Patient Name_____

Barriers	**(Check one) Yes or No**	
History of Eviction	☐ Yes	☐No
Felony Conviction	☐ Yes	☐No
Low income	☐ Yes	☐No
Lacks steady, full-time employment	☐ Yes	☐No
Less than high school or GED education	☐ Yes	☐No
Limited English proficiency	☐ Yes	☐No
No car and no/inadequate access to public transportation	☐ Yes	☐No
Lack of child care	☐ Yes	☐No
Lack of work history	☐ Yes	☐No
Denial that services are needed	☐ Yes	☐No
Lack of a support system	☐ Yes	☐No
Untreated mental illness/not taking meds	☐ Yes	☐No
Not knowing resources	☐ Yes	☐No
Ineligible for Public Programs	☐ Yes	☐No
No Phone	☐ Yes	☐No
Unstable Living	☐ Yes	☐No
Abuse	☐ Yes	☐No
Trauma	☐ Yes	☐No
Chemical Abuse	☐ Yes	☐No
Developmental Disability	☐ Yes	☐No
HIV/AIDS	☐ Yes	☐No
Mental Illness	☐ Yes	☐No
Physical /Medical (no accessibility features required)	☐ Yes	☐No
Physical /Mobility Limits (accessibility features required)	☐ Yes	☐No
Dual Diagnosis (MI/CD)	☐ Yes	☐No
Hearing Impaired	☐ Yes	☐No
Vision Impaired	☐ Yes	☐No
Other (Speech) Impaired	☐ Yes	☐No