



Please type or print clearly. All fields must be entered.

Submitted by: (Person filling out the form with the member)	
Name and Role:	
Agency:	
Date of Assessment:	

Client/Member Information				
Demographics:				
Name:		Preferred Name:		
Gender:		Ethnicity:		
Preferred Pronouns:		Race:		
Date of Birth:		SSN:		
Address:		Phone:		
City:		Email:		
State/Zip:				
Are you a member of a Native American Tribe?				
<input type="checkbox"/> No <input type="checkbox"/> Yes – Are you enrolled? _____ If so, what tribe? _____				
Have you been discharged from the armed forces of the United States?				
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Relationship Status:				
<input type="checkbox"/> Single		<input type="checkbox"/> Divorced		
<input type="checkbox"/> Married		<input type="checkbox"/> Widowed/Widower		
<input type="checkbox"/> Married & Separated		<input type="checkbox"/> Significant Other		
<input type="checkbox"/> Domestic Partner		<input type="checkbox"/> Other (Specify)		
List of Family members living with you:				
Name (not Applicant)	Relationship to Applicant	Social Security Number	Gender	Date of Birth



**Employment and Financial Circumstances**

- 1) Current employment Status (Check all that apply):
- |   |   |
|---|---|
| <input type="checkbox"/> Employed Part-Time                           | <input type="checkbox"/> Involved in job training |
| <input type="checkbox"/> Employed Full-Time                           | <input type="checkbox"/> Unable to work           |
| <input type="checkbox"/> Actively looking for employment              | <input type="checkbox"/> Permanently Disabled     |
| <input type="checkbox"/> Haven't been looking but interested in a job | <input type="checkbox"/> Retired                  |
|   | <input type="checkbox"/> Not employed             |

2) Complete the requested income information for all household members, regardless of age or relationship:

Source of Income	Person(s) Receiving Income	Gross Monthly Amount Received
Employment		
Unemployment		
Child Support		
Alimony		
Veterans' Benefits		
Retirement		
Worker's Compensation		
Social Security Income (SSI)		
Social Security Disability Income (SSDI)		
Private Disability Insurance		
Public Assistance		
Temporary Aid to Needy Families (TANF)		
Other Source		
No financial resources		

3) Do you or any members of your household participate in any of the following programs? Check all that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)                              | <input type="checkbox"/> TANF Childcare Services  |
| <input type="checkbox"/> Medicaid health insurance program   | <input type="checkbox"/> TANF transportation Services   |
| <input type="checkbox"/> Medicare health insurance program   | <input type="checkbox"/> Housing Subsidy (Please indicate type Ex. Section 8, Housing Choice Voucher or other:) |
| <input type="checkbox"/> State Children's health insurance program (HMK)                               | _____   |
| <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | <input type="checkbox"/> Other sources, please list:  |
| <input type="checkbox"/> Veteran's Administration (VA) Medicaid Services                               | _____   |



4) Are there other people and/or agencies/organizations or programs that are helping you now?

May we contact them?  Yes  No

5) Please list any outstanding debts and/or financial obligations (type and amount):

- |  |   |
|--|---|
| <input type="checkbox"/> Rent          | <input type="checkbox"/> IRS                                    |
| <input type="checkbox"/> Utilities     | <input type="checkbox"/> Auto Loan                              |
| <input type="checkbox"/> Phone         | <input type="checkbox"/> Student Loan                           |
| <input type="checkbox"/> Internet      | <input type="checkbox"/> Credit cards                           |
| <input type="checkbox"/> Medical       | <input type="checkbox"/> Storage                                |
| <input type="checkbox"/> Child Support | <input type="checkbox"/> Other (please specify type and amount) |
| <input type="checkbox"/> Alimony       |   |

6) What type of credit history do you have?

- Good
- Bad
- No credit history
- Don't know

7) Do you know your credit score?

8) Do you have a bank account?

- No
- Yes: Checking: \$\_\_\_\_\_ Savings: \$\_\_\_\_\_ Other: \$\_\_\_\_\_

Education:

1) What is the highest grade of school completed:

- |  |  |
|--|--|
| <input type="checkbox"/> Grade School (Kindergarten – Grade 5) | <input type="checkbox"/> Vocational training or apprenticeship |
| <input type="checkbox"/> Middle School (Grades 6-8)            | <input type="checkbox"/> Some college                          |
| <input type="checkbox"/> High School (Grades 9-12)             | <input type="checkbox"/> College graduate                      |
| <input type="checkbox"/> GED or Equivalent                     |  |

2) Are you currently in school or working on a degree or certificate?

- Yes
- No

Current Housing Situation:

1) What best describes your current housing situation?

- |  |   |
|--|---|
| <input type="checkbox"/> Homeless                            | <input type="checkbox"/> Sleeping on a friend's couch |
| <input type="checkbox"/> Very Close to Homeless              | <input type="checkbox"/> Behind on rent or utilities  |
| <input type="checkbox"/> Housed, but at risk of homelessness | <input type="checkbox"/> Stably Housed                |



2) Where did you spend the night last night?

- |  |  |
|--|--|
| <input type="checkbox"/> Emergency Shelter           | <input type="checkbox"/> Hotel or motel  |
| <input type="checkbox"/> Rental (house or apartment) | <input type="checkbox"/> A place not meant for residence (car, tent, abandoned building) |
| <input type="checkbox"/> A place I own               | <input type="checkbox"/> Other – please explain: _____                                   |
| <input type="checkbox"/> With friends or family      |  |

3) What events or circumstances led to your need to apply for tenancy support services (ex. Job loss, eviction, etc.)? Please explain:

4) If you are being evicted, do you have a written eviction notice or order to vacate?

- Yes
- No
- Not being evicted

5) Is your name on the lease agreement?

- Yes
- No
- I do not have a lease agreement

6) What is the reason for eviction:

- |   |   |
|---|---|
| <input type="checkbox"/> Behind in rent         | <input type="checkbox"/> Loss or reduction in employment  |
| <input type="checkbox"/> Behind in utilities    | <input type="checkbox"/> Involvement with law enforcement |
| <input type="checkbox"/> Facing eviction        | <input type="checkbox"/> Medical issues                   |
| <input type="checkbox"/> Landlord issues        | <input type="checkbox"/> Unforeseen expenses              |
| <input type="checkbox"/> Neighbor issues        | <input type="checkbox"/> Other                            |
| <input type="checkbox"/> Increased rental costs |   |

7) By what date must you be out?

8) What is the amount of your monthly rent?

9) How much money do you owe in arrears?

10) Do you need assistance finding a new place to live?

- Yes
- No

11) What utilities do you pay?

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> Gas      | <input type="checkbox"/> Sewer                        |
| <input type="checkbox"/> Electric | <input type="checkbox"/> Garbage                      |
| <input type="checkbox"/> Propane  | <input type="checkbox"/> Other, please explain: _____ |
| <input type="checkbox"/> Water    |   |



12) Please provide contact information for your landlord (if applicable):

Name: \_\_\_\_\_ Phone : \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

13) What other resources do you have to find a safe, appropriate place you can stay – either permanently or while you look for other housing? Please explain:

14) Would any of the following people be able to offer you housing or financial assistance to help you with housing?

- Family
- Friends
- Faith-based group
- Other groups
- There is no other help available

15) Do you have any funds, assets, property, or resources of value that could be immediately available to help you keep or get housing?

- Yes, please list them: \_\_\_\_\_
- No

16) Have you applied for other public programs, emergency financial assistance, or utility assistance?

- Yes, please indicate which programs: \_\_\_\_\_
- No

**Other Questions**

1) Have you or anyone in your household had any contact with law enforcement or have you gone to jail within the last month?

- No
- Yes – please explain:

2) Have you ever been convicted of a felony?

- No
- Yes – please explain and provide date(s):

3) Have you ever been required to register as a sex or violent offender in any jurisdiction?

- No
- Yes – please explain and provide date(s):



4) Have you or anyone in your household been to the emergency room or the hospital in the last month?

No

Yes – please explain and provide date(s):

\_\_\_\_\_

5) Have you or anyone in your household been a victim of human trafficking?

No

Yes – please explain and provide date(s):

\_\_\_\_\_

6) In the last 30 days, have you resided in an inpatient psychiatric facility, congregate care setting, or institutional setting?

No

Yes – please explain and provide date(s):

\_\_\_\_\_

### Services and Supports Needed

Administer the CMS social determinants of health (SDOH) screen tool below called, "CMS AHC Health-Related Social Needs (HRSN) Screening.

This will be used to identify other services and supports that might be needed by an applicant.

## The Accountable Health Communities Health-Related Social Needs Screening Tool

### What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.<sup>1</sup> We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

### Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

### What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.



### What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper,<sup>2</sup> we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs
- Interpersonal safety

In the final version below, we made small revisions to the original 10 questions based on cognitive testing we did since we shared the first version. In the final version we also included questions in 8 supplemental domains that we haven't shared before:

- Financial strain
- Employment
- Family and community support
- Education
- Physical activity
- Substance use
- Mental health
- Disabilities

<sup>1</sup> United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. <https://innovation.cms.gov/initiatives/ahcm>.

