

Health + Housing Project – CHW Encounter Form

CHW INITIALS: _____

ENCOUNTER DATE: ____ / ____ / ____
MM DD YYYY

SALESFORCE ID: _____

ENCOUNTER START TIME: ____ : ____ : ____
HH MM AM / PM

Section A

A1. Resident First and Last Name: _____

A2. a. Encounter Method:

- | | |
|--------------------------------------------|-----------------------------|
| <input type="radio"/> In-person individual | <input type="radio"/> Email |
| <input type="radio"/> In-person group | <input type="radio"/> Text |
| <input type="radio"/> Phone | |

b. IF IN-PERSON INDIVIDUAL, NOTE LOCATION:

- | | |
|-----------------------------------------------|------------------------------------------------------------|
| <input type="radio"/> Resident home | <input type="radio"/> Hospital |
| <input type="radio"/> Community Room | <input type="radio"/> Doctor's Office or Outpatient Clinic |
| <input type="radio"/> Henry Street Settlement | <input type="radio"/> Other |

c. IF OTHER (A2b = OTHER), SPECIFY _____

OR d. IF IN-PERSON GROUP (A2a = IN-PERSON GROUP), FILL IN NUMBER IN GROUP: _____ (IF GROUP, COMPLETE FORM FOR EACH PARTICIPANT)

A3. a. Language of Encounter:

- | | |
|--------------------------------|---------------------------------|
| <input type="radio"/> English | <input type="radio"/> Cantonese |
| <input type="radio"/> Spanish | <input type="radio"/> Other |
| <input type="radio"/> Mandarin | |

b. IF OTHER (A3a = OTHER), SPECIFY _____

A4. a. Reason for resident encounter:

- | | |
|--------------------------------------------|------------------------------------------------------|
| <input type="radio"/> Intake visit attempt | <input type="radio"/> Mental/behavioral health visit |
| <input type="radio"/> Intake visit | <input type="radio"/> Benefits screening |
| <input type="radio"/> Home visit attempt | <input type="radio"/> Property management visit |
| <input type="radio"/> Home visit | <input type="radio"/> Environmental assessment visit |
| <input type="radio"/> Primary care visit | <input type="radio"/> Hospital visit |
| <input type="radio"/> Specialist visit | <input type="radio"/> Other |

b. IF OTHER (A4a = OTHER), SPECIFY _____

Section B

B1. a. Interventions during this visit: **CHECK ALL THAT APPLY**

- | | |
|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Medical Appointment Scheduling | <input type="checkbox"/> Assistance Obtaining Medication / Refills |
| <input type="checkbox"/> Henry Street Settlement Appointment Scheduling | <input type="checkbox"/> Medication Adherence Strategies |
| <input type="checkbox"/> Pre-Appointment Discussion/Appointment Reminder | <input type="checkbox"/> Healthful Eating Information |
| <input type="checkbox"/> Transport Planning For Appointments / Other | <input type="checkbox"/> Exercise Strategies |
| <input type="checkbox"/> Assistance With Transportation To An Appointment/Clinic Visit | <input type="checkbox"/> Other Health Education |
| <input type="checkbox"/> Attend Appointment With Resident | <input type="checkbox"/> Goal Setting |
| <input type="checkbox"/> Communication With Care Providers | <input type="checkbox"/> Review Of Previous Goals |
| <input type="checkbox"/> Communication With Family/Care Givers | <input type="checkbox"/> Referral |
| <input type="checkbox"/> Motivational Interviewing | <input type="checkbox"/> Referral Follow Up |
| <input type="checkbox"/> Disease Management Strategies(Glucose Testing, Blood Pressure, etc.) | <input type="checkbox"/> Other |

b. IF OTHER (B1a = OTHER), SPECIFY _____

B2. a. Referrals made during this visit: **CHECK ALL THAT APPLY**

- | | |
|------------------------------------------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Henry Street Settlement – Neighborhood Resource Center | <input type="checkbox"/> Community Group/Classes |
| <input type="checkbox"/> Henry Street Settlement – Community Consultation Center (CCC) | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Henry Street Settlement – Senior Services | <input type="checkbox"/> Eye Care/Eye Exam |
| <input type="checkbox"/> Henry Street Settlement – ATTAIN Computer Lab | <input type="checkbox"/> Tobacco Cessation |
| <input type="checkbox"/> Henry Street Settlement – Workforce Development Center | <input type="checkbox"/> Senior Center |
| <input type="checkbox"/> Henry Street Settlement – Youth Services | <input type="checkbox"/> Gouverneur Health |
| <input type="checkbox"/> Primary Care Provider(Doctor/Nurse Practitioner/Physician's Assistant | <input type="checkbox"/> Exercise Classes/Gym |
| <input type="checkbox"/> Food Pantry/Food Assistance | <input type="checkbox"/> Other |

b. IF OTHER (B2a = OTHER), SPECIFY _____

B3. a. Referral follow-through: *IF REFERRALS WERE MADE DURING A PREVIOUS VISIT, SPECIFY WHICH PRIOR REFERRAL(S) THE RESIDENT SUCCESSFULLY FOLLOWED-UP ON*

