

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



**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: \_\_\_\_\_

**IHA Medical Group**

**Form Completed by (please check one):**

- ☐ Family Member (parent)
- ☐ Family Member (sibling)
- ☐ Family Member (extended family)
- ☐ Care Giver
- ☐ Self
- ☐ Significant Other
- ☐ Other

**\* 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.**

**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. For some needs, we may not be able to connect you with resources to assist you with them, but we would like to identify community needs that we need to create resources to address as well.

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 circle 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. I can get 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 need help finding or paying for care for your love ones? For example, childcare or elderly care for an older adult?  
Yes      No
12. 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
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