Patient Name: _____ Date of Birth:_____

	Yes / No
In the past 12 months, have you had any difficulty **affording any of your basic needs**, such as food, water, electric, housing, prescriptions, medical care and medical equipment, phone service, etc.?	Y N
In the last 12 months, have you **had a support person/community resource to support you** (Spouse, Family Member, Friend, Church Member, Community Group, etc.)?	Y N
In the last 12 months, have you been able to independently **complete your activities for daily living** (ex. Cleaning, Shopping, Meal Preparation, Dressing, Bathing, Toileting, etc.)?	Y N
In the last 12 months, have you ever had to go without health care/missed an appointment because you **did not have transportation or the money to pay for transportation**?	Y N
In the last 12 months, have you had **Medical, Prescription and Dental coverage**?	Y N
In the last 12 months, have you taken all your **medications exactly as prescribed**?	Y N
In the last 12 months, did you know the reason **why you were taking the medications** that are prescribed to you?	Y N
In the last 12 months, have you **felt depressed, hopeless, anxious, nervous, etc.**?	Y N
In the last 12 months, have you had any **issues with any substances** like alcohol, illegal or prescription drugs, that have caused you or your loved ones' concern?	Y N
In the last 12 months, have you **felt safe in your home and community**?	Y N
In the last 12 months, have you ever **needed help understanding** your hospital/medical paperwork?	Y N
Do you have an **Advanced Directive, Living Will and Medical Power of Attorney**?	Y N