CHECK ALL THAT APPLY

- | | |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Henry Street Settlement – Neighborhood Resource Center | <input type="checkbox"/> Community Group/Classes |
| <input type="checkbox"/> Henry Street Settlement – Community Consultation Center (CCC) | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Henry Street Settlement – Senior Services | <input type="checkbox"/> Eye Care/Eye Exam |
| <input type="checkbox"/> Henry Street Settlement – ATTAIN Computer Lab | <input type="checkbox"/> Tobacco Cessation |
| <input type="checkbox"/> Henry Street Settlement – Workforce Development Center | <input type="checkbox"/> Senior Center |
| <input type="checkbox"/> Henry Street Settlement – Youth Services | <input type="checkbox"/> Gouverneur Health |
| <input type="checkbox"/> Primary Care Provider (Doctor/Nurse Practitioner/Physician's Assistant) | <input type="checkbox"/> Exercise Classes/Gym |
| <input type="checkbox"/> Food Pantry/Food Assistance | <input type="checkbox"/> Other |

b. IF OTHER (B3a = OTHER), SPECIFY _____

B4. a. Housing intervention: *IF VISIT WAS RELATED TO ASSESSING OR ADDRESSING STRUCTURAL ISSUES WITHIN THE RESIDENT'S APARTMENT*

CHECK ALL THAT APPLY

- | | |
|------------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Initial Environmental Assessment | <input type="checkbox"/> Appointment Scheduling For Repairs |
| <input type="checkbox"/> Assistance With Minor Repairs Or Upkeep | <input type="checkbox"/> Follow Up On Repairs |
| <input type="checkbox"/> Assistance Reporting Repairs Needed | <input type="checkbox"/> Legal Services |
| <input type="checkbox"/> Pest Control | <input type="checkbox"/> Other |

b. IF OTHER (B4a = OTHER), SPECIFY _____

Section C

C1. a. Were appointments scheduled at this meeting?

☐ Yes ☐ No

b. IF APPOINTMENTS WERE SCHEDULED (C1a = YES), SPECIFY HERE THE TYPE OF APPOINTMENT

CHECK ALL THAT APPLY

- | | |
|--------------------------------------------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Henry Street Settlement – Neighborhood Resource Center | <input type="checkbox"/> Community group/classes |
| <input type="checkbox"/> Henry Street Settlement – Community Consultation Center (CCC) | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Henry Street Settlement – Senior Services | <input type="checkbox"/> Eye Care/Eye Exam |
| <input type="checkbox"/> Henry Street Settlement – ATTAIN Computer Lab | <input type="checkbox"/> Tobacco cessation |
| <input type="checkbox"/> Henry Street Settlement – Workforce Development Center | <input type="checkbox"/> Senior center |
| <input type="checkbox"/> Henry Street Settlement – Youth Services | <input type="checkbox"/> Gouverneur Health |
| <input type="checkbox"/> Primary care provider (doctor/nurse practitioner/physician's assistant) | <input type="checkbox"/> Exercise Classes/Gym |
| <input type="checkbox"/> Food Pantry/Food Assistance | <input type="checkbox"/> Other |

c. IF OTHER (C1b = OTHER), SPECIFY _____

C2. a. Were resident goals addressed at this meeting?

☐ Yes ☐ No

b. IF YES, DESCRIBE EACH GOAL BRIEFLY AND HOW MUCH PROGRESS HAS BEEN MADE TOWARDS ACHIEVING IT

Goal 1 _____

☐ No Progress ☐ Goal Partially Achieved ☐ Goal Completely Achieved ☐ Did Not Try

Goal 2 _____

☐ No Progress ☐ Goal Partially Achieved ☐ Goal Completely Achieved ☐ Did Not Try

Goal 3 _____

☐ No Progress ☐ Goal Partially Achieved ☐ Goal Completely Achieved ☐ Did Not Try

Goal 4 _____

☐ No Progress ☐ Goal Partially Achieved ☐ Goal Completely Achieved ☐ Did Not Try

Goal 5 _____

☐ No Progress ☐ Goal Partially Achieved ☐ Goal Completely Achieved ☐ Did Not Try

C3. a. Were new goals made at this meeting?

☐ Yes

☐ No

b. IF YES, LIST NEW GOALS MADE:

C4. Is this the final meeting with this resident?

☐ Yes

☐ No

C5. Description of interaction and follow up plan:
