



PATIENT FORM (long version)

Please answer the following.

HOUSING

1. What is your housing situation today?¹
 - I do not have housing (I am 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)
 - I have housing today, but I am worried about losing housing in the future
 - I have housing
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)¹
 - Bug infestation
 - Mold
 - Lead paint or pipes
 - Inadequate heat
 - Oven or stove not working
 - No or not working smoke detectors
 - Water leaks
 - None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.¹
 - Often true
 - Sometimes true
 - Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.¹
 - Often true
 - Sometimes true
 - Never true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)¹
 - Yes, it has kept me from medical appointments or getting medications
 - Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
 - No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?¹
 - Yes
 - No
 - Already shut off

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?
 - Yes
 - No

EMPLOYMENT

8. Do you have a job?
 - Yes
 - No

EDUCATION

9. Do you have a high school degree?
 - Yes
 - No

FINANCES

10. How often does this describe you:
I don't have enough money to pay my bills:
 - Never
 - Rarely
 - Sometimes
 - Often
 - Always



PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?¹
- Never
 - Rarely
 - Sometimes
 - Fairly often
 - Frequently
12. How often does anyone, including family, insult or talk down to you?¹
- Never
 - Rarely
 - Sometimes
 - Fairly often
 - Frequently
13. How often does anyone, including family, threaten you with harm?¹
- Never
 - Rarely
 - Sometimes
 - Fairly often
 - Frequently
14. How often does anyone, including family, scream or curse at you?¹
- Never
 - Rarely
 - Sometimes
 - Fairly often
 - Frequently

ASSISTANCE

15. Would you like help with any of these needs?
- Yes
 - No

Questions 1-10 are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

REFERENCE:

1. Billioux A, Verlander K, Anthony S, and Alley D. National Academy of Medicine. Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool. National Academies Press. Washington, D.C. <https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf>. Accessed November 14, 2017.



Social Determinants of Health Patient Action Plan

Instructions: The Patient Action Plan can be used with the American Academy of Family Physicians' (AAFP) social needs screening tool. Once you've identified the social need(s) of a patient from the screening tool, document resources and/or actions to assist with those needs.

Name: _____ Date of Birth: _____ Date: _____

Social Needs Resources and Actions

Housing | Resource and/or action:

Food | Resource and/or action:

Transportation | Resource and/or action:

Utilities | Resource and/or action:

Child care | Resource and/or action:



Employment | Resource and/or action:

Education | Resource and/or action:

Finances | Resource and/or action:

Personal Safety | Resource and/or action:

Follow-up Plan:

