

IDAHO MEDICAL CASE MANAGEMENT ASSESSMENT

Client Name: _____ Date: ____/____/____ URN: _____

1. FINANCIAL AND RESOURCE EVALUATION

HOUSEHOLD COMPOSITION				
Name	Relation to Applicant	Date of Birth	Gender	
		____/____/____	Male	Female
		____/____/____	Male	Female
		____/____/____	Male	Female
		____/____/____	Male	Female
		____/____/____	Male	Female
		____/____/____	Male	Female
		____/____/____	Male	Female

MONTHLY HOUSEHOLD INCOME					
Source	Applicant	Household	Source	Applicant	Household
Wages	\$	\$	TANF/TAFI	\$	\$
Social Security	\$	\$	Food Stamps	\$	\$
Social Security Disability	\$	\$	WIC	\$	\$
Supplemental Security Income	\$	\$	Alimony	\$	\$
Unemployment Compensation	\$	\$	Child Support	\$	\$
Veteran's Benefits	\$	\$	Enhanced Rent	\$	\$
Private Insurance Benefits	\$	\$	Energy Assistance	\$	\$
Total Income	\$	\$	Total Income	\$	\$

MONTHLY HOUSEHOLD EXPENSES					
Source	Applicant	Household	Source	Applicant	Household
Housing	\$	\$	Medical	\$	\$
Utilities	\$	\$	Clothing	\$	\$
Groceries	\$	\$	Telephone	\$	\$
Sundry Items	\$	\$	Cable	\$	\$
Auto	\$	\$	Credit Card(s)	\$	\$
Auto Fuel	\$	\$	Entertainment	\$	\$
Auto Insurance	\$	\$	Miscellaneous / Other:	\$	\$
Total Expenses	\$	\$	Total Expenses	\$	\$

Total Applicant Income- Total Applicant Expenses = Net Difference
 (_____) - (_____) = (_____)

Total Household Income- Total Household Expenses = Net Difference
 (_____) - (_____) = (_____)

Family Size	Gross Monthly Income: \$ _____		Gross Annual Income: \$ _____	
1	0 – 866	867 – 1733	1734– 2600	2601 & OVER
2	0 – 1166	1167 – 2333	2334 – 3500	3501 & OVER
3	0 – 1466	1467 – 2933	2934– 4400	4401& OVER
4	0 – 1766	1767 – 3533	3534– 5300	5301& OVER
5	0 – 2066	2067– 4100	4101– 6200	6201& OVER
6	0 –2366	2302 – 4602	4603 – 7100	7101 & OVER
7	0 –2666	2667 – 5333	5334– 8000	8001 & OVER
8	0 –2966	2967– 6350	6351 – 8900	8901& OVER
Additional	Add 300	600	900	
Poverty Level	0 – 100%	101% - 200%	201% - 300%	Over 300%
Co-Pay	\$0	\$10	\$20	\$ Pay in Full
Co-Pay Maximum	0%	5% of Gross Annual \$\$	7% of Gross Annual \$\$	10% of Gross Annual \$\$
		\$ _____	\$ _____	\$ _____

