

Social Determinants of Health (SDoH) Screening Tool for CHWs

Instructions: Please read each of the following questions and select the response(s) that most closely reflect your present situation. Your answers will assist our team in referring you to the most appropriate resources available to you.

Client ID/DOB:	Client Name:
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Client Number:	Client Email:
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Screening Completed by:

Screening Completed by:				
	Questions	YES	NO	N/A
1.	In the past 12 months, did you run out of food before you had money to buy more?			
2.	In the past 12 months, did the food you bought just not last and you didn't have money to buy more?			
3.	Do you have housing?			
4.	Are you worried you may lose your housing?			
5.	In the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?			
6.	Within the past 12 months, has lack of transportation keep you from medical appointments, getting your medicines, getting to appointments, work, or other things you need?			
7.	Do you feel physically and emotionally safe?			
8.	Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?			
9.	Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?			
10.	Do you have a permanent job?			
11.	Are your children in school?			
12.	Do you have someone that can care for your children safely while you are away from the home?			
12.	Are you comfortable reading, writing, and understanding English?			
13.	Do you need help reading and understand health and medical information or how to take your medications?			
14.	Do you have questions about your eligibility for benefits or need help applying for benefits?			
15.	Do you have any legal issues that worry you?			
16.	Do you need assistance with of these needs?			

Priority Needs

ACTION PLAN

Need(s):

Referral(s):

Notes:
