

## CIS Action Plan

Initial     Quarterly

### Part I: Agency Information

CIS Agency:	CIS Provider ID:	Interviewer Name & ID (If applicable):
Date Initiated:	Date Completed:	

### Part II: Member Information

Member First Name:	Member Last Name:	Middle Initial:	Medicaid ID#:	Birthdate:  Age (Years):
HMIS ID# <input type="checkbox"/> Unknown <input type="checkbox"/> Not in HMIS	Medicaid Redetermination Date:	Other Relevant IDs (VA, etc.) (specify):	Other ID Number(s):	

#### Current Residential Address/Location

Street or Location:	City:	Zip Code:
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#### Mailing Address (if different from current address)

Street:	City and State:	Zip Code:
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<b>Contact Information:</b>	Phone Number	Can receive texts?	Email Address:	Any friends or family who can help reach you? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify:	Contact Name:
	1.	Yes <input type="checkbox"/> No <input type="checkbox"/>			Contact Ph Number:
	2.	Yes <input type="checkbox"/> No <input type="checkbox"/>			Relationship to Member:

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*Read to member: I am going to ask you some questions about your health, well-being, housing history and access to resources. This information will help us understand what is important to you and find out which services best suit your needs. If you do not want to answer a question, you don't have to.*

### Part III: Member Health and Well-being

1. Would you say that in general your health is:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
2. Now thinking about your physical health, which includes physical illness and injury, for how many days during <u>the past 30 days</u> was your physical health not good?	Number of Days _____				
3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during <u>the past 30 days</u> was your mental health not good?	Number of Days _____				
4. During <u>the past 30 days</u> , for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?	Number of Days _____				

### Part IV: Member Housing

5. In the last 30 days, how many days have you lived: (enter number of days)	Outside (e.g., street, car, camper/RV or park)  _____ days	at an emergency shelter  _____ days	at a temp/transitional shelter  _____ days	in a supervised group home  _____ days	in a shared apartment  _____ days	in an independent apartment  _____ days
6. Do you have any new accessibility needs?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	*6a. If yes, what are your accessibility needs?			
7. Are you currently housed?	<input type="checkbox"/> Yes. If <b>yes</b> : 7a. What <u>type of housing</u> : <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary/Transitional <input type="checkbox"/> Institutional <input type="checkbox"/> Other 7b. Are you newly housed since the last assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> No. If <b>no</b> : 7c. Have you <u>lost housing</u> since last assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No		

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<b>8. Tenancy Only:</b> Are you satisfied with your current housing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No*	*8a. If no, what are your concerns?
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### Part V: Services/Resource Utilization

Services/Resources	USED this service (past 30 days)	NEED this service	Not interested in this service
<b>Financial</b>			
1. Financial help for rent/rent subsidies, utilities, or other one-time costs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Budgeting Assistance/Money Management; establishing credit; financial counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Housing</b>			
3. Housing Documents; ID assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Rental housing information; applications; interviews; appeals; CES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Finding accessible/affordable housing that meets my/my family's needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Emergency shelter/Temp housing/Transitional housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Permanent housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Landlord mediation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Development of/Changes to Eviction Prevention Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ongoing housing subsidies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Healthcare</b>			
11. Accessing Medical services; vision; nutrition/dietitian, dental; primary care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Accessing Mental health services and social supports; crisis services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Substance abuse treatment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Compliance with Medical/Mental Health/Substance Use Plan of Care and medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Health Coordination</b>			
15. Health Coordination by Health Plan <i>If member needs or refuses health coordination, refer to health plan for review</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<b>Social Services</b>			
16. Securing/maintaining Medicaid Eligibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Benefits services, including TANF, SSI and SSDI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Accessing food/necessities; soup kitchen or food pantry; cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Legal assistance; probation; parole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Clothes closet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Day center with telephones, mailrooms, or restrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Employment Assistance</b>			
22. Job readiness, job search, or employment assistance, vocational services; education, volunteer supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Transportation</b>			
23. Transportation assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other Services/Resources</b>			
24. Individual and/or family Counseling, skills coaching; support Groups, natural supports, anger management/Domestic violence/AA-NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Caregiving for children and other relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. End of life planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Personal Care (Long-term Support Services)		<input type="checkbox"/>	<input type="checkbox"/>

### Part VI: Person-Centered Housing Goals

28. What are your <b>housing</b> goals (short-term and long-term)? <b>(Complete during initial assessment. Review and revise as needed quarterly)</b>
a.
b.
c.
d.

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**Part VII: Other Interviewer Notes and Observations:**

29. Person-centered plan meeting or revision plan meeting held with member: <input type="checkbox"/> Yes <input type="checkbox"/> No
30. CIS assessment completed during this quarter: <input type="checkbox"/> Yes <input type="checkbox"/> No
31. Notes:

**Part VIII: Discharge from CIS:**

32. Is member exiting CIS?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	*If <u>yes</u> , what type of housing is the member exiting to/remaining in? <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary/Transitional <input type="checkbox"/> Institutional <input type="checkbox"/> Place not meant for habitation (e.g., car, beach, street, park, etc.) <input type="checkbox"/> Other (Deceased, Relocated out of state)_____
Date of Discharge ( <i>mm/dd/yy</i> ):                    /                    /			

**Signatures**

This information was collected in good faith and is as accurate as possible:

Member Signature	Member Advocate Signature (if applicable)	Date
CIS Interviewer Signature	CIS Interviewer Name & Title	Date