Community Health Center of the North Country

Patient Name: _____

Date: _____

Date of Birth: _____

NYS Health Related Social Needs Screening Questionnaire

Housing/Utilities	
1. What is your living situation today?	☐ I have a steady place to live ☐ I have a place to live today, but I am worried about losing it in the future ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY.	☐ Pests such as bugs, ants or mice ☐ Oven or stove not working ☐ Mold ☐ Smoke detectors missing or not working ☐ Lead paint or pipes ☐ Water Leaks ☐ Lack of heat ☐ None of the Above
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	☐ Yes ☐ Already Shut Off ☐ No
Food Security	
4. Within the past 12 months, you worried that your food would run out before you got money to buy more.	☐ Often true ☐ Never true ☐ Sometimes true
5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	☐ Often true ☐ Never true ☐ Sometimes true
Transportation	
6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed tor daily living?	☐ Yes ☐ No
Employment	
7. Do you want help finding or keeping work or a job?	☐ Yes, help finding work ☐ Yes, help keeping work ☐ I do not need or want help
Education	
8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivelant?	☐ Yes ☐ No
Interpersonal Safety **Because violence and abuse happens to a lot of people and affects their health, we are asking the following questions.**	**A score of 11 or more when the numerical values for answers to the following four questions are added, shows that the person might not be safe**
9. How often does anyone, including family and friends, physically hurt you?	☐ Never (1) ☐ Fairly Often (4) ☐ Rarely (2) ☐ Frequently (5) ☐ Sometimes (3)
10. How often does anyone, including family and friends, insult or talk down to you?	☐ Never (1) ☐ Fairly Often (4) ☐ Rarely (2) ☐ Frequently (5) ☐ Sometimes (3)
11. How often does anyone, including family and friends, threaten you with harm?	☐ Never (1) ☐ Fairly Often (4) ☐ Rarely (2) ☐ Frequently (5) ☐ Sometimes (3)
12. How often does anyone, including family and friends, scream or curse at you?	☐ Never (1) ☐ Fairly Often (4) ☐ Rarely (2) ☐ Frequently (5) ☐ Sometimes (3)

Patient Signature _____ **Date/Time** _____

Clinical Staff Signature _____ **Date/Time** _____