<sup>2</sup> Billieux, A., MD, DPhil, Verlander, K., MPH, Anthony, S., DrPH, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National Academy of Medicine Perspectives, 1-9. <https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf>.

### Who should use the AHC HRSN Screening Tool?

The questions in the AHC HRSN Screening Tool are meant to be used for individual respondents who answer the questions themselves. A parent or caregiver can answer for an individual, too, if that makes more sense. Clinicians and their staff can easily use this short tool as part of their busy clinical workflows with people of all different ages, backgrounds, and settings.

In the next 5 years, hundreds of participating clinical delivery sites across the 32 AHCs will screen over 7 million Medicare and Medicaid beneficiaries using the 10 core domain questions. The AHCs can also choose to add any of the supplemental domain questions into their standard screening processes.

### Who made the AHC HRSN Screening Tool?

We made this tool with a panel of experts from around the country including:

- Tool developers
- Public health and clinical researchers
- Clinicians
- Population health and health systems executives
- Community-based organization leaders
- Federal partners

We got permission from the original authors of the questions to use, copy, modify, publish, and distribute the questions for the AHC Model and our use only. Based on feedback from the original question authors, CMS has created [this table](#) to specify the citation and notification process for each screening question in the AHC HRSN Screening Tool if the questions are used outside of CMS and the AHC Model.



## AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

### Living Situation

1) What is your living situation today?<sup>3</sup>

- I have a steady place to live
- I have a place to live today, but I **am worried** about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2) Think about the place you live. Do you have problems with any of the following?<sup>4</sup>

CHOOSE ALL THAT APPLY

- Pests such as bugs, ants, or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above

### Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.<sup>5</sup>

<sup>3</sup> National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. <http://www.nachc.org/research-and-data/prapare/>

<sup>4</sup> Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. *Journal of Healthcare for the Poor and Underserved*, 26(2), 321-327.

<sup>5</sup> Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. *Pediatrics*, 126(1), 26-32. doi:10.1542/peds.2009-314

3) Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true
- Sometimes true
- Never true

4) Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- Often true
- Sometimes true
- Never true

### Transportation

5) In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?<sup>6</sup>

- Yes
- No



### Utilities

6) In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?<sup>7</sup>

- Yes
- No
- Already shut off

### Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions. <sup>8</sup>

7) How often does anyone, including family and friends, physically hurt you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

8) How often does anyone, including family and friends, insult or talk down to you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

9) How often does anyone, including family and friends, threaten you with harm?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

<sup>6</sup> National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. <http://www.nachc.org/research-and-data/prapare/>

<sup>7</sup> Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M. M., Chilton, M., . . . Cutts, D. B. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. *Pediatrics*, 122(4), 867-875. doi:10.1542/peds.2008-0286

<sup>8</sup> Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. *Family Medicine*, 30(7), 508-512

10) How often does anyone, including family and friends, scream or curse at you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

A score of 11 or more when the numerical values for answers to questions 7-10 are added shows that the person might not be safe.



## AHC HRSN Screening Tool Supplemental Questions

### Financial Strain

11) How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is:<sup>9</sup>

- Very hard
- Somewhat hard
- Not hard at all

### Employment

12) Do you want help finding or keeping work or a job?<sup>10</sup>

- Yes, help finding work
- Yes, help keeping work
- I do not need or want help

### Family and Community Support

13) If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?<sup>11</sup>

- I don't need any help
- I get all the help I need
- I could use a little more help
- I need a lot more help

14) How often do you feel lonely or isolated from those around you?<sup>12</sup>

- Never
- Rarely
- Sometimes
- Often
- Always

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9. Hall, M. H., Matthews, K. A., Kravitz, H. M., Gold, E. B., Buysse, D. J., Bromberger, J. T., . . . Sowers, M. (2009). Race and Financial Strain are Independent Correlates of Sleep in Midlife Women: The SWAN Sleep Study. *Sleep*, 32(1), 73-82. doi:10.5665/sleep/32.1.73

10. Identifying and Recommending Screening Questions for the Accountable Health Communities Model (2016, July) Technical Expert Panel discussion conducted at the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Baltimore, MD.

