Behavioral Health

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Reset

Substance Use Disorder – Care Coordination Needs Determination Screening Tool

☐ **Appointment** ☐ **Phone Screening**

1. Presenting Problem(s) /Immediate Needs	
Do you or any of your family members need help with any urgent or pressing problem right now?	☑ Yes ☐ No
Notes:	

2. Other Care Coordination Providers	
Are you working with any other agencies?	☐ Yes ☐ No
If yes, what is the agency?	
What services do they provide?	
Are you working with a care coordinator or receiving Care Coordination services?	☐ Yes ☐ No
If yes, where and with whom are you receiving Care Coordination services?	
Are these services meeting your needs?	☐ Yes ☐ No
Notes:	

3. Fluency in English and Ease in Navigating Care Systems	
Do you have any difficulty understanding English?	☐ Yes ☐ No
Filling out forms in English?	☐ Yes ☐ No
Do you find it easier to talk to people with someone translating for you?	☐ Yes ☐ No
Do you have any trouble making your own appointment, understanding medical instruction, getting what you need from a medical or social services agency?	☐ Yes ☐ No
Notes:	

Client Name:
DOB:
Phone Number:
Client ID #:

4. Immigration Status	
Are you a US Citizen or documented resident?	☐ Yes ☐ No
If not, do you need help with immigration issues?	☐ Yes ☐ No
Notes:	

5. Housing	
Do you have problems with your current housing?	☐ Yes ☐ No
Is your housing safe and stable?	☐ Yes ☐ No
Is your housing in good repair, with adequate furniture and working appliances?	☐ Yes ☐ No
Do you have a working phone?	☐ Yes ☐ No
Do you receive rental assistance?	☐ Yes ☐ No
Do you need assistance paying rent?	☐ Yes ☐ No
Notes:	

6. Support System	
Do your children, partner(s), or other close supports have needs that affect your ability to sustain your recovery?	☐ Yes ☐ No
Do you have a steady source of emotional support from family and friends?	☐ Yes ☐ No
Notes:	

7. Medical Insurance/Medi-Cal	
Do you have medical insurance?	☐ Yes ☐ No
Do you have Medi-Cal?	☐ Yes ☐ No
Do you need help getting your medical care?	☐ Yes ☐ No
Do you need help paying for prescriptions?	☐ Yes ☐ No
Are there any problems, limitations, or restrictions with your medical coverage?	☐ Yes ☐ No

Client Name:
DOB:
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7. Medical Insurance/Medi-Cal (Continued)
Notes:

8. Medical/Dental Needs	
How is your health right now?	
Are you currently experiencing any symptoms or disabilities?	☐ Yes ☐ No
Do you have any illnesses?	☐ Yes ☐ No
Have you recently seen your medical provider?	☐ Yes ☐ No
If no, when was the last time you saw your medical provider?	
Have you recently seen your dental provider?	☐ Yes ☐ No
If no, when was the last time you saw your dental provider?	
Do you need any help getting your prescriptions filled and taking your medications?	☐ Yes ☐ No
Notes:	

9. Finances	
Do you have a steady source of income right now?	☐ Yes ☐ No
Does your income meet your basic expenses?	☐ Yes ☐ No
Do you have any serious outstanding bills?	☐ Yes ☐ No
Do you need any help applying for or keeping benefits?	☐ Yes ☐ No
Do you have a bank account?	☐ Yes ☐ No
Notes:	

10. Incarceration	
Are you on parole or probation?	☐ Yes ☐ No
Are you serving any type of sentence currently (i.e., community service hours)?	☐ Yes ☐ No

Client Name:
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10. Incarceration (Continued)	
Any outstanding warrants, summonses, cases pending?	☐ Yes ☐ No
Notes:	

11. Mental Health	
Have you ever seen a mental health counselor?	☐ Yes ☐ No
Have you ever received psychiatric care?	☐ Yes ☐ No
Are you currently seeing a mental health counselor?	☐ Yes ☐ No
Are you currently prescribed medications for depression or other mental health concerns?	☐ Yes ☐ No
Who do you speak to when you feel down?	
Notes:	

