Opioid Health Home Needs Assessment

Customer Name: **Customer Number**:

Phone Number: **Email Address**:

Provider: **Date Completed**:

Substance Use:

1. Current substance use: ☐Yes ☐No
    a. Name of Substance:
        i. Frequency of Use: Daily
    b. Name of Substance:
        i. Frequency of Use: 1-2 days in the past week
    c. Name of Substance:
        i. Frequency of Use: No use in the past month
2. Medication Assisted Treatment: ☐Yes ☐No
    a. Type of Medication: Other
    b. Prescribing agency:
    c. Any issues/concerns:
3. History of overdose: ☐Yes ☐No
    a. Most recent:
    b. Does customer have access to Naloxone? ☐Yes ☐No
        i. If no, resources provided:
4. Current support group attendance: ☐Yes ☐No
    a. If no, is customer interested: ☐Yes ☐No
        i. If yes, information provided:
5. Current tobacco use: ☐Yes ☐No
    a. If yes, is customer interested in information about cessation: ☐Yes ☐No
        i. If yes, information provided:

Address Substance Use Needs on Care Plan: ☐Yes ☐No

Substance Use Needs Notes:

Physical Health:

1. Does the customer have a primary care physician: ☐Yes ☐No
    a. If yes, name of physician:
        i. Date of last appointment:
    b. If no, referral needed: ☐Yes ☐No
        i. If yes, referred to:
2. Current health conditions:

3. Current medications:
4. Is the customer currently pregnant: ☐Yes ☐No ☐N/A
    a. If yes, is the customer under care of an OBGYN: ☐Yes ☐No
        i. If yes, name of OBGYN:
            1. Date of last appointment:
        ii. If no, referral needed:
5. Does the customer have a vision provider: ☐Yes ☐No
    a. If yes, name of provider:
        i. Date of last appointment:
    b. If no, referral needed:
6. Does the customer have a dental provider? ☐Yes ☐No
    a. If yes, name of provider:
        i. Date of last appointment:
    b. If no, referral needed:
7. Does the customer need their hearing checked: ☐Yes ☐No
    a. If yes, referral needed:
8. Are there STI or communicable disease testing needs: ☐Yes ☐No
    a. If yes, referral needed:
9. Does the customer exercise or participate in any physical activity:
10. Does the customer have any physical disabilities impacting daily living: ☐Yes ☐No
    a. If yes, what:
11. Does the customer have support services for their physical disability: ☐Yes ☐No
    a. If yes, what:

Address Physical Health Needs on Care Plan: ☐Yes ☐No

Physical Health Needs notes:

Mental Health:

1. Does the customer indicate any mental health concerns: ☐Yes ☐No
    a. If yes, does the customer have a mental health provider: ☐Yes ☐No
        i. If yes, name of provider:
            1. Date of last appointment:
            2. Services received:
        ii. If no, referral needed:
2. Does the customer have trauma impacting their recovery: ☐Yes ☐No
    a. If yes, is customer's trauma being adequately treated in current services: ☐Yes ☐No
        i. If no, referral needed:
3. Does the customer have a history of suicidal ideation, self-injurious behavior, and/or suicide attempts: ☐Yes ☐No
    a. If yes, any current risk:
        i. If yes, information provided:
4. Does the customer have a personal safety plan: ☐Yes ☐No

a. If no, is customer interested in creating one: ☐Yes ☐No
    i. If yes, information provided:
5. Does the customer know how to access after-hour crisis resources: ☐Yes ☐No
    a. If no, information provided:

Address Mental Health Needs on Care Plan: ☐Yes ☐No

Mental Health Needs notes:

Daily Living – Housing:

1. Does the customer have stable living arrangements: ☐Yes ☐No
    a. Current living arrangements: Independent (alone, roommate, friend's house, etc)
2. Does the customer need emergency shelter: ☐Yes ☐No
    a. If yes, referral provided:
3. Does the customer need help in locating/maintaining affordable housing: ☐Yes ☐No
    a. If yes, referral provided:

