Social Health Survey

Transgender Pre-operative Assessment

IEHP
A Public Entity
Inland Empire Health Plan

The purpose of this survey is to help Inland Empire Health Plan (IEHP) assess social needs that are supportive to your health, such as housing, transportation, safety and other basic needs. Resources and/or referrals to organizations that can help, if desired, for the unmet social needs identified by the survey.

Preface survey that respondent can choose not to answer question if they prefer.

Patient Name:_____ **Date of Birth:**_____

HOUSING:

1. **What is your housing situation today?**
   - ☐ I have housing
   - ☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
2. **Are you worried about losing your housing?** ☐ Yes ☐ No
3. **How many family members, including yourself, do you currently live with?** _____
4. **What is the address where you live?** _____

Housing Resources

Housing Authorities	Riverside: (951)351-0700	San Bernardino: (909)890-0644
Fair Housing	Riverside: (800)655-1812	San Bernardino: (800)321-0911

Shelters/ Transitional Housing

Salvation Army	Riverside: (951)784-4490	San Bernardino: (909)888-1336
Catholic Charities	Riverside: (951)924-9964	San Bernardino: (909)388-1239
Path of Life	Riverside: (951)962-9822	
Homeless Coalition		San Bernardino: (909)723-1590

BASIC NEEDS:

5. **In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?** ☐ Yes ☐ No
6. **In the last 12 months, has your utility company shut off your service for not paying your bills?**
   ☐ Yes ☐ No

General Resources/Food Pantries/Utility Assistance

Transgender Community Coalition	Riverside: (833)944-5433	San Bernardino: (833)944-5433
Helping Hands Pantry		San Bernardino: (909)796-4222
Feed America	Riverside: (951)359-4757	San Bernardino: (951)359-4757
CAP Programs/Weatherization	Riverside: (951)955-4900	San Bernardino: (909)723-1500

TRANSPORTATION:

7. **In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?** ☐ Yes ☐ No

Transportation Resources

Medical _ ALC (IEHP Benefit)	Riverside: (800)440-4347	San Bernardino: (800)440-4347

LANGUAGE ACCESS:

8. Do you ever need help reading or filling out medical forms?"

☐ Yes ☐ No

Language/ Disability Access Resources

IEHP Member Services ..... Riverside: (800)440-4347 ..... San Bernardino: (800)440-4347

SAFETY / LEGAL AID:

9. Are you afraid you might be hurt by someone, including family, where you live?

☐ Yes ☐ No

10. How often does anyone, including family, physically hurt you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

11. How often does anyone, including family, threaten you with harm?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

Legal/Safety Resources

Inland Counties Legal Services ..... Riverside: (888)455-4257 ..... San Bernardino: (888)455-4257

Disability Rights California..... Riverside: (213)427-8747 ..... San Bernardino: (213)427-8747

Domestic Violence Resources

24 Hour Crisis Hot-line..... Riverside: (951)683-0829

24 Hour House of Ruth..... San Bernardino: (909)988-5559

Foothills AIDS Project..... Riverside: (800)448-0858..... San Bernardino: (800)448-0858

CAREGIVER NEEDS:

12. Do you need help with any of these self-care skills? Please check all that apply.

☐ Cleaning the house
☐ Taking your medicines
☐ Making/cooking meals
☐ Dressing or undressing
☐ Getting out of a chair
☐ Moving in or out of bed
☐ Paying your bills or handling your money
☐ Combing hair or brushing teeth
☐ Shopping for food or clothes
☐ Walking or climbing stairs around the house
☐ Bathing
☐ Feeding yourself
☐ Other
☐ None
☐ Going to the toilet

13. If you become sick or are not able to care for yourself, do you have a family member, friend, or emergency back-up caregiver to help you at home? ☐ Yes ☐ No

Name_____Telephone Number: _____

Relationship to you: _____

14. Can IEHP, or contracted provider, speak with the person (caregiver) named above about your health care needs or plan of care? ☐ Yes ☐ No

Patient Signature_____ Date: _____

15. Are you able to make all choices about your health care, housing, transportation, caregiver and other social needs? ☐ Yes ☐ No

If needs and resources are identified in any section of the survey (or if additional needs or resources are identified but not listed in the survey), please encourage the Member to contact IEHP Member Services at **1-800-440-IEHP (4347)**.