











Supplemental File 1. Social Needs Screening Tool

ENGLISH

PLEASE PLACE PATIENT LABEL HERE

Your care team is interested in your complete wellness. Please take a moment to answer the questions below prior to seeing your doctor. **This is an optional questionnaire.**

		YES / NO
	Are you worried that in the next 2 months, you may not have a safe or stable place to live? (risk of eviction, being kicked out, homelessness)	<input type="checkbox"/> Y <input type="checkbox"/> N
	Are you worried that the place you are living now is making you sick? (has mold, bugs/rodents, water leaks, not enough heat)	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the past 12 months, has the electric, gas, oil or water company threatened to shut off services to your home?	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, did you worry that your food could run out before you got money to buy more?	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, has lack of transportation kept you from medical appointments or getting your medications?	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, did you have to skip buying medications or going to doctor's appointments to save money?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Do you need help getting child care or care for an elderly or sick adult?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Do you need legal help? (child/family services, immigration, housing discrimination, domestic issues, etc)	<input type="checkbox"/> Y <input type="checkbox"/> N
	Are you finding it hard to get along with a partner, spouse, or family members?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Does anyone in your life hurt you, threaten you, frighten you or make you feel unsafe?	<input type="checkbox"/> Y <input type="checkbox"/> N

Phone Number: _____

Best time to Call: _____

Montefiore Social Determinants of Health Screen
As of: March 9, 2018

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