SOCIAL NEEDS SCREENING TOOL

Name: _____ Phone Number: _____

Please Print

Best time to call: _____

	In the last 12 months, **did you ever eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has the **gas, electric, or water company threatened to shut off services** in your home?	Y N
	Are you worried that in the next 2 months, **you may not have stable housing**?	Y N
	In the last 12 months, have you needed to see a doctor **but could not because of cost**?	Y N
	In the last 12 months, has **lack of transportation** kept you from medical appointments, work, or getting things done for daily living?	Y N
	Do you ever need help **reading materials at the doctor's office**?	Y N
	Do you often feel that **you lack companionship**?	Y N
	Do you have any other non-medical needs that need addressed? If so, please explain: _____	Y N
	**Are any of your needs urgent?** For example: I don't have food or I don't have a safe place to sleep.	Y N
	If you checked YES to any of the boxes above, **would you like to receive assistance** with any of these needs?	Y N

By signing below, you are confirming that you consent to have the information on this form shared with the Community Health Worker at the Heritage Community Clinic.

_____ _____

Signature Date

For clinic use only

Clinic Type/Date:_____ Referral made by:_____

Screening tool adapted from the *Health Leads* Social Needs Screening Toolkit and graphic design elements from freepik.com