

Participant ID: _____

Date: _____

Navigator: _____

Welters Barrier Assessment

*Please ask patients the following questions and record patient responses.

Financial Resource Strain

- ☐ In the last 12 months, have you needed to see a doctor but could not because of cost? **Yes No**
- ☐ Sometimes people find that their income does not cover their living costs. In the last 12 months has this happened to you? **Yes No**
- ☐ In the last 12 months, did you skip medications to save money? **Yes No**

Food insecurity

- ☐ In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? **Yes No**

Housing instability

- ☐ Are you worried that in the next 12 months, you may not have stable housing? **Yes No**

Utility needs

- ☐ In the last 12 months has the electric, gas, oil or water company threatened to turn off your services in your home? **Yes No Already Shut Off**

Dependent care

- ☐ Do problems getting childcare make it difficult for you to work or to study? **Yes No**
- ☐ Are you responsible for the support and care of a disabled or elderly relative? **Yes No**

Transportation challenges

- ☐ In the last 12 months, have you ever had to go without health care because you didn't have a way to get there? **Yes No**
- ☐ Are you regularly able to get a friend or relative to take you to doctor's appointments? **Yes No**

Exposure to violence

- ☐ Are you afraid you might be hurt by violence in your neighborhood? **Yes No**
- ☐ Over the last 12 months, has anyone physically hurt, insulted or talked down to, screamed, cursed at, or threatened to hurt you? **Yes No**

Participant ID: _____

Date: _____

Navigator: _____

Education/Health Literacy

- How often do you have a problem understanding what is told to you about your medical condition? **Always Often Sometimes Occasionally Never**
- Do you ever need help reading medical materials? **Yes No**

Physical comorbidity

- In the past 12mos have you needed the help of other people with your routine activities because of a disability or major health problem? **Yes No**

Social Isolation & Support

- Do you often feel that you lack companionship? **Yes No**

Immigration status

- In the past 12 months have you needed to see a doctor but did not because of your immigration status? **Yes No**

Employment

- What was your main activity during most of the last 12 months?
Worked for pay Attended school Household duties Unemployed
Permanently unable to work Other
- Do you have a disability that prevents you from accepting any kind of work during the next six months? **Yes No**

Mental Health

- Over the last two weeks, have you been bothered by any of the following problems?
 - Feeling down, depressed or hopeless **Yes No**
 - Trouble falling or staying asleep, or sleeping too much. **Yes No**
 - Feeling tired or having little energy **Yes No**

Mental Health Co-morbidity

- In the past year have you used the following?
 - Alcohol **Yes No**
 - Tobacco Products **Yes No**
 - Prescription drugs for non-medical reasons **Yes No**
 - Illegal drugs **Yes No**