














### Social Needs Survey

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Preferred Best Time \_\_\_\_\_ am/pm  
 (mm/dd/yyyy): \_\_\_\_\_ Language: \_\_\_\_\_ to Call: \_\_\_\_\_

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