

This form only needs to be completed once a year per patient. If you have filled out this form for the patient being seen today in the past 12 months you do not need to complete it today.

Patient Name: _____ DOB: _____

Patient Declined: I do not wish to complete this form
 I have already completed this form for another child/family member in the past year
Name/Date of Birth for whom this form was already completed: _____

Form Completed by (please check one): Family Member (parent) Family Member (sibling)
 Family Member (extended family) Care Giver Self Significant Other Other

The Community Connect Screening Tool

At IHA, we believe that basic needs influence a patient's overall health. We would like to begin to screen patients for different types of basic needs so that we could help connect them with resources to assist them with these needs. We may not be able to connect you with assistance for some needs, but the information will help us to know where resources need to be created in our community.

We would appreciate it if you would answer the following questions. If you would prefer not to answer these questions, that is fine. Your information is kept confidential by IHA and may only be used or shared in accordance with our Notice of Privacy Practices. If you do identify a need, we will need your permission to connect you with a resource to help with this. Additionally, only one form required per household. (Please check one answer per question.)

1. Within the past 12 months we worried whether our food would run out before we got money to buy more.

Never True Sometimes True Often True

2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

Never True Sometimes True Often True

3. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

Very Hard Hard
 Somewhat Hard Not very hard

4. Are you worried that in the next 2 months you may not have stable housing?

Yes No

5. Do you have access to a variety of food including fruits and vegetables?

Yes No

6. Within the last 3 months, how many times did you visit the emergency department for your medical care? Number: _____

7. Has the lack of transportation kept you from meetings, work, or from getting things needed for daily living?

Yes No

8. Has the lack of transportation kept you from medical appointments or from getting medications?

Yes No

9. How often do you feel lonely or isolated from those around you?

Never Rarely Sometimes
 Often Always

10. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never Rarely Sometimes
 Often Always

11. Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?

Yes No N/A

12. Do you need help finding or paying for care for your loved ones? For example, childcare or elderly care for an older adult?

Yes No

13. Are you afraid that you might be hurt by violence in your neighborhood?

Yes No

14. Are you afraid that you might be hurt by violence in your apartment or home?

Yes No

15. If you checked YES to any boxes above, would you like to receive assistance with any of these needs?

Yes No

15a. Are any of your needs urgent?

For example, I don't have food tonight or I don't have a place to sleep tonight.

Yes No

Today's date: _____