New York State Department of Health
Health Home Functional Questionnaire

- This form has been developed to be administered with the FACT-GP (Version 4) Form.
- Please circle or check one answer per line to indicate your response as it applies to the past 7 days.

Name of Health Home ______________________________

Medicaid Client Identification Number (CIN) ______________________________

Date Administered ____/____/____
MM / DD / YY

Assessment Type (Check (✓) one)

☐ Initial ☐ Annual ☐ Discharge

	Questions	**Not at all**	**A little bit**	**Some-what**	**Quite a bit**	**Very much**
HH1	I need assistance dressing myself	0	1	2	3	4
HH2	I need assistance eating………..	0	1	2	3	4
HH3	I need interpretation services…..	0	1	2	3	4
HH4	I have people to help me if I need it…………………………..	0	1	2	3	4
HH5	I go to my doctor/clinic to address my behavioral/medical health needs…………………….	0	1	2	3	4

	Question	**Yes**	**No**
HH6	I am homeless…………………	☐	☐

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Care Manager Name (print) Original Signature Date

5 Mar 2012