Department of Human Services
Med-QUEST Division

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#	☐ Unknown ☐ 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:
Mailing Address (if different from current address)				
Street:		City and State:		Zip Code:

Contact Information:	Phone Number	Can receive texts?	Email Address:	Any friends or family who can help reach you? Yes ◯ No ◯ If yes, please specify:	Contact Name:
	1.	Yes ◯ No ◯			Contact Ph Number:
	2.	Yes ◯ No ◯			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:	◯ Excellent	◯ Very Good	◯ Good	◯ Fair	◯ Poor
2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days 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 the past 30 days was your mental health not good?	Number of Days _____				
4. During the past 30 days, 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)	at an emergency shelter	at a temp/transitional shelter	in a supervised group home	in a shared apartment	in an independent apartment
	_____ days	_____ days	_____ days	_____ days	_____ days	_____ days
6. Do you have any new accessibility needs?	◯ Yes*	◯ No	*6a. If yes, what are your accessibility needs?			

7. Are you currently housed?	☐ Yes. If **yes**:	☐ No. If **no**:
	7a. What type of housing: ◯ Permanent ◯ Temporary/Transitional ◯ Institutional ◯ Other 7b. Are you newly housed since the last assessment: ◯ Yes ◯ No	7c. Have you lost housing since last assessment: ◯ Yes ◯ No

8. **Tenancy Only:** Are you satisfied with your current housing?	◯ Yes	◯ No*	*8a. If no, what are your concerns?

Part V: Services/Resource Utilization

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

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

Part VI: Person-Centered Housing Goals

28. What are your **housing** goals (short-term and long-term)? **(Complete during initial assessment. Review and revise as needed quarterly)**
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: ◯ Yes ◯ No
30. CIS assessment completed during this quarter: ◯ Yes ◯ No
31. Notes:

Part VIII: Discharge from CIS:

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

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