Yes [ ]  N/A |
| 1. Are you currently in recovery for alcohol or substance use?
 | [ ]  No [ ]  Yes  |
| 1. How many times in the past year have you had 4 or more drinks in a day?
 | [ ]  None [ ]  1 or more |
| 1. In the past year, have you used a recreational drug other than marijuana or used a prescription medication for non-medical reasons? [ ]  No [ ]  Yes
2. If yes to #20, have you shared needles in the past 6 months? [ ]  No [ ]  Yes
3. If yes to #20 , are you regularly seeing a substance use professional? [ ]  No [ ]  Yes [ ]  N/A
 |  |
| 1. If you are not regularly seeing a substance use professional, do you want a referral or help connecting with your substance use professional?
 | [ ]  No [ ]  Yes [ ]  N/A |
| 1. If you are regularly seeing a substance use professional, have you missed any substance use treatment appointments in the last month?
 | [ ]  No [ ]  Yes [ ]  N/A |
| 1. Have you had unprotected sex in the past 6 months?
 | [ ]  No [ ]  Yes  |
| 1. Would you like to be notified about health education classes when they become available in your area?
 | [ ]  No [ ]  Yes—we will contact you if class is available |
| 1. Would you like to speak to the care coordinator for any other reason?
 | [ ]  No [ ]  Yes |
| Comments:       |
| 1. List all the ways you can be reached for follow-up on “yes” responses above *(include new contact information)*:

[ ]  Phone:       [ ]  Mail:       [ ]  Email:        |
| 1. If number 26 is blank, when will you check in with your Care Coordinator regarding the “yes” responses?
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| **Office use only: If “yes” has been answered please refer to CC, indicate below the steps taken:**  |
| [ ]  Referred to CC by phone, date: |       | Initials: |  |
| [ ]  Referred to CC by e-mail, date: |       | Initials: |  |
| [ ]  Referred to CC in person, date: |       | Initials: |  |
| [ ]  No referral needed |       | Initials: |  |
| [ ]  CC confirms contact with client, date: |       | Initials: |  |
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