Arizona Department of Economic Security
Division of Developmental Disabilities

Needs Assessment Supplemental Screening Tool

Member Name: _____ Date: _____

ASSIST ID: _____ Date of Birth: _____

Instructions

The below screening questions are additional information to be gathered during the needs assessment. These questions will help the Support Coordinator in identifying the Member's needs which will ultimately lead to the identification of which supports and services would most benefit the Member. All screening questions must be completed annually and within 10 days of discharge from a hospital depending on the age of the Member. Additional instructions are listed for each set of screening questions as to who needs to have it completed.

The questions may be read aloud or given to the Member to read. The Member and/or Responsible Person will select one answer choice for each question. If the Support Coordinator is not able to understand the Member's responses or the Member is not able to understand the questions, a Responsible Person, advocate, or designated representative may answer on behalf of the Member. Indicate at the bottom of the form who all provided information. If responses received are from the Member and a secondary person, indicate the secondary person's answer in the descriptor comment box for each question. If the Member and responsible person, advocate, or designated representative decline to answer, mark the appropriate boxes and conduct a new screening within one year or within 10 days of a hospital discharge. If provided, document the reason why the person declined to answer in the please describe text box. If a need is identified, care coordination should be documented in the appropriate section of the planning document.

I. Self-Reported Health Status Screening Question

This question helps to understand how the Member feels about their overall health in general, including both their physical and behavioral health.

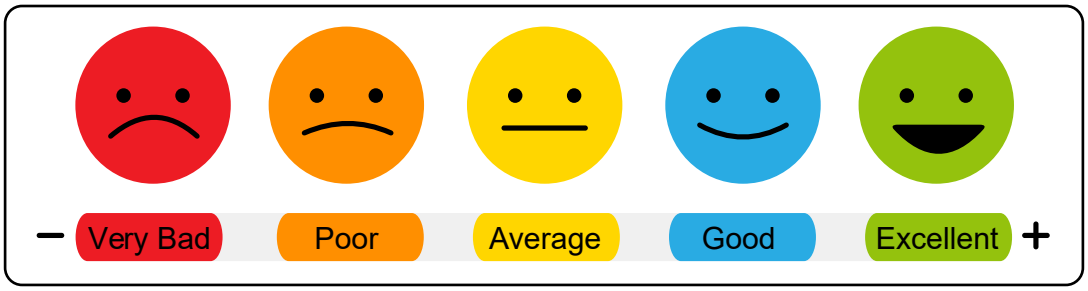
Ask this screening question to all Members. If the Member is a minor under the age of 18, the Responsible Person shall be asked the question. If the minor child is 12 years or older, the question shall be asked of them as well. If it helps to understand the Member's response, have them point to one of the faces to provide their answer. Have the Member and/or Responsible Person explain their response if it contradicts with what the Member or Responsible Person shared about their health.

Check the box if the person declines to answer: ☐

1. How would you rate your overall health status?

   Answer Choices:

   1. ☐ Very Bad
   2. ☐ Poor
   3. ☐ Average
   4. ☐ Good
   5. ☐ Excellent



See page 14 for EOE/ADA disclosures

Please describe.

II. SOCIAL ISOLATION/LONELINESS SCREENING QUESTIONS

Ask these screening questions of all Members age 12 years of age and older.

Check the box if the screening is not applicable or the person declines to answer: ☐

1. How often do you feel that you lack companionship?
   Companionship is a feeling of friendship or fellowship with someone else. It includes spending time with someone who you enjoy being with.

   Answer Choices:

   1. ☐ Hardly Ever
   2. ☐ Some of the time
   3. ☐ Often

   Please describe.

2. How often do you feel left out?

   Answer Choices:

   1. ☐ Hardly Ever
   2. ☐ Some of the time
   3. ☐ Often

   Please describe.

3. How often do you feel isolated from others?
   Being isolated means a lack of social contact and relationships with people outside your home, who are not paid caregivers.

   Answer Choices:

   1. ☐ Hardly Ever
   2. ☐ Some of the time
   3. ☐ Often

   Please describe.

Scoring the Answers

Using the numbers next to each answer choice, sum the total of all the Member's answers.

Screening Questions	Score
Question #1	
Question #2	
Question #3	
Total Score:	

A total score of 3 - 5 means a Member is not likely experiencing social isolation/loneliness. A score of 6 - 9 indicates a Member may be experiencing social isolation/loneliness and could benefit from additional supports and service planning.

III. BEHAVIORAL HEALTH SCREENING QUESTIONS

Ask these screening questions to all Members age 12 and older and to any Member under the age of 12 who is exhibiting possible behavioral health symptoms.

Check the box if the screening is not applicable or the person declines to answer: ☐

1. Have you been feeling unhappy, hopeless or depressed?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe.

2. Do you worry often and it makes you feel unsure, uncomfortable, anxious or angry?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe.

3. Have you lost interest in or don’t like doing things you used to enjoy?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe.

4. Do you ever hear whispers, noises, or voices that other people don't hear?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe.

5. Do you ever see things that other people cannot see?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe.

6. Are you having a hard time because someone you love has died or you have lost something important to you?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe.

7. Have you experienced something difficult in the past that you need help talking about?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe.

8. Is it ever hard for you to fall asleep or stay asleep?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe.

IV. SUBSTANCE USE SCREENING QUESTIONS

Ask these screening questions to all Members age 18 and over and to any Member under the age of 18 who may be exhibiting indicators of substance use.

Check the box if the screening is not applicable or the person declines to answer: ☐

1. Do you drink alcohol?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe the type of alcohol, the frequency, and the amount.

2. Have you used an illegal drug or prescription medication for non-medical reasons in the past year?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe what type of drug(s), the frequency, and the amount.

3. Do you smoke, vape or use tobacco?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe what type of product, the amount, and do you want to slow down or stop?

4. Would you like to have the support of a counselor, peer support specialist or other behavioral health professional?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No

   If yes, please describe.

V. MEMORY COGNITION SCREENING QUESTIONS

Ask these screening questions to all Members age 18 and over.

These screening questions are not about measuring skill level, they are about monitoring for changes to memory or cognition over time. If an answer to any question is no, ask the Member or Responsible Person to describe what they are experiencing and how it is impacting their daily life and overall well-being. If the Member's existing symptoms are worse or the Member is exhibiting any new symptoms, ask the Member or Responsible Person to explain the changes or provide examples.

Check the box if the screening is not applicable or the person declines to answer: ☐

1. Are you able to recognize people you know (family/friends/staff)?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No, not always
   3. ☐ I don't know

If no, not always, please describe.

2. Are you able to remember the names of people you know?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No, not always
   3. ☐ I don't know

   If no, not always, please describe.

3. Are you able to remember recent events in the past week or less?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No, not always
   3. ☐ I don't know

   If no, not always, please describe.

4. Are you able to find your way in places that you know?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No, not always
   3. ☐ I don't know

   If no, not always, please describe.

5. Do you know what day of the week it is and what season it is?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No, not always
   3. ☐ I don't know

   If no, not always, please describe.

6. Do you remember where you place your things?

   Answer Choices:

   1. ☐ Yes
   2. ☐ No, not always
   3. ☐ I don't know

   If no, not always, please describe.

7. Do you put your things where they belong?

Answer Choices:

1. ☐ Yes
2. ☐ No, not always
3. ☐ I don't know

If no, not always, please describe.

VI. Information Provided By:

List all individuals who provided information to the above screening questions.

☐ Member

☐ Responsible Person

Full Name _____

Relationship to Member _____

☐ Other

Full Name _____

Relationship to Member _____