**Introduction script**

Hello, my name is \_\_\_\_\_\_\_ I am a CHW and I am calling you from the KC CARE and \_\_\_\_\_\_\_\_\_. You were referred by \_\_\_\_\_\_\_\_\_\_\_\_\_ because\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Is now a good time to talk you?

As a CHW I can help you address the social and medical needs that you might have at this moment such as finding a doctor, food, transportation, etc…. *What Community Health workers do is connect our patients with resources, go with them to those resources and ultimately teach them how to do it on their own.*

*Does this make sense? Do you have any question?*

*Now I am going to confirm some basic personal information like Name, phone number, address.*

*In order to assist you I am going to ask you some questions to determine what we can work together on. I can do this right now or at the time we schedule the home visit.*

***(If you are meeting the patient in person, and time allows it, you can perform assessment at this time)***

*If you still have some time now I can keep gathering additional personal information for our system. This will save us some time later during our visit in person but this is completely up to you.*

**ASSM introduction**

Now I am going to be asking some questions that will help us to identify things to work on together. Once we get all the responses, we will be able to decide how to work together. I will be tacking notes and at the end we will discuss the information I gathered.

Are you interested?

**Findings after the ASSM (how to introduce this to patient)**

Let’s review your responses and come up with a plan of what goals to work on together.

 (Review every single domain with patient – Even if that doesn’t trigger a goal)

* It seems like you haven’t seen a doctor since the last year and your blood pressure is out of control, Is this something you would like me to help you with? (Maybe explain a little bit how you would help)
* I heard you saying that you couldn’t attend your appointment at the SS office because your ride didn’t show up. We can look into alternatives to get you a more reliable transportation.

Our next step is coming up with a plan to help you with these needs, are you interested?

**Care Plan:**

We have gone over all the items that we could work on. Ranking in order from most important to least important tell me the top three things that we can work together on.

Are there any needs that are creating anxiety that we need to work on today?

Great, here are the three items that you would like to work on:

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Let’s make a plan so we can begin to work on the goals together:

Let’s talk about goal number one: (Do this for each of the goals)

-What are they going to work on?

-Who is going to be doing what?

-When is this goal going to be completed?

**-**Where are they going to accomplish it?

-Why is this goal important for you?

It seems like we have a plan. Is there anything else we need to address today?

**Health Questions**

Now I need to ask you some questions that will help me to determine if you are improving through our program. I will be asking you these same questions at the time you graduate from our program.

**Final Steps:**

* Consent: Provide a copy to patient and save one for you.
* ROI: Fill this out only if necessary.
* Health Literacy Notebook: Explain purpose of the HLN.
* Confirm next step with the patient. IE. “I will call you in two days to follow up on you and on the meant time you will gather the documents required to schedule an appointment with the clinic.”