HOPE REVEALED
BEHAVIORAL HEALTH CENTER LLC
"Healing yesterday, giving hope for tomorrow"

CASE MANAGEMENT ASSESSMENT

Name: _____ Address: _____

Cell phone number: _____ Home phone number: _____

Which number would you prefer to be contacted? _____

A. Daily Structures/ Activities of Daily Living (*please circle all that apply*)

1. Current living situation: Homeless Shelter Permanent

House/Apartment Jail Residential Program Doubled Up Subsidized

Other:_____

2. Who do you live with: Alone Friends or Roommate(s) Spouse/Lover/Partner

Children Parents Relatives

Other/Specify:_____

3. Do you rent or own your home? Yes No

What is your monthly mortgage/rent? _____ Is it affordable? _____

4.Do you need financial or utility assistance? _____

5. Is your housing situation safe and stable? Yes or No

Any housing concerns or input? _____

6. Do you need assistance with transportation? Yes No

B. Nutritional Needs

1. Obtaining enough to eat? Yes No

2. Any food assistance utilized at this time? Yes No

If so, what kind? Food Stamps Food Pantry Home Delivered Congregate Food Voucher

Other: _____

Any nutritional concerns? _____

3. Do you need any assistance receiving food for you and your household? Yes No

4. Would you like information regarding wellness, recreational areas, and/or fitness facilities? Yes No

C. Daily Living/Clothing Assistance

1. Do you need help with any daily living needs? If yes, please specify:

_____

2. Do you have appropriate clothing for the season? Yes No

3. Would you like help with clothing assistance? Yes No

Any clothing concerns? _____

D. Financial/Insurance/Legal Issues (Probation, fines, etc.):

1. Monthly Income-Work: _____ Any other income? (SSI, SSDI, Unemployment, etc.)

_____

2. Total Household Income: _____

3. Are you using any financial resources? _____

If so, which ones? SSI SSDI Unemployment TANF Food Stamps Other: _____

4. Do you have medical insurance? Yes No If yes, what kind?_____

Any financial or medical concerns?_____

5. Do you have any legal issues? (Examples: arrests, incarcerations, probation, parole, fines)

Yes or No If yes, please explain: _____

_____

E. Educational/ Vocational

1. Educational &/or Vocational Training History

_____

2. Are you interested in getting more vocational or educational training? Yes No

Any educational concerns?

_____

3. Would you like us to provide you with assistance in tutoring? _____

4. Are you interested in information regarding daycares available? Yes No

5. Do you have a disability? Yes No

If yes, please explain:_____

Do you need any type of assistance? _____

6. Are you employed? Yes No

If yes, how much are you working? Full-Time Part-Time Seasonal

If no, would you like assistance in finding a job? _____

F. Social Supports/ Family/ Friends

1. Other than family, whom do you have for support?

_____

2. What does support look like to you?

_____

3. Who do you call family?

_____

G. Mental Health/Substance Abuse/Addiction Disorders

1. Do you take any medications for mental or behavioral issues? Yes No

If so, any side effects with these medications? Yes No

Please name some of your current side effects:

_____

2. Do you take your medications as prescribed? Yes No

If no, please explain why not: _____

3. Are you currently seeing a psychiatrist (Whom prescribes medication)?

Yes No If yes, please name: _____

4. Do you smoke or use other tobacco products? Yes No

If yes, are you interested in stopping? _____

5. Do you or someone else in your family feel that you have a problem with substance abuse or another addiction? Yes No

If so, would you like information or assistance for recovery:_____

6. Any mental health/substance abuse/addiction disorders concerns?

_____

H. Health/Medical:

1. Do you have a current family doctor? Yes No If yes, please name: _____

2. Do you have a current dentist? Yes No If yes, please name: _____

If no, do you need dental assistance?

_____

3. Do you see your Healthcare Providers on a regular basis? _____

4. Do you have any current health issues? Yes No If yes, please explain:

_____

5. When was your last physical/check up:

_____

Date of last Woman's Well-Check/ mammogram _____

Date of last Prostate Check_____

6. Are you or your partner pregnant? Yes No

If so, are you/they receiving prenatal care? Yes No

Do you/they need infant formula assistance or clothing assistance for the child? _____

7. Do your children need a check-up or immunizations? Yes No

8. Any health/medical concerns? _____

I. What would you like to work on?

_____

Case Manager Signature: _____ Date: _____

Consumer Signature: _____ Date: _____