SSVF Health Care Navigator
Screening Tool

Client Name:	
Date of Birth:	
Client ID:	

Staff Name:	
Date of Assessment:	
Referral to HCN:	☐Yes ☐No

1. **Client Information (Check Box)**
   a. Self-identified gender (check box)
      - ☐ Male
      - ☐ Female
      - ☐ Non-binary
      - ☐ MTF
      - ☐ FTM
      - ☐ Other_____

   b. Race/Ethnicity (check box)
      - ☐ Black/African American
      - ☐ White
      - ☐ Native American/Alaskan Native
      - ☐ Asian Pacific Islander
      - ☐ LatinX
      - ☐ Mixed race

   c. Primary language _____
   d. Secondary language _____
   e. Highest education level received (check box)
      - ☐ Did not graduate high school
      - ☐ High School/GED
      - ☐ College degree
      - ☐ Graduate School

   f. Current employment status (check box)
      - ☐ Employed
      - ☐ Unemployed

   g. Household Income (check box)
      - ☐ $0-$10,000 annually
      - ☐ $10,000-$20,000 annually
      - ☐ $40,000-$50,000 annually
      - ☐ >$50,000 annually

   h. Source of income_____
   i. Number in household _____

2. **Healthcare Information**

   Primary Care Physician (name) _____

   Last appointment (date) _____

   Specialists

   Specialty, Name, Date of Last appointment:

   _____

   _____

   _____

   VA benefits enrollment ☐Yes ☐No ☐Not Eligible

   Secondary insurance information ☐Yes ☐No

   Secondary insurance provider _____

   Dental insurance

   Dental insurance provider _____

   Medicare ☐Yes ☐No ☐Not Eligible

   Medicaid ☐Yes ☐No ☐Not Eligible

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3. Health Triage

a. In general, would you say your health is:

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

b. In general, do you have all the resources you need to address your health needs? ☐Yes ☐No

c. The following questions are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

i. **Moderate activities**, such as moving a table?

☐ No, not limited at all
☐ Yes, limited a little
☐ Yes, limited a lot

ii. Climbing **several** flights of stairs?

☐ No, not limited at all
☐ Yes, limited a little
☐ Yes, limited a lot

d. <u>During the past month,</u> have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

i. Accomplished **less** than you would like:

☐ No, none of the time
☐ Yes, some of the time
☐ Yes, most of the time

ii. Were limited in the **kind** of work or other activities:

☐ No, none of the time
☐ Yes, some of the time
☐ Yes, most of the time

e. <u>During the past month</u>, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

i. **Accomplished less** than you would like.

☐ No, none of the time
☐ Yes, some of the time
☐ Yes, most of the time

ii. Didn't do work or other activities as **carefully** as usual.

☐ No, none of the time
☐ Yes, some of the time
☐ Yes, most of the time

f. During the past month, how much did **pain** interfere with your normal life?
- ☐ Not at all
- ☐ Moderately
- ☐ Extremely

These questions are about how you feel and how things have been with you during the past month. For each question, please give the one answer that comes closest to the way you have been feeling.

g. How much of the time during the past month:

i. Have you felt calm and peaceful? :
- ☐ All of the time
- ☐ Some of the time
- ☐ None of the time

ii. Did you have a lot of energy?
- ☐ All of the time
- ☐ Some of the time
- ☐ None of the time

iii. Have you felt downhearted and blue?
- ☐ All of the time
- ☐ Some of the time
- ☐ None of the time

iv. Have you thought about hurting yourself?
- ☐ All of the time
- ☐ Some of the time
- ☐ None of the time

h. During the past month, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?
- ☐ All of the time
- ☐ Some of the time
- ☐ None of the time

Now, we'd like to ask you some questions about how your health may have changed.

i. Compared to one year ago, how would you rate your **physical health** in general now?
- ☐ Much better
- ☐ About the same
- ☐ Much worse

j. Compared to one year ago, how would you rate your **emotional problems** (such as feeling anxious, depressed or irritable) **now?**
- ☐ Much better
- ☐ About the same
- ☐ Much worse

4. Do you have any health questions or concerns that you need support in addressing at this time?

_____

5. Do you have health goals for yourself that you need support in addressing? _____

_____

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_____	_____	_____	_____
Client Signature	**Date**	**Staff Signature**	**Date**