

As part of whole person care offered at Orchid Health, we have Community Health Workers (CHWs) available to support you with connection to resources beyond the medical clinic.

Name _____ DOB _____ Today's Date _____

1. **What is something that makes you happy or that you're proud of?**

2. **Do you currently live in a shelter or have no steady place to sleep at night?**

Yes No

3. **Do you think you are at risk of becoming homeless? OR at risk of facing eviction?**

Yes No

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**

Often true Sometimes true Never true

5. **Within the past 12 months, you worried whether your food would run out before you got money to buy more.**

Often true Sometimes true Never true

6. **Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?**

Yes No

Please indicate if you have concerns about any of the following:

- | | | | |
|---|--|---|---|
|  | <input type="checkbox"/> Alcohol/Substance Use |  | <input type="checkbox"/> Health Insurance |
|  | <input type="checkbox"/> Child or Elder Care |  | <input type="checkbox"/> Pests / Mold / Air Quality |
|  | <input type="checkbox"/> Clothing |  | <input type="checkbox"/> Prescription Costs |
|  | <input type="checkbox"/> Dental Care |  | <input type="checkbox"/> Social Connection |
|  | <input type="checkbox"/> Education |  | <input type="checkbox"/> Utility Costs |
|  | <input type="checkbox"/> Employment |  | <input type="checkbox"/> Vision Care |

Would you like assistance with any of the above areas? Yes No Not Sure