Whole-Person Needs and Barriers Map

A person-centered review of needs, urgency, strengths, barriers, preferences, supports, referrals, responsibilities, and follow-up across major life domains.

COMPREHENSIVE CLINICIAN PACKAGE

Included	Designed for
Clinician guide and implementation sequence	Case managers, social workers, counselors, care coordinators, community health workers, multidisciplinary teams, and behavioral-health programs.
Comprehensive adult/client worksheets	Individual, group, community, or case-management use
Adolescent adaptation where appropriate	Use with clinical judgment and developmental adaptation
Processing questions and progress review	Session use or structured between-session practice
One-page client quick sheet	Printable and digitally fillable

Professional scope and safety

This original educational resource supports professional conversation, reflection, skills practice, service planning, and documentation. It is not a validated assessment, diagnostic instrument, psychotherapy protocol, treatment-plan substitute, risk assessment, crisis plan, or emergency intervention. Clinicians and programs are responsible for determining appropriateness, obtaining consent, adapting language, protecting confidentiality, and following applicable laws, ethical standards, agency policies, and supervision requirements.

Do not use this worksheet to delay emergency evaluation or mandated action. If there is concern about imminent danger, abuse, neglect, exploitation, grave disability, medical instability, or another urgent safety issue, follow local emergency and organizational procedures.

Original content and permitted use

Clinician Guide

The Whole-Person Needs and Barriers Map supports collaborative identification and prioritization of needs that affect safety, stability, health, engagement, and quality of life. It is designed to preserve client voice and strengths while organizing concrete next steps.

Best-fit uses

- Initial engagement or broad needs review
- Service coordination and referral planning
- Identifying practical barriers to treatment or program participation
- Preparing for case conference or multidisciplinary coordination
- Periodic reassessment and transition planning

Use additional caution or choose another tool when

- The form is being treated as a validated social-needs screener or eligibility instrument
- Information is requested without explaining purpose, privacy, choice, and mandatory limits
- The client faces immediate safety, medical, abuse, neglect, exploitation, housing, food, or other crisis needs requiring urgent action
- The professional cannot provide or responsibly refer for the service being discussed
- Completion would create documentation or disclosure risk without adequate safeguards

Suggested implementation sequence

1. Explain purpose and choice
Clarify why information is requested, how it will be used, privacy limits, and that the client may decline nonrequired items.

2. Begin with client priorities
Ask what matters most before reviewing professional concerns.

3. Review domains selectively
Do not force every section when it is irrelevant or overly burdensome.

4. Identify strengths and current resources
Document what is already working and who the client trusts.

5. Prioritize collaboratively
Consider client preference, urgency, safety, deadlines, and realistic capacity.

6. Assign concrete next steps
Specify person responsible, required documents, referral status, and follow-up date.

7. Close the loop
Confirm whether connection occurred and whether the resource was acceptable and effective.

Suggested processing questions

- What is creating the greatest pressure right now?
- Which change would make other goals easier?
- What has already been tried?
- What barriers are practical, relational, cultural, systemic, financial, or accessibility-related?
- What support is acceptable to the client?
- Who is responsible for the next step, and how will follow-up occur?

Conceptual influences

Conceptual influences include person-centered planning, social determinants and health-related social needs frameworks, trauma-informed care, shared decision-making, and closed-loop referral practice. This original map is not a validated screening or eligibility tool.

1. Client Priorities, Strengths, and Preferences

Start with the client's words, not the program's categories.

What matters most to the client right now - in the client's own words

Strengths, abilities, relationships, routines, cultural resources, and past successes

Preferences for communication, identity language, decision-making, accessibility, and involvement of others

Information-sharing permissions and limits to confirm before coordination

2. Basic Stability and Daily Living

Review only what is relevant and explain why each area matters.

