L.A. Care HEALTH PLAN®

Community Health Worker Benefit Assessment Form

Member Information

Member's First Name: _____ Member's Last Name: _____

Gender: ☐ M ☐ F Other _____ D.O.B.: M M / D D / Y Y Y Y Age: ___

Preferred Language: _____ LOB: ☐ MCLA ☐ DSNP

Address: _____ City: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

What is the best time to contact you? ☐ Morning ☐ Afternoon ☐ Evening

What is your employment situation? ☐ **Part-time/temporary** ☐ **Full-time work** ☐ **Unemployed**
☐ **Otherwise unemployed but not seeking work (ex. student, retiried, disabled, unpaid primary caregiver)** ☐ **I choose not to answer**

What is the highest level of school that you have finished? ☐ **Less than high school degree**
☐ **High school diploma or GED** ☐ **More than high school degree** ☐ **I choose not to answer**

Military Status: ☐ **Never Served** ☐ **Veteran** ☐ **Spouse of a Veteran**

Are you a refugee? ☐ **Yes** ☐ **No** ☐ **Decline to state**

At any point in the last 2 years, has seasonal or migrant farmwork been you or your family's main source of income?
☐ **Yes** ☐ **No** ☐ **I choose not to answer**

Total Income: $ ___,___

Type of Income: _____

Is Your Income Reliable? ☐ Yes ☐ No

Where do you live? (Check all that apply) ☐ House/Apartment ☐ Couch surfing ☐ Board and care facility
☐ Residential treatment center ☐ Permanent supportive housing ☐ Protective housing ☐ Homeless
☐ Other (please specify) _____ ☐ I choose not to respond

If you are homeless, where are you staying (transitional housing, in a motel, shelter, with friends)? _____

If you are living with others, who lives with you? _____

Are you worried about losing your housing/shelter (i.e. pending eviction, being asked to leave, unable to pay)?
☐ Yes ☐ No

If yes, describe concerns:

_____

_____

How often do you see or talk to people that you care about and feel close to (ex. talking to friends on the phone, visiting friends or family, going to church or club meetings)?

☐ **Less than once a week** ☐ **1-2 times per week** ☐ **3-5 times per week**
☐ **More than 5 times per week** ☐ **I choose not to answer this question**

L.A. Care HEALTH PLAN®

Community Health Worker Benefit Assessment Form

Medical Needs *(Including Health Navigation and Health Education Needs)*

Do you have any new or current diagnosis you would like help for?

Diagnosis	How long have you had this diagnosis?	What do you need the most help with to understand your diagnosis?

Stress is when someone feels tense, nervous, anxious or can't sleep at night because their mind is troubled. How stressed are you? ☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much ☐ I choose not to answer this question

Have you recently been told that you are at increased risk of a chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels, etc.) that could lead to a diagnosis?

Condition	What are your biggest risk factors?

Tell us about your providers:

Name of Provider	Type of Provider	Last Appointment	Do you have any upcoming appointments?	What are some challenges you have that have made you miss your appointments?

Do you sometimes have difficulty scheduling appointments or understanding your medical coverage? ☐ Yes ☐ No

If so, explain: _____

Have you received the following preventive medical services in the last 12 months? If not, why?

Type of Service	Yes/No	I would like help scheduling this appointment?	Are there any barriers that will stop you from attending this appointment?
Annual Check-up			
Dental			
Optometry			
Vaccine Updates			
Lab Work			

Do you engage in any of the following?

Substance	Have you received treatment for this?	If yes, when and where?	Do you want more information about how to stop?	Do you want more information about enrolling into a program?
Tobacco Use				
Alcohol Use				
Recreational Drug Use				
Prescription Drug Misuse				

Has lack of transportation kept you from your medical appointments, meetings, work, or from getting things needed for daily living? ☐ Yes ☐ No ☐ I choose not to answer

In the past year, have you or your family members you live with been unable to get any of the following when it was really needed? ☐ Food ☐ Clothing ☐ Utilities ☐ Childcare ☐ Medicine or any health care (medical, dental, mental health, vision) ☐ Phone ☐ Other (please specify) _____ ☐ I choose not to answer

SDOH Needs

Do you need help with any of the following?

Need	Yes/No	Comments from member	CHW's plan
Food			
Transportation			
Utility Assistance			
Low Cost Internet/Phone			
Employment			
Applying for Government Benefits			
Caregiving Services			
Essential Baby (formula/diapers)			
Legal (e.g. housing rights, immigration assistance, etc.)			
Clothing			
Other:			

Social Support:

Name of Agency	Are you receiving Case Management? Y/N	Type of Services you are receiving	Social Worker/Case Management Name	Contact Information	May we contact your SW/CM?

Current community resources: _____

What is something you are good at or really proud of?

_____

Do you need legal/advocacy assistance for any of the following categories?

Type	Yes/No	Comments
Housing Rights/Eviction		
Benefits Assistance		
Traffic Tickets		
Immigration Services		
Domestic Violence		
CPS/Custody Issues		
Other:		

Summary of needs and interventions *(Notes should be written in GIP format and should include frequency and duration and should list specific services required for meeting the written objectives)*:

LA4944 08/23