Atlanta EMA Screening Tool

(Case Management, Legal, Substance Use and Mental Health Screen)

Client's Full Name: _____ Date: _____ / _____ / _____

Client's DOB: _____ / _____ / _____

Client's sex at birth (circle one): Male Female Client served in military (circle one): Yes No

Client's gender (circle one): Male Female Transgender MTF Transgender FTM Transgender unspecified

Screener's name: _____

Agency: _____ Start time: _____

Intro: "*I'm going to ask you some Yes or No questions about your personal behavior and living situation to get you started. We ask these questions of all of our new clients as part of our intake process.*"

- ✓ Fill out information below
- ✓ Answer prescreen question based on your knowledge and observation of the client
- ✓ Complete the remainder of questions on the screen, circling the appropriate response
- ✓ Total the client's responses where indicated in the gray right hand column
- ✓ Record the screen results and any referrals made on the last page

DO NOT ASK CLIENT, complete before beginning screen:

Is there a barrier that prevents the agency/client from completing the screen (cannot communicate in English, is deaf or hard of hearing, lack of capacity etc.)?

Y **N**

If **yes:**

- **End** screen
- **Fill out** screen disposition on back page
- **Refer** for case management assessment

	Ask the client:		**Circle the client's response**		
1.	Are you able to do things that are necessary for your health and well being? Some examples are getting to your doctor's appointments, preparing meals, filling out forms **OR** budgeting.	**Y (SKIP to Question 2)**	**N** → Is there someone who is always able to help you when you need assistance?	**Y**	**N**
2.	Do you have a doctor, nurse or other health care provider that is treating you for your HIV?			**Y (ask next)**	**N (skip to 4)**
			In the **past year,** have you ever missed your appointments AND not rescheduled them?	**Y**	**N**

Client's Name: _____ Client's DOB: _____

Screener's Name: _____ Date: _____

	Ask the client:		Circle the client's response		
3.	Are you **currently** taking any prescribed medications? These could be any kind of medications, such as antiretrovirals for your HIV or medications for another illness like diabetes or depression.	**Y**	**N** **(Skip to Question 4)**		
		Are you taking these medications the way your health care provider has instructed you? →		**Y**	**N**
4.	Are your basic needs for things like food and toiletries met **every month**?			**Y**	**N**
5.	Do you need assistance with access to benefits, such as Social Security, TANF, and SNAP, Medicaid, Medicare or other programs?	**Y**	**N**		
	Do you need legal assistance with matters such as:				
	• Guardianship/ Wills/ Power of Attorney	**Y**	**N**		
	• Probation or Parole/ Criminal History	**Y**	**N**		
	• Bankruptcy/Debt	**Y**	**N**		
	• Housing Conditions	**Y**	**N**	**Y**	**N**
	• Eviction proceedings	**Y**	**N**		
	• Employment Discrimination	**Y**	**N**		
6.	In the **past year**, have you been sexually active?	**Y**	**N** **(Skip to Question 8)**		
		In the **past year**, have you used condoms every time you had sex? →		**Y**	**N**
	DO NOT ASK CLIENT:				
7.	Screener recommendation for assessment: If yes, note observations of client here:			**Y**	**N**

TOTAL NUMBER OF CIRCLES IN GRAY COLUMN FOR 1 – 7 HERE ☐

Client's Name: _____ Client's DOB: _____

Screener's Name: _____ Date: _____

8.	During the **next three months**, are you going to need help finding a place to live OR are you currently past due on your utilities, rent or mortgage?	**Y**	**N**

TOTAL NUMBER OF CIRCLES IN GRAY COLUMN FOR 8 HERE ☐

	Ask the client:			**Circle the client's response**
9.	Are you **currently** being treated for a substance use problem? This includes getting help from a professional like a psychologist or counselor**.**	**Y**	**N / DK**	If **yes**: • **SKIP to question 16**
10.	Have you **ever** drank alcohol or done drugs?	**Y**	**N**	If **no**: • **SKIP to question 16**

11.	During the **past month**, have you felt you ought to cut down on your drinking or drug use?	**Y**	**N**
12.	During the **past month**, have people annoyed you by criticizing your drinking or drug use?	**Y**	**N**
13.	During the **past month**, have you felt bad or guilty about your drinking or drug use?	**Y**	**N**
14.	During the **past month**, have you had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (an eye-opener)?	**Y**	**N**
15.	In the **past year**, have you used a needle to inject drugs? **Y** → In the **past year**, have you shared needles or works?	**Y**	**N**
	N →	**Y**	**N**

TOTAL NUMBER OF CIRCLES IN GRAY COLUMN FOR 9 – 15 HERE ☐

16.	Are you **currently** being treated for a mental health problem? This includes getting help from a professional like a psychologist or counselor, or taking medication for depression or anxiety.	**Y**	**N / DK**	If **yes**: • **END** screen • **Score** screen

17.	During the **past month**, have you experienced hearing or seeing things that other people don't seem to hear or see?	**Y**	**N**
18.	During the **past month**, have you experienced or been bothered by feeling down, sad, depressed, or hopeless?	**Y**	**N**

Client's Name: _____ Client's DOB: _____

Screener's Name: _____ Date: _____

19.	During the **past month**, have you experienced or been bothered by a decreased interest or pleasure in doing things?			**Y**	**N**
	During the **past month**, have you noticed that you don't enjoy doing things as much as you used to?			**Y**	**N**
20.	During the **past month**, have you had thoughts:				
	Of wanting to give up?	**Y**	**N**	**Y**	**N**
	Of going to sleep and not wanting to wake up?	**Y**	**N**		
	Of not wanting to go on living?	**Y**	**N**		
	That you would be better off if you were dead?	**Y**	**N**		
	Of wanting to hurt or harm yourself in some way?	**Y**	**N**		
	Of wanting to kill yourself?	**Y**	**N**		
21.	During the **past month**, have you had thoughts of:				
	Wanting to harm or hurt other people?	**Y**	**N**	**Y**	**N**
	Wanting to kill other people?	**Y**	**N**		

TOTAL NUMBER OF CIRCLES IN GRAY COLUMN FOR 16 – 21 HERE ☐

Conclusion: "Thank you for your time."

End time: _____

Client's Name: _____ Client's DOB: _____

Screener's Name: _____ Date: _____

Results

Questions	Total Number of Circles in Gray Column	Case Management Assessment	Substance Use Assessment	Mental Health Assessment	Legal Assessment
1 - 7		YES if 2 or higher			
5					YES if 1
8		YES if 1			
9		YES if 1			
11 - 15		YES if 2 or higher	YES if 2 or higher		
16		YES if 1			
17 - 21		YES if 1 or higher		YES if 1 or higher	

Screen Disposition

If screen was not completed:			Referred to:	Date Referred:	Kept Appt.?	
Barrier List Barrier:	Y	N		/ /	Y	N
Client refused	Y	N				

Case management screen results:			Referred to:	Date Referred:	Kept Appt.?	
Referred for case management assessment	Y	N		/ /	Y	N
			If no, client offered resource packet?	Y	N	

Substance use screen results:			Referred to:	Date Referred:	Kept Appt.?	
Referred for substance use assessment	Y	N		/ /	Y	N

Date:_____

Mental health screen results:			Referred to:	Date Referred:	Kept Appt.?	
Referred for mental health assessment	Y	N		/ /	Y	N

Legal screen results:			Referred to:	Date Referred:	Kept Appt.?	
Referred for legal check-up	Y	N		/ /	Y	N

Comments:

Referring Agency Information

Client's Name		
	First Name	Last Name

Agency Information	
Agency's Name	
Address	
Phone Number	
Screener's Name	