

Required data elements for screenings conducted outside the SCN IT Platform

*Indicates a required field for data submission to receive reimbursement

Item	Question	Response
Screening Entity Responses		
Type*	Screening Entity Type	Healthcare Provider Hospital Department Organizational Team Government Insurance Company Payer Educational Institute Religious Institution Clinical Research Sponsor Community Group Non-Healthcare Business or Corporation Other
ID*	Screening Entity ID	<i>Screener's TIN, FEIN, MMIS or NPI</i>
Name*	Name of entity conducting the screening	<i>Cannot be NULL</i>
Address 1*	Address Line 1 that the Screening Entity is located	<i>Cannot be NULL</i>
Address 2	Address Line 2 that the Screening Entity is located	
City*	City that the Screening Entity is located	<i>Cannot be NULL</i>
Postal Code*	Postal Code that the Screening Entity is located	<i>Data Format: 5 digits</i>
County*	County that the Screening Entity is located	<i>Data format: Text</i>
State*	State that the Screening Entity is located	<i>Data format: 2 Characters</i>
Screen Identifier*	Unique interaction identifier assigned to a screening.	
Screen Language*	Language in which the screening was conducted.	<i>See response options for "Spoken Language", below</i>
NYS HRSN Parent Local Code*	Local code to identify the provision of the NYS-specific interaction of the AHC screening.	NYSAHCHRSN
Screen Domains*	Social care needs domain reflective of Gravity Project social history categories for AHC HRSN questions.	Housing Instability Homeless Inadequate Housing Utility Insecurity Food Insecurity Transportation Insecurity Employment Status SDOH Category Unspecified



Screen Potential Unmet Risk*	Local code to identify the provision of the NYS-specific interaction of the AHC screening.	LOINC response codes from AHC Screening (below) for which the patient indicated positive need
Member Responses		
Question 0*	We use this survey to understand needs our [Members / patients / clients] have which could interfere with good health. We may share your answers with your other healthcare providers, and with your health plan and social services organizations, so they can determine if you qualify for any free non-medical services that could be helpful. Please check this box if you agree to continue. You can choose not to answer this survey, but we can only check for services if you do answer.	Permit
		Deny
Medicaid Client Identification Number (CIN)*	Unique identification number assigned by NYS Medicaid Program to a patient at time of initial enrollment through either the county or NYSoH.	Data Format: AA00000A
Medical Record Number (MRN)*	Unique identification number assigned by the organization who screens the patient and used to identify the patient within the organization's records.	Content may vary from different sources.
Social Security Number (SSN)	Unique identification number assigned by the Social Security Administration to a patient.	Cannot be NULL Data Format: 999999999
Patient Last Name*	Patient's last name, reported by patient at time of interaction.	Cannot be NULL
Patient First Name*	Patient's first name, reported by patient at time of interaction.	Cannot be NULL
Patient Middle Initial	Patient's middle initial, reported by patient at time of interaction.	
Date of Birth*	Patient's date of birth	Data format: DD/MM/YYYY
Sex*	Patient's administrative gender, reported by patient at time of interaction.	Male
		Female
		Other
		Unknown
Patient Address Line 1*	Patient's residential county street address, reported by patient at time of interaction.	Cannot be NULL
Patient Address Line 2	Patient's residential county street address, reported by patient at time of interaction.	
Patient City*	Patient's residential county city, reported by patient at time of interaction.	Cannot be NULL
Patient Postal Code*	Patient's residential county postal code, reported by patient at time of interaction.	Cannot be NULL Data format: 5 digits
Patient County*	Patient's residential county, reported by patient at time of interaction.	Cannot be NULL Data format: text
Patient State*	Patient's residential state, reported by patient at time of interaction.	Cannot be NULL Data format: 2 characters
NYS Accountable Health Communities (AHC) Health-Related Social Needs Screening (HRSN) Tool	1. What is your living situation today?*	I have a steady place to live
		I have a place to live today, but I am worried about losing it in the future
		I do not have a steady place to live (I am temporarily staying with others, in a



	hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY*	Pests such as bugs, ants, or mice
	Mold
	Lead paint or pipes
	Lack of heat
	Oven or stove not working
	Smoke detectors missing or not working
	Water leaks
	None of the above
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home*	Yes
	No
	Already shut off
4. Within the past 12 months, you worried that your food would run out before you got money to buy more.*.	Often true
	Sometimes true
	Never true
5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.*.	Often true
	Sometimes true
	Never true
6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?*	Yes
	No
7. Do you want help finding or keeping work or a job?*	Yes, help finding work
	Yes, help keeping work
	I do not need or want help
8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.*	Yes
	No
9. How often does anyone, including family and friends, physically hurt you?	Never (1)
	Rarely (2)
	Sometimes (3)
	Fairly Often (4)
	Frequently (5)
10. How often does anyone, including family and friends, insult or talk down to you?	Never (1)
	Rarely (2)
	Sometimes (3)
	Fairly Often (4)
	Frequently (5)
11. How often does anyone, including family and friends, threaten you with harm?	Never (1)
	Rarely (2)



		Sometimes (3)
		Fairly Often (4)
		Frequently (5)
	12. How often does anyone, including family and friends, scream or curse at you?	Never (1)
		Rarely (2)
		Sometimes (3)
		Fairly Often (4)
		Frequently (5)
	13. Safety Score	Sum of response values 9-12
Gender	What is the Member's gender identity?	Female Gender Identity
		Male Gender Identity
		Non-Binary Identity
		Asked but Declined
		Unknown
Preferred Pronouns	What are the Member's preferred pronouns?	He/Him/His/His/Himself
		She/Her/Hers/Herself
		They/Them/Their/Theirs/Themselves
		Other
		Unknown
Sexual Orientation	What is the Member's sexual orientation?	Bisexual
		Heterosexual
		Homosexual
		Other
		Asked but Unknown
		Unknown
Ethnicity	What is the Member's ethnicity?	Hispanic or Latino
		Not Hispanic or Latino
		Asked but Unknown
		Unknown
Race	What is the Member's race?	American Indian or Alaska Native
		Asian
		Black or African American
		Native Hawaiian or Other Pacific Islander
		White
		Asked but Unknown
Spoken Language	What is the Member's preferred language spoken?	Arabic
		Bengali
		Czech
		Danish
		German



		German (Austria) German (Switzerland) German (Germany) Greek English English (Australia) English (Canada) English (Great Britain) English (India) English (New Zeland) English (Singapore) English (United States) Spanish Spanish (Argentina) Spanish (Spain) Spanish (Uruguay) Finnish French French (Belgium) French (Switzerland) French (France) Frysian Frysian (Netherlands) Hindi Croatian Italian Italian (Switzerland) Italian (Italy) Japanese Korean Dutch Dutch (Belgium) Dutch (Netherlands) Norwegian Norwegian (Norway) Punjabi Polish Portuguese Portuguese (Brazil) Russian Russian (Russia) Serbian Serbian (Serbia) Swedish Swedish (Sweden) Telegu Chinese Chinese (China) Chinese (Hong Kong) Chinese (Singapore) Chinese (Taiwan)
Physical Disability	Does the Member have serious difficulty walking or climbing stairs (5 years old or older)?	Yes
		No



		Decline to Answer
		Yes
	Does the Member have serious difficulty dressing or bathing (5 years old or older)?	No
		Decline to Answer