PRIVATE INSURANCE					
Client eligible for insurance? <input type="checkbox"/> NO <input type="checkbox"/> YES	If YES, is client enrolled? <input type="checkbox"/> NO <input type="checkbox"/> YES		If NO, why?		
Maximum yearly or lifetime benefits:	Does your insurance cover medications? <input type="checkbox"/> NO <input type="checkbox"/> YES		Deductible:		
Medication co-pays: \$	Medical visit co-pays: \$		Other information:		
MEDICARE					
Medicare: If No, eligible? <input type="checkbox"/> NO <input type="checkbox"/> YES	If Yes, Effective Date: ____/____/____ Medicare Coverage: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D				
Comments:					
MEDICAID					
Medicaid: If No, eligible? <input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, effective date: ____/____/____ Case Worker: _____ Telephone #: () -				
Comments:					
RYAN WHITE PART B & C PROGRAMS					
Part B: <input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, effective date: ____/____/____	No, eligible? <input type="checkbox"/> NO <input type="checkbox"/> YES	Medical Case Manager: _____	Telephone #: () -	
Part C: <input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, effective date: ____/____/____	No, eligible? <input type="checkbox"/> NO <input type="checkbox"/> YES	Medical Case Manager: _____	Telephone #: () -	
Utilizes ADAP for HIV Medications? <input type="checkbox"/> NO <input type="checkbox"/> YES		Comments:			
Which of the following RWPB services would benefit you?					
<input type="checkbox"/>	Medical Case Management	<input type="checkbox"/>	Mental Health Services	<input type="checkbox"/>	Dental Care
<input type="checkbox"/>	Outpatient Medical Care	<input type="checkbox"/>	Short-Term Emergency Assistance	<input type="checkbox"/>	Transportation to Medical Appointments
If available, would you benefit from any of the following services?					
<input type="checkbox"/>	Outpatient substance abuse	<input type="checkbox"/>	Help locating primary medical care	<input type="checkbox"/>	Hospice care
<input type="checkbox"/>	Home Health Care	<input type="checkbox"/>	Home & community based health	<input type="checkbox"/>	Medical nutrition therapy
<input type="checkbox"/>	Housing services	<input type="checkbox"/>	Health Education / Risk Reduction	<input type="checkbox"/>	Referral for Health / Supportive
<input type="checkbox"/>	Psychosocial support	<input type="checkbox"/>	Child care during medical and program meetings	<input type="checkbox"/>	Interpreting and translation services
<input type="checkbox"/>	Permanency planning for minor children	<input type="checkbox"/>	Legal services for benefits access or end of life needs	<input type="checkbox"/>	Residential substance abuse
Comments:					
HOPWA					
Currently receiving HOPWA? <input type="checkbox"/> NO <input type="checkbox"/> YES	If no, eligible? <input type="checkbox"/> NO <input type="checkbox"/> YES		If yes, application date: ____/____/____		
Services: <input type="checkbox"/> LTRA <input type="checkbox"/> STMTRU <input type="checkbox"/> Medical <input type="checkbox"/> Mental Health <input type="checkbox"/> Transportation					

2. SAMISS¹ (Substance Abuse and Mental Illness Symptoms Screener)

SUBSTANCE ABUSE ITEMS:

SCORE

1. How often do you have a drink containing alcohol? (*Alcoholic drinks include one beer, one glass of wine, a mixed drink of hard liquor, or wine cooler. Each of these counts as one drink, unless they have double shots, which would equal two drinks.*) (If you do not drink, go to question #4.)

0	[]	Never	3	[]	2-3 times a week
1	[]	Monthly or less	4	[]	4 or more times a week
2	[]	2-4 times a month			

2. How many drinks do you have on a typical day when you are drinking?

0	[]	1 or 2	3	[]	7 to 9
1	[]	3 or 4	4	[]	10 or more
2	[]	5 or 6			

3. How often do you have four or more drinks on one occasion?

0	[]	Never	3	[]	2-3 times a week
1	[]	Monthly or less	4	[]	4 or more times a week
2	[]	2-4 times a month			

Sum of responses for Questions 1 -3

[]

4. In the past year, how often did you use nonprescription drugs to get high to change the way you feel?

0	[]	Never	3	[]	2-3 times a week
1	[]	Monthly or less	4	[]	4 or more times a week
2	[]	2-4 times a month			

5. In the past year, how often did you use drugs prescribed to you or to someone else to get high or change the way you feel?

0	[]	Never	3	[]	2-3 times a week
1	[]	Monthly or less	4	[]	4 or more times a week
2	[]	2-4 times a month			

Sum of responses for Questions 4 -5

[]

6. In the last year, how often did you drink or use drugs more than you meant to?

0	[]	Never	3	[]	2-3 times a week
1	[]	Monthly or less	4	[]	4 or more times a week
2	[]	2-4 times a month			

7. How often did you feel you wanted or needed to cut down on your drinking or drug use in the last year, and not been able to?

