Social Needs Survey

Name: ______________________________ Phone Number: ____________

Date of Birth (mm/dd/yyyy): _________ Preferred Language: ________ Best Time to Call: _________ am/pm

Today's Date (mm/dd/yyyy):	___________________________________	**YES**	**NO**
	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	☐	☐
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	☐	☐
	Are you worried that in the next 2 months, you **may not have stable housing**?	☐	☐
	Do problems getting **child care make it difficult for you to work** or study? (*leave blank if you do not have children*)	☐	☐
	In the last 12 months, have you needed to see a doctor, **but could not because of cost**?	☐	☐
	In the last 12 months, have you taken less medicine than you are supposed to because of **trouble affording your medicine**?	☐	☐
	In the last 12 months, have you ever had to go without health care because you **didn't have a way to get there**?	☐	☐
	Do you ever need help **reading hospital materials**?	☐	☐
	Are you **afraid you might be hurt by someone else** in your apartment building or house?	☐	☐
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	☐	☐
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	☐	☐
	Do you feel lonely or isolated from those around you?	☐	☐
???	Are there any other barriers to receiving care you would like addressed?	☐	☐