12. Safety Issues	
Do you ever feel unsafe in your current living situation?	☐ Yes ☐ No
Do you ever feel you or a family member/partner would resort to force when interacting?	☐ Yes ☐ No
In the past, have you ever been involved in a violent relationship?	☐ Yes ☐ No
Notes:	

13. Substance Use	
Are you enrolled in a treatment program?	☐ Yes ☐ No
If yes, do you ever think about quitting your program or not going for the day?	☐ Yes ☐ No
If yes, who do you talk to when you feel this way?	
Do you consider yourself in recovery?	☐ Yes ☐ No
Do you attend self-help groups?	☐ Yes ☐ No
Do you have a sponsor?	☐ Yes ☐ No

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13. Substance Use (Continued)
Notes:

14. Healthy Habits	
Do you need information about how to keep yourself healthy?	☐ Yes ☐ No
Do you need information on healthy eating habits?	☐ Yes ☐ No
Do you have a regular source of healthy foods?	☐ Yes ☐ No
Do you exercise or feel you get enough exercise?	☐ Yes ☐ No
Notes:	

15. Supportive Services	
Do you have food or enough food?	☐ Yes ☐ No
Do you need help obtaining groceries or meals?	☐ Yes ☐ No
Do you have enough clothing to keep you comfortable and protected?	☐ Yes ☐ No
Do you have your Driver's License, Social Security Card and Birth Certificate?	☐ Yes ☐ No
Do you have your own transportation?	☐ Yes ☐ No
Do you have access to and can use public transportation?	☐ Yes ☐ No
Do you need a referral for legal help?	☐ Yes ☐ No
Do you need help with paying utility bills?	☐ Yes ☐ No
Do you need a referral for credit counseling services?	☐ Yes ☐ No
Do you need help with budgeting?	☐ Yes ☐ No
Do you have an open Children and Family Services (CFS) case?	☐ Yes ☐ No
Are you an active member of the military or a veteran?	☐ Yes ☐ No
Notes:	

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16. Employment	
Are you currently employed?	☐ Yes ☐ No
If yes, where?	
If yes, what do you do in your job?	
If no, when did you last work?	
Do you know how to use a computer?	☐ Yes ☐ No
Do you need help completing a resume?	☐ Yes ☐ No
Do you need help in filling out a job application?	☐ Yes ☐ No
Notes:	

17. Education	
Do you have a high school diploma or GED?	☐ Yes ☐ No
If no, what is the highest grade you completed?	☐ 1st-6th grade ☐ 7th–8th grade ☐ 9 ☐ 10 ☐ 11 ☐ 12
Have you attended college?	☐ Yes ☐ No
If yes, please indicate:	☐ Some College – did not receive a degree ☐ AA/AS ☐ BA/BS ☐ MA/MS or Higher
Did you attend a vocational education program?	☐ Yes ☐ No
If yes, did you complete the program?	☐ Yes ☐ No
If yes, what type of vocational education program did you attend?	
Notes:	

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---SUD Administration Use Only---

DISPOSITION

Care Coordination recommended? ***(If no, provide patient with CC brochure and inform patient that access to CC is available if a future need arises)***
☐ Yes ☐ No
Comments:

Care Coordination accepted? ***(If accepted patient will be asked to sign the Consent for Care Coordination Services)***
☐ Care Coordination Accepted ☐ Care Coordination Declined
Comments:

Patients Preferred Location/Method of Care Coordination Services?
☐ SUDRS Location:
☐ Telephone
☐ Telehealth
☐ Community Location:

If other agencies or individuals are to be contacted, has a release of information been signed? ☐ Yes ☐ No

Other Immediate Referral Made: ***(Include contact name)***	
Agency:	For:
Agency:	For:
Agency:	For:
Agency:	For:
Agency:	For:

Signature SUD Care Coordinator   Date:

Client Name:
DOB:
Phone Number:
Client ID #: