**Enrollment Packet**

Patient Name: Enrollment Date: Community Health Worker:

***Acknowledgement of Services***

My Community Health Worker will help me:

* Get the health care I need
* Understand how I can be healthier
* Connect me to community services and
* Show me how to do these things on my own

I understand that the program will not last forever, and my Community Health Worker will talk with me regularly about when it is time to graduate.

* I agree to:
  + Stay in contact with my Community Health Worker during the program.
  + Tell my Community Health Worker if my address, phone number or email changes.
  + Keep my appointments with my Community Health Worker and any services my CHW helps me get.
  + Respect my Community Health Worker’s personal and professional boundaries.
  + Demonstrate appropriate behavior during appointments with my CHW.
  + Finally, I understand it is my choice to join this program, I can stop at any time, and if I stop working with my Community Health Worker, I can still get health care on my own.

***Confidentiality Policy and Informed Consent***

Information discussed with your Community Health Worker (CHW) is confidential. There are a few exceptions to this:

* Your CHW is required by law to report to the appropriate authority information about suspected abuse or neglect of a child, an incompetent or disabled person, or an elderly person. Your CHW is also required, if court ordered, to disclose your medical record.

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| **Verbal Consent Obtained?** | ❑ Yes ❑ No |

* If you reveal information that indicates a clear threat of harm to yourself or others, your CHW will need to contact appropriate authorities, warn the potential victim, or take other reasonable action to prevent harm from occurring.

**Patient Details**

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| --- | --- | --- | --- | --- | --- |
| **General** | | | | | |
| **First Name:** | | | | **Middle Initial:** | **Suffix:** |
| **Last Name:** | | | | **Sex:** ❑ Female ❑ Male | |
| **Date of Birth:** | | | | ❑ Unknown ❑ Refused | |
| **Race:** | ❑ American Indian/Alaska Native ❑ Asian | | | **Ethnicity:** ❑ Latino/Hispanic | |
|  | ❑ Black/African American ❑ Native Hawaiian | | | ❑ Not Latino/Hispanic | ❑ Refused/Unreported |
|  | ❑ Other Pacific Islander ❑ White | | | **More than one race:** | ❑ Yes ❑ No |
|  | ❑ Other ❑ Refused/Unreported | | | **Clinic:** | |
| **Primary Phone:** | | **Leave message:** ❑ Yes ❑ No | | **Referred By:** | |
| **Notes:** | | | | | |
|  |
| **Communication Details** | | | | | |
| **Secondary Phone:** | | | **Leave message:** ❑ Yes ❑ No | | |
| **Email:** | | | **Send Email:** ❑ Yes ❑ No | | |
| **Preferred Contact Method:** | | | **Send Text:** ❑ Yes ❑ No | | |
| **Preferred Language:** | | | **Translator Needed:** ❑ Yes ❑ No | | |
| **Primary Address:** | | | **Second Address (if needed):** | | |
| **City:** | | | **City:** | | |
| **State:** | | | **State:** | | |
| **Zip:** | | | **Zip:** | | |
| **County:** | | | **County:** | | |
| **Send Mail:** ❑ Yes ❑ No | | | **Send Mail:** ❑ Yes ❑ No | | |
| **Notes:** | | | | | |
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**Enrollment Questionnaire**

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| --- | --- | --- | --- | --- |
| When inputting answers to Blueprint: | | | | |
| 1 = Poor | 2 = Fair | 3 = Good | 4 = Very Good | 5 = Excellent |
| 1 & 2 = Not at All True | | 3 = Hardly True | 4 = Moderately True | 5 = Exactly True |

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| --- | --- | --- | --- | --- | --- |
| 1) | On a scale of 1 to 5, how would you rate your health? *(1 being the worst and 5 being the best)* 1 2 3 4 5 | | | | |
| 2) | On a scale of 1 to 5, how satisfied are you with your health? *(1 being the worst and 5 being the best)* 1 2 3 4 5 | | | | |
| 3) | On a scale of 1 to 5, how confident are you that you can find a solution when confronted with a health problem? 1 2 3 4 5 | | | | |
| 4) | On a scale of 1 to 5, how motivated are you to be healthy? *(1 being the worst and 5 being the best)* 1 2 3 4 5 | | | | |  | |  | | | |  |
| 5) | During the past 3 months, did you visit a hospital emergency room for your own health? | | | | |  | |  | | | |  |
|  | | ❑ Yes If yes, how many times? | ❑ No | | ❑ Can't Remember ❑ Refused |  | | | | |
| 6) | During the past 3 months, were you a patient in a hospital overnight or longer? | | | | |  | |  | | | |  |
|  | | ❑ Yes If yes, how many times? | ❑ No | ❑ Can't Remember ❑ Refused | | |
| 7) | How many days out of the past 30 days did you feel your physical health was not good? \_\_\_\_\_\_\_\_\_ days | | | | | | | | | | |  |
| 8) | How many days out of the past 30 days did you feel your mental health was not good? \_\_\_\_\_\_\_\_\_ days | | | | | | | | | | |  |
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