

Opioid Health Home Needs Assessment

Customer Name:

Customer Number:

Phone Number:

Email Address:

Medical Health:

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Any medical issues that need follow-up? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Is the customer pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Is the customer experiencing pain? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Is the customer prescribed any medication? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Does the customer need a referral to a dentist? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Does the customer need a referral for an eye exam? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Would the customer benefit from getting his/her hearing checked? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Does the customer exercise or participate in any physical activity? |
-

Medical health needs identified:

Mental Health:

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Is the customer currently receiving mental health treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Has the customer previously received any mental health treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Is the customer aware of receiving a mental health diagnosis? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Does the customer indicate any mental health concerns? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Does the customer need a referral for a mental health assessment? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Has the customer experienced or witnessed any trauma in the past or currently? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Does the customer have or need a personal safety plan? |
-

Mental Health needs identified:

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Activities of Daily Living:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Does the customer need emergency shelter? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Does the customer need help in locating and/or maintaining affordable and suitable housing? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Does the customer live alone? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Does the customer have transportation needs? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Does the customer have any physical disabilities impacting daily living? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Does the customer have support services for his/her physical disability? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Does the customer need support meeting basic nutritional needs for self and/or children? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Does the customer need budget and/or credit counseling services? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Does the customer have any cultural issues, including language which impact daily living? |
-

Activities of daily living needs identified:

Family/Relationships:

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Is the customer's significant others supportive of customer's treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Does the customer have any children? |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Does the customer need help finding childcare? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Does the customer need a pediatric referral? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Is there Department of Human Services (FIA) involvement? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Is there Child Protective Services (CPS) involvement? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Are any minor children living in foster care? |
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Family/relationship needs identified:

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Educational/Vocational:

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Is the customer employed or on disability? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Does the customer need assistance obtaining a job? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Is the customer in school or interested in returning? |
-

Educational/vocational needs identified:

Legal Issues:

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Is the customer on probation, parole, or awaiting court proceedings? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Is the customer involved with Drug Treatment Court? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Are there any other legal or civil concerns? |
-

Legal needs identified:

Identify which needs the customer would like to address at this time and incorporate into the care plan.

Completed by: _____

Date Completed: _____