Appendix A. Physical Therapy Intake Form

The following questions will ask you about your access to health care, how you live, home life, etc. We ask these questions to all patients in order to connect you with appropriate resources, as these factors play a role in your health and recovery. Please answer these questions to the best of your ability and know that under HIPAA, we (physical therapists, students, and interpreters) are prohibited from sharing this information with anyone.

<u>In the past 6 months,</u>

1. **Does anything impact your ability to attend health care appointments?** ☐ Often ☐ Sometimes ☐ Never
2. **Do you have a primary care provider?** ☐ Always ☐ Sometimes ☐ Never
3. **Do you understand the documents and papers you must read and submit to obtain health care and/or social services and resources you need?** ☐ Always ☐ Sometimes ☐ Never
4. **Do you have adequate nutrition and access to healthy food?** ☐ Always ☐ Sometimes ☐ Never
5. **Are you able to pay your basic expenses: rent, groceries, utilities, phone?** ☐ Always ☐ Sometimes ☐ Never
6. **Do you have a safe and stable place to live and sleep?** ☐ Always ☐ Sometimes ☐ Never
7. **Do the places where you spend your time each day feel safe and healthy**? ☐ Always ☐ Sometimes ☐ Never
8. **Do you have friends, family, or others who help you when you need it?** ☐ Always ☐ Sometimes ☐ Never
9. **Is there anything else that might limit your ability to participate in physical therapy?** ☐ Yes ☐ No

   If yes, please describe____

Appendix B. Screening for Social Determinants of Health

We are implementing a brief survey to screen all of our patients for Social Determinants of Health.

The survey will be included in the intake form. Please take the time to follow-up as outlined below.

- Check the screening intake form. If all questions are marked Never, **no follow-up is needed.**
- If any questions are marked Often/Always or Sometimes, **please ask follow-up questions.** See below for sample follow-up questions. Please document the answers on the intake form.
- If resources are needed and the patient receives services at Cherry Health or Clinica Santa Maria, please advise the patient to call the appropriate clinic social worker to assist them with accessing resources (give handout).
- If patient does not have a PCP, please give them the list of clinics that offer primary care services.
- If patient does not have a PCP ***and*** needs an additional service, please reference the complete list of services at each clinic before making a recommendation and providing appropriate handout(s).
- Please document all services that are recommended to the patient on the intake form.

In the past 6 months,

10. **Does anything impact your ability to attend health care appointments?** ☐ Often ☐ Sometimes ☐ Never
    - *If Yes, please describe.*
11. **Do you have a primary care provider?** ☐ Always ☐ Sometimes ☐ Never
    - *If Sometimes or Never, please describe.*
12. **Do you understand the documents and papers you must read and submit to obtain health care and/or social services and resources you need?** ☐ Always ☐ Sometimes ☐ Never
    - *If Sometimes or Never, can you tell me more about this?*
    - *In what language(s) can you read? What is the highest level of education you have completed?*
13. **Do you have adequate nutrition and access to healthy food?** ☐ Always ☐ Sometimes ☐ Never
    - *If Sometimes or Never, please describe. Can you tell me more about your nutrition and access to healthy food?*
    - *What factors in your life impact this?*
14. **Are you able to pay your basic expenses: rent, groceries, utilities, phone?** ☐ Always ☐ Sometimes ☐ Never
    - *If Sometimes or Never, please describe.*
    - *Are there specific hardships contributing to this?*
15. **Do you have a safe and stable place to live and sleep? ☐ Always ☐ Sometimes ☐ Never**
    - *If Sometimes or Never, please describe. Can you tell me more about your housing situation?*
16. **Do the places where you spend your time each day feel safe and healthy? ☐ Always ☐ Sometimes ☐ Never**
    - *If Sometimes or Never, please describe. Can you tell me more about why they do not feel safe or healthy?*
17. **Do you have friends, family, or others who help you when you need it? ☐ Always ☐ Sometimes ☐ Never**
    - *If Sometimes or Never, please describe. Can you tell me more about who could support or help you when you need it?*
18. **Is there anything else that might limit your ability to participate in physical therapy? ☐ Yes ☐ No**
    If yes, please describe____

If any factors above:

- **For _____(state factor), have you sought any services to help you? Which one (s)? Were they helpful? Are there specific services or resources that you feel would be helpful that you are currently not receiving?**

Appendix C. Follow-up for SDOH Resources provided

If resources were suggested to the patient, please ask the following questions, and document the answers below.

1. Were you able to seek out assistance from _______________(resource provided)? ☐Yes ☐ No

   If yes: Was this helpful)? ☐Yes ☐ No Please explain____________________

2. Are there any other resources you believe that would be helpful to you?)? ☐Yes ☐ No

   ____