11. Kaiser Permanente. (2012, June). Medicare Total Health Assessment Questionnaire. Retrieved from [https://mydoctor.kaiserpermanente.org/ncal/Images/Medicare%20Total%20Health%20Assessment%20Questionnaire\\_tcm75-487922.pdf](https://mydoctor.kaiserpermanente.org/ncal/Images/Medicare%20Total%20Health%20Assessment%20Questionnaire_tcm75-487922.pdf)

12. Anderson, G. Oscar and Colette E. Thayer. Loneliness and Social Connections: A National Survey of Adults 45 and Older. Washington, DC: AARP Research, September 2018. <https://doi.org/10.26419/res.00246.001>

### Education

15) Do you speak a language other than English at home?<sup>13</sup>

- Yes
- No



16) Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.<sup>14</sup>

- Yes  
 No

### Physical Activity

17) In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?<sup>15</sup>

- 0  
 1  
 2  
 3  
 4  
 5  
 6  
 7

18) On average, how many minutes did you usually spend exercising at this level on one of those days?<sup>16</sup>

- 0  
 10  
 20  
 30  
 40  
 50  
 60  
 90  
 120  
 150 or greater

Follow these 2 steps to decide if the person has a physical activity need:

1. Calculate ["number of days" selected] x ["number of minutes" selected] = [number of minutes of exercise per week]
2. Apply the right age threshold:
  - Under 6 years old: You can't find the physical activity need for people under 6.
  - Age 6 to 17: Less than an average of 60 minutes a day shows an HRSN.
  - Age 18 or older: Less than 150 minutes a week shows an HRSN.

<sup>13</sup> United States, US Census Bureau. (2017). American Community Survey. Retrieved from <https://www.census.gov/programs-surveys/acs/>

<sup>14</sup> Identifying and Recommending Screening Questions for the Accountable Health Communities Model (2016, July) Technical Expert Panel discussion conducted at the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Baltimore, MD.

<sup>15</sup> Coleman, K. J., Ngor, E., Reynolds, K., Quinn, V. P., Koebnick, C., Young, D. R., . . . Sallis, R. E. (2012). Initial Validation of an Exercise "Vital Sign" in Electronic Medical Records. *Medicine and Science in Sport and Exercise*, 44(11), 2071-2076. doi:10.1249/MSS.0b013e3182630ec1

<sup>16</sup> Ibi



## Substance Use

The next questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances are prescribed by a doctor (like pain medications), but only count those if you have taken them for reasons or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask in order to identify community services that may be available to help you.<sup>17</sup>

19) How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

20) How many times in the past 12 months have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarettes)?

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

21) How many times in the past year have you used prescription drugs for non-medical reasons?

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

22) How many times in the past year have you used illegal drugs and/or marijuana?

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

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<sup>17</sup> United States, U.S. Department of Health and Human Services, National Institutes of Health. (n.d.). Helping Patients Who Drink Too Much: A Clinician's Guide (2005 ed., pp. 1-34).

## Mental Health

23) Over the past 2 weeks, how often have you been bothered by any of the following problems?<sup>18</sup>

a) Little interest or pleasure in doing things?

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)

b) Feeling down, depressed, or hopeless?

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)



If you get 3 or more when you add the answers to questions 23a and 23b the person may have a mental health need.

24) Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?<sup>19</sup>

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

State specific questions

In the past 30 days have you often experienced one or more of the following symptoms:

- Yes    No   Had feelings (negative, sad, angry, etc.) that kept you from caring about your personal hygiene, your living space, or taking care important personal business like paying bills or and reading mail?
- Yes    No   Had the feeling you are seeing things others do not see or that other people could hear your thoughts?
- Yes    No   Had been having a very strong need to complete certain behaviors or had been having repeated negative thoughts?
- Yes    No   Consistently felt detached or distant from others or yourself or your surroundings.
- Yes    No   Had feelings (negative, sad, angry, etc.) that made it difficult to get along with others (e.g., friends, family, strangers, etc.).

Disabilities

25. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?<sup>20</sup> (5 years old or older)

- Yes
- No

26. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?<sup>21</sup> (15 years old or older)

- Yes
- No

<sup>18</sup> Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. *Medical Care*, 41(11), 1284-1292.

<sup>19</sup> Elo, A.L., Leppänen, A., & Jahkola, A. (2003). Validity of a Single-Item Measure of Stress Symptoms. *Scandinavian Journal of Work*, 29(6), 444-451.

<sup>20</sup> United States, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (n.d.). Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status. Retrieved from <https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status>

<sup>21</sup> Ibid.



Notes

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Signatures

Completed by:  
Tenancy Support Specialist: \_\_\_\_\_

Agency: \_\_\_\_\_

Date: \_\_\_\_\_

Applicant: \_\_\_\_\_

Date: \_\_\_\_\_