Hearts & Minds Patient Advocacy INC

New Client Intake & Needs Assessment Form

Mission: We provide support and advocacy for patients and their families as they encounter health obstacles. **Vision:** Each patient and/or family member feels adequately supported and heard during their health endeavors improving their healthcare experience.

Section 1: Client/Patient Contact Information

Field	Details
Full Legal Name:	_____
Date of Birth:	_____
Phone Number:	_____
Current Mailing Address:	_____
Primary Language Spoken:	_____ *(Helps evaluate language barriers)*
Primary Support Person/Next of Kin:	_____ *(Important if patient is isolated)*
Contact Phone for Support Person:	_____

Section 2: Patient Profile & Demographics

Please check the category(ies) that best describe the patient's situation, based on our target populations .

A. Patient Status:

- □ **Elderly** (Needs help with day-to-day tasks or wellness checks)

- □ **Critically Ill** (Debilitating illness/terminal condition)
- □ **Disabled Person** (Handicap needing help with daily tasks/resources)
- □ **Expecting Mother** (Need help adjusting or attaining post-partum resources)
- □ **Family of Patient** (Seeking support for their role as a primary caregiver)
- □ **Low-Income Family**
- □ **Other Chronic Condition**

B. Referral Information:

- **How did you hear about Hearts & Minds?**
  - □ Hospital Social Worker/Case Manager
  - □ Community Health Center/Clinic
  - □ Government Agency (e.g., Medicaid office)
  - □ Friend/Family/Word-of-mouth
  - □ Marketing Material (Flyer/Brochure)
  - □ Other: _____

Section 3: Specific Advocacy Needs Assessment

Please check **all** areas where you or your family require immediate support. This information will be used to develop your strategic support plan.

A. Healthcare and Coordination

- □ Need to be **accompanied to doctor appointments** (regular or specialist)
- □ Need assistance with **regular wellness checks**
- □ Need help understanding or adjusting to a **new diagnosis/illness**
- □ Need help coordinating with **multiple healthcare providers** (doctors, specialists, therapists)
- □ Need assistance with **hospital discharge planning**

B. Resources and Logistical Support

- □ Need help **attaining financial resources** (e.g., government aid, grants)
- □ Need help attaining **post-partum resources** (for expecting mothers/families)
- □ Need assistance with **housing instability**
- □ Need assistance with **day-to-day tasks** related to the illness/condition

C. Financial and Legal Planning

- □ Need help with **financial management** related to illness
- □ Need assistance with **will planning** or other legal directives

D. Isolation and Social Support

- □ I feel I have **minimal support** (isolated or no next of kin)
- □ My **family/support system** is also struggling and needs assistance

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Section 4: Current Situation (Narrative)

Please briefly describe your primary medical challenge and your most urgent need right now.

Current Medical Challenge:

_____
_____

Most Urgent Need for Advocacy:

_____
_____

For Internal Use Only | Case Coordinator Assigned: | _____ | | Intake Date: | _____ | | Strategic Plan Developed (Y/N): | □ Yes □ No |