Address Daily Living – Housing Needs on Care Plan: ☐Yes ☐No

Housing Needs notes:

Daily Living – Transportation:

1. Does the customer have reliable transportation: ☐Yes ☐No
    a. If yes, type: Utilizes medical transportation
2. Are there barriers to transportation that need to be addressed: ☐Yes ☐No
    a. If yes, what:
3. Does the customer have a valid driver's license/Michigan ID: ☐Yes ☐No
    a. If no, referral needed:
4. Are there any other vital records needed (SS care, birth certificate, etc): ☐Yes ☐No
    a. If yes, what:

Address Daily Living – Transportation Needs on Care Plan: ☐Yes ☐No

Transportation Needs notes:

Daily Living – Food:

1. Does the customer need support meeting basic nutritional needs for self/family: ☐Yes ☐No
    a. If yes, referral needed:
2. Does the customer receive assistance from MDHHS: ☐Yes ☐No
    a. If yes, what type: Food
    b. If no, does customer need help applying: ☐Yes ☐No

Address Daily Living – Food Needs on Care Plan: ☐Yes ☐No

Food Needs notes:

Daily Living – Utilities:

1. Are there utility needs (heat, water, etc): ☐Yes ☐No
    a. If yes, referral needed:

Address Daily Living - Utilities Needs on Care Plan: ☐Yes ☐No

Utilities Needs notes:

Daily Living – Budget/Finance:

1. Does the customer need budget/credit counseling services: ☐Yes ☐No
    a. If yes, referral needed:

Address Daily Living – Budget/Finance Needs on Care Plan: ☐Yes ☐No

Budget/Finance Needs notes:

Family/Relationships:

1. Is the customer's significant other/family supportive of their treatment: ☐Yes ☐No
2. Are there any relationships which are negatively impacting the customer: ☐Yes ☐No
    a. If yes, explain:
3. Are there any safety concerns at home, such as domestic violence, abuse, etc.: ☐Yes ☐No
    a. If yes, explain:
4. Does the customer have any minor children: ☐Yes ☐No
    a. Does the customer need help with childcare: ☐Yes ☐No
        i. If yes, referral needed:
    b. Does the customer need a pediatric referral: ☐Yes ☐No
        i. If yes, referral needed:
    c. Does the customer wish to explore parenting skills: ☐Yes ☐No
        i. If yes, referral needed:

Address Family/Relationship Needs on Care Plan: ☐Yes ☐No

Family/Relationship Needs notes:

Education/Vocation:

1. Is the customer on disability: ☐Yes ☐No
    a. If no, does customer need assistance with applying: ☐Yes ☐No
2. Is the customer employed: ☐Yes ☐No
    a. If yes: Part-Time
    b. If no, does customer need assistance obtaining employment: ☐Yes ☐No
        i. If yes, referral needed:
3. Did the customer graduate high school/GED: ☐Yes ☐No
    a. If no, interested in completing: ☐Yes ☐No
        i. If yes, referral needed:

4. Does the customer have any literacy needs (difficulty reading, IEP in school, special education, etc): ☐Yes ☐No

Address Education/Vocation Needs on Care Plan: ☐Yes ☐No

Education/Vocation Needs notes:

Legal:

1. Is the customer experiencing legal problems: ☐Yes ☐No
    a. If yes, is the customer: Involved with any specialty court
2. Is Child Protective Services or foster care currently involved: ☐Yes ☐No
    a. If yes, name of CPS/FC worker:

Address Legal Needs on Care Plan: ☐Yes ☐No

Legal Needs notes:

Needs identified to be addressed on Care Plan:

☐ Substance Use

☐ Physical Health

☐ Mental Health

☐ Housing

☐ Transportation

☐ Food

☐ Utilities

☐ Budget/Finance

☐ Family/Relationships

☐ Education/Vocation

☐ Legal

Completed by: Date: