FALLON HEALTH CARE NEEDS SCREENING FORM

PLEASE DO NOT FOLD.

Please take a few minutes to complete this screening. Your Care Needs Screening will help Fallon Health provide better health services and coordinate the care you receive. We will keep the information you provide private. By submitting this form, you are giving us permission to share your information with the people involved in your care. Your answers will NOT affect your MassHealth/Medicaid benefits.

Answer all the questions. Mail it back to us. Get a $10 gift card!

(Limit: one card every 12 months.)

Survey instructions:

1. Please fill out one screening form for each new member. If you are answering for your child and/or your family, please answer each question as it applies to your child and/or your family.

2. "The member" refers to you, or the individual for which you are completing the screening for.

3. You will need to have on hand:
    a) The member's plan member ID number
    b) The name, phone number and address of the member's doctor or nurse

4. Answer each of the questions by checking the appropriate box or filling in the space provided.

5. Your are sometimes told to skip over questions in this survey. When this happens, you will see a note that tells you what question to answer next.

6. This screening will take about 10 minutes to complete.

7. If you need help or have questions about completing this form, please call Customer Service at the number on the back of your member ID card, Monday through Friday from 8 a.m. to 6 p.m.

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General member information

Q1 The member's name Last, First, MI)

Last name

First name

MI

Q2 The member's Fallon MassHealth member ID number

Q3 The member's Date of Birth (e.g., 12/25/1995)

Q4 Relationship (to member) of person completing this form:

Self……..……. ☐
Parent……..…….. ☐
Spouse/Partner……..... ☐
Family or relative……..…….. ☐
Professional caregiver……..…….. ☐
Authorized representative……...… ☐

Q5 Address (number and street)

Number

Street

City/Town

State

ZIP

Q6 Phone numbers

Home:

Cell:

Work:

Other:

Q7 Best time to call:

Morning…….. ☐ Afternoon……. ☐

Q8 Email address

Q9 Preferred language spoken

English……..……..……. ☐
Spanish……..……...….. ☐
Other……..... ☐

If other, please specify:

Q10 The member's gender

Male……..……...……..…. ☐
Female……..……...……..…..... ☐
Non-binary……..……..... ☐
Transgender……..… ☐
Intersex…….. ☐
Gender non-conforming…….. ☐
Other……... ☐

If other, please specify:

Q11 Is the member hearing impaired?

Yes……..……..……. ☐
No……..……...….. ☐
Not sure……..... ☐

Q12 Is the member visually impaired?

Yes……..……..……. ☐
No……..……...….. ☐
Not sure……..... ☐

Q13 Does the member currently get services from any state agency?

Yes…… ☐

No…… ☐

Not sure……..... ☐

If yes, please check as many as apply:

Massachusetts Commission for the Blind……. ☐

Massachusetts Commission for the Deaf and Hard of Hearing…….. ☐

Massachusetts Rehabilitation Commission…….. ☐

Department of Mental Health…….. ☐

Department of Developmental Services…… ☐

Division of Children and Families……... ☐

Special Education……. ☐

Early Intervention Program……. ☐

Other……... ☐

Q14 Does the member currently get services from a Long Term Service and Support (LTSS) Program?

Yes…… ☐

No…… ☐

Not sure……..... ☐

a. If yes, what is the name of the agency?

b. What services does the member currently receive, and how many hours per week for each service?

Service:

Hours per week: ☐☐

Service:

Hours per week: ☐☐

Service:

Hours per week: ☐☐

c. Are they in-home or out-of-the-home services?

In-home…….. ☐ Out-of-the-home…..…. ☐

d. Do family members provide these services?

Yes……... ☐ No…….…. ☐

Q15 Does the member currently get services from a behavioral health program?

Yes…… ☐

No…… ☐

Not sure……..... ☐

a. If yes, what is the name of the agency?

b. What services does the member receive?

c. What services did the member receive in the past 6 months?

Information about the member's health

Q16 How would you describe the member's health now?

- Excellent ☐
- Good ☐
- Fair ☐
- Poor ☐

Q17 What is the member's height without shoes?

Example: 5 feet and 6 inches = 5'6"

Q18 What is the member's weight?

Example: Please enter "150" for 150 lbs.

Q19 Does the member have trouble doing any of the following things because of their health?

Select all that may apply:

- Walking several blocks ☐
- Preparing meals ☐
- Eating ☐
- Bathing/showering ☐
- Doing light household chores ☐
- Sleeping ☐
- Attending work/school ☐
- Exercising/playing ☐

Q20 Does the member currently take any prescription medication on a regular basis?

- Yes ☐
- No ☐
- Not sure ☐

a. If yes, how many medications is the member currently taking?

1-2 ☐ 3-4 ☐ More than 4 medications ☐

Please list the medications the member currently takes:

Q21 