

Montana Health Justice Partnership Screening Tool

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Patient Information

*If patient is a minor, parent or custodial guardian should fill out this form with the child's information.

Full Name _____
 First _____ Last _____ Middle _____

Address _____
 Street _____ City _____ State _____ Zip _____ Apt./Unit# _____

Phone _____ Birth Date __/__/____ Sex _____ Fema Mal

SSN XXX-XX-____ Chief Complaint: _____

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.	<input type="checkbox"/>	Food	<input type="checkbox"/>	Medicine or any health care (medical, dental, mental health, vision)
	<input type="checkbox"/>	Clothing		
	<input type="checkbox"/>	Utilities		
	<input type="checkbox"/>	Child care	<input type="checkbox"/>	Other (Please write) _____
	<input type="checkbox"/>	Phone		
	<input type="checkbox"/>	I choose not to answer this question		
Do you have a problem with your housing? (e.g. pests, mold, lead, having utilities shut off, landlord disputes)	<input type="checkbox"/>	Yes		
	<input type="checkbox"/>	No		
	<input type="checkbox"/>	I choose not to answer this question		
Are you worried about losing your housing?	<input type="checkbox"/>	Yes		
	<input type="checkbox"/>	No		
	<input type="checkbox"/>	I choose not to answer this question		
Are your wages being garnished or are you being harassed by collection companies?	<input type="checkbox"/>	Yes		
	<input type="checkbox"/>	No		
	<input type="checkbox"/>	I choose not to answer this question		
Are you having any problems receiving child support? Have your circumstances changed so that the amount of support you are getting should be adjusted?	<input type="checkbox"/>	Yes		
	<input type="checkbox"/>	No		
	<input type="checkbox"/>	I choose not to answer this question		
Are your children unable to get the services they need from their school?	<input type="checkbox"/>	Yes		
	<input type="checkbox"/>	No		
	<input type="checkbox"/>	I choose not to answer this question		
Do you feel physically and emotionally safe where you currently live?	<input type="checkbox"/>	Yes		
	<input type="checkbox"/>	No		
	<input type="checkbox"/>	Unsure		
	<input type="checkbox"/>	I choose not to answer this question		
In the past year, have you been afraid of your partner or ex-partner?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	I have not had a partner in the past year
	<input type="checkbox"/>	No		
	<input type="checkbox"/>	Unsure	<input type="checkbox"/>	I choose not to answer this question
Have you applied for and been denied unemployment or disability benefits?	<input type="checkbox"/>	Yes		
	<input type="checkbox"/>	No		
	<input type="checkbox"/>	I choose not to answer this question		
Are you having any federal tax problems and/or have you received any notices from the IRS?	<input type="checkbox"/>	Yes		
	<input type="checkbox"/>	No		
	<input type="checkbox"/>	I choose not to answer this question		
Would you like to speak with a legal advocate about these or other civil legal issues?	<input type="checkbox"/>	Yes		
	<input type="checkbox"/>	No		