Domains

- [ ] Housing
- [ ] Food
- [ ] Utilities
- [ ] Clothing
- [ ] Transportation
- [ ] Phone/internet
- [ ] Identification
- [ ] Daily living
- [ ] Child/dependent care
- [ ] Immediate safety
- [ ] Other

Current status, urgency, deadlines, and client-defined concern

Existing resources and what is already working

Barriers to access or stability

Immediate and next-step response

3. Health, Behavioral Health, and Recovery Supports

Do not use this page as diagnosis, medical advice, or risk assessment.

Areas to consider

- ☐ Primary care
- ☐ Medication access
- ☐ Dental
- ☐ Vision/hearing
- ☐ Pain/mobility
- ☐ Mental health
- ☐ Substance use
- ☐ Sleep
- ☐ Nutrition
- ☐ Health coverage
- ☐ Crisis support
- ☐ Other

Client priorities, current providers, and care-coordination needs

Access barriers, previous negative experiences, cultural concerns, or accommodations

Consent and information needed for coordination

Next action and responsible party

4. Income, Education, Employment, Legal, and Community

Document concrete barriers without implying professional expertise outside role.

Domains

- ☐ Income/benefits
- ☐ Employment
- ☐ Education
- ☐ Debt/financial
- ☐ Legal/court
- ☐ Immigration referral
- ☐ Veteran services
- ☐ Community connection
- ☐ Spiritual/cultural
- ☐ Recreation
- ☐ Other

Client goals and current status

Deadlines, documentation, eligibility questions, or referral needs

Barriers, strengths, and acceptable supports

Next action, responsible party, and follow-up date

5. Prioritization Matrix

Balance client preference, urgency, safety, deadlines, and capacity.

Priority 1 - need, why now, desired outcome, first action, owner, and date

Priority 2 - need, why now, desired outcome, first action, owner, and date

Priority 3 - need, why now, desired outcome, first action, owner, and date

Needs acknowledged but intentionally deferred - reason and review date

6. Referral and Closed-Loop Follow-Up

A referral is not complete until the outcome is known.

Resource/provider, contact information, eligibility, documents, and accessibility

Referral date, method, consent, and responsible person

Outcome: reached, scheduled, waitlisted, denied, declined, unavailable, or alternative needed

Client experience and whether the resource was acceptable/useful

Next follow-up action and date

Adolescent Adaptation

Center the young person's priorities while recognizing legal, developmental, caregiver, school, and system factors.

Use with developmental and family-system awareness

- Clarify youth and caregiver roles
- Ask who the young person trusts
- Include school, transportation, technology, food, safety, and peer context
- Do not promise confidentiality beyond legal limits
- Avoid making the youth repeat sensitive information unnecessarily

What the young person wants help with first

What adults or systems are most helpful right now

What gets in the way at home, school, appointments, or in the community

What the young person wants adults to understand

Next step, who will do it, and when the youth will receive an update

Adult support without taking over

Adults should provide understandable choices, explain decisions, reduce repeated storytelling, and document the young person's perspective even when the final plan includes responsibilities held by adults.

Progress Review and Clinical Integration

Use this page to review what changed, what remained difficult, and what should happen next. Avoid treating worksheet completion as proof of clinical improvement.

What did the client notice or understand that was not clear before?

What skill, action, referral, support, or environmental change was attempted?

What was the observable result? Include client-reported benefit, burden, or unintended effect.

What barriers, cultural factors, accessibility needs, risks, or contextual pressures affected the result?

What should be continued, modified, stopped, or referred for additional support?

Clinical documentation note: objective summary, client voice, intervention, response, and follow-up plan.

Whole-Person Priority Map

Identify the most important needs, strengths, barriers, and next actions without completing a full assessment.

What matters most right now - in the client's own words

Current strengths, resources, and supportive people

Most urgent practical, health, emotional, legal, or safety-related need

Main barrier preventing progress

First action, responsible person, and target date

How and when the client will receive follow-up

Use this page as a conversation and reflection aid. It is not a diagnosis, assessment, safety plan, or substitute for individualized professional care.