0	[]	Never	3	[]	2-3 times a week
1	[]	Monthly or less	4	[]	4 or more times a week
2	[]	2-4 times a month			

Sum of responses for Questions 6 -7

[]

Patient considered positive for substance abuse symptoms if any of the following criteria are met:

- The **sum** of responses for **Questions 1-3 is ≥ 5**
- The **sum** of responses for **Questions 4-5 is ≥ 3**
- The **sum** of responses for **Questions 6-7 is ≥ 1**

¹ Whetten, K., Reif, S., Swartz, M., Stevens, R., Ostermann, J., Hanisch, L., Eron, J.J. (2005). A brief mental health and substance abuse screener for persons with HIV. *AIDS Patient Care and STDs* 19(2), 89-99.

MENTAL HEALTH ITEMS:

Medications/antidepressants

8. During the past 12 months, were you ever on medication/antidepressants for depression or nerve problems?
1. YES
 2. NO

Major depression

9. During the past 12 months, was there ever a time when you felt sad, blue, or depressed for two weeks or more in a row?
1. YES
 2. NO
10. During the past 12 months, was there ever a time lasting 2 weeks or more when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?
1. YES
 2. NO

Generalized anxiety disorders

11. During the past 12 months, did you ever have a period lasting 1 month or longer when most of the time you felt worried and anxious?
1. YES
 2. NO

Panic disorder

12. During the past 12 months, 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?
1. YES
 2. NO
13. During the past 12 months, 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 respondent volunteers "only when having a heart attack or due to physical causes," mark "NO"]
1. YES
 2. NO

Patient considered positive for symptoms of mental illness if he/she responded yes to *any* mental health question

3. HOMELESS PREVENTION SCREENING TOOL²

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.

Gender: Male Female

- 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 enough money to meet your needs? (Food, rent, utilities, transportation, etc.) NO YES

- 3. Do you have housing problems?** NO YES If yes, what are they? _____
- | | |
|---|--|
| <input type="checkbox"/> Legal eviction notice within the past 30 days | <input type="checkbox"/> Doubled up with family or friends |
| <input type="checkbox"/> Did not pay last month's rent | <input type="checkbox"/> Overcrowded living situations |
| <input type="checkbox"/> Did not pay utility bill(s) | <input type="checkbox"/> Threats of being kicked out |
| <input type="checkbox"/> Building in bad condition (Windows, locks, plumbing, insects, rodents, hot/cold water, electricity, etc) | <input type="checkbox"/> Other: _____ |

- 4. In the past 30 days (or 30 days prior to hospitalization / incarceration, etc.) where did you live?**
- | | |
|--|-----------------------|
| <input type="checkbox"/> Owned apartment, room or house | Number of Days: _____ |
| <input type="checkbox"/> Rented apartment, room or house | Number of Days: _____ |
| <input type="checkbox"/> Family of friend's home / apartment | Number of Days: _____ |
| <input type="checkbox"/> Shelter | Number of Days: _____ |
| <input type="checkbox"/> Hotel or SRO | Number of Days: _____ |
| <input type="checkbox"/> Abandoned building, park, train station, car, streets | Number of Days: _____ |
| <input type="checkbox"/> Institution (hospital, halfway house, nursing home) | Number of Days: _____ |
| <input type="checkbox"/> Foster home or group home | Number of Days: _____ |
| <input type="checkbox"/> Jail, prison or detention center | Number of Days: _____ |
| <input type="checkbox"/> 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. Were you ever homeless as a child? NO YES

7. Before you were 18, did you ever live out of your home and away from your family? NO YES

8. Is there anyone you can contact in an emergency or time of need? NO YES

Who is that person? Name: _____ Relationship: _____

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

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

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

² Developed by the Office of Mental Health – Homeless Action Committee

12. Did you drink or use street drugs in the last 30 days? (If No, skip to #13). NO YES

a. What kind of substance did you use? _____

b. How often did you use the substance?

Daily

Once a week

Less than once a week

4 – 6 times a week

2 -3 times a week

c. How much of the substance did you use? _____

13. Did you ever live in or participate in a detox program, a halfway house or a residential substance abuse treatment program? NO YES

14. Before you were 18, were you ever physically, emotionally or sexually abused? NO YES

15. Have you experienced domestic violence, abuse or assault in last 30 days? NO YES

16. Have you ever received treatment for an emotional or psychiatric problem? NO YES

a. When and were you most recently treated?

b. Where did you receive treatment? _____

c. Were you prescribed medication for that emotional / psychiatric problem? NO YES

d. Medication(s) prescribed: _____

17. Have you ever spent time in a hospital overnight for an emotional / psychiatric problem? NO YES

RISK OF HOMELESSNESS:

Total number of boxes checked "YES"

a. High = 8 + Boxes checked "YES"

b. Moderate = 3 – 7 Boxes checked "YES"

c. Mild = 1 – 2 Boxes checked "YES"

Score: _____ Level: _____

Do not count question 1 towards the number of boxes checked "YES." If question checked "YES" client is currently homeless.

4. DOMESTIC VIOLENCE (The HITS Scale³ (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)

5. VACCINATION HISTORY

Does client have immunization card with them?	<input type="checkbox"/> NO <input type="checkbox"/> YES
If client does not have immunization card, can he/she bring it?	<input type="checkbox"/> NO <input type="checkbox"/> YES (Date: ____/____/____)
If immunization card is not available, will client sign a release of information in order to obtain vaccination history?	<input type="checkbox"/> NO <input type="checkbox"/> YES

³ 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.

6. 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
- Ride from program volunteer
- Walk
- Other _____

Do you have difficulty arranging transportation? Yes No

If yes, why? _____

Note any transportation barriers or concerns below:

7. 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? Yes No Preparing food/cooking? Yes No
 Grocery shopping? Yes No Food storage? Yes No

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	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Food pantry	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Home delivered meals	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Congregate meals	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Food voucher	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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

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

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

How is your appetite?

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

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

Do you have adequate clothing? Yes No

Do you have any other basic needs? Yes No

Note any nutrition or basic needs concerns below:

8. ADHERENCE ASSESSMENTS⁴

(REALM-R, Medication Knowledge, Readiness Ruler, Duke-UNC FSSQ)

REALM-R (Rapid Estimate of Adult Literacy in Medicine - Revised)	
Fat	
Flu	
Pill	
Allergic	
Jaundice	
Anemia	
Fatigue	
Directed	
Colitis	
Constipation	
Osteoporosis	
<i>Fat, Flu, and Pill are not scored. We have previously used a score of 6 correct or less to identify patients at risk for poor literacy.</i>	

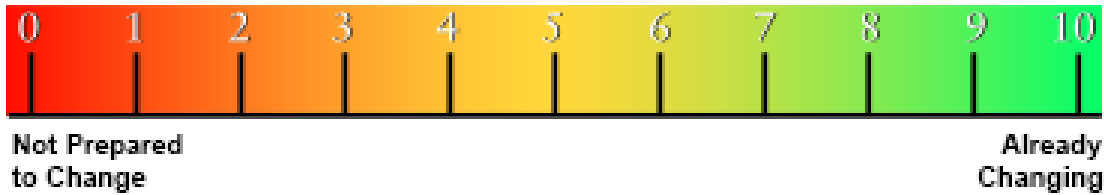
MEDICATION KNOWLEDGE SURVEY								
Check all boxes patients can successfully read and fill in the information they provide to you about each of their medications.								
Medication	Name of Medication	Why are you taking medication?	How much to take each time?	When to take the medication?	Effects to 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								

⁴ Case Management Society of America, *Case Management Adherence Guidelines*, 2006.

Readiness-to-Change Ruler

One the line below, mark where you are now on this line that measures your change
in _____

Are you not prepared to change, somewhere in the middle or already changing?



Readiness-to-Change Ruler

One the line below, mark where you are now on this line that measures your change
in _____

Are you not prepared to change, somewhere in the middle or already changing?



Readiness-to-Change Ruler

One the line below, mark where you are now on this line that measures your change
in _____

Are you not prepared to change, somewhere in the middle or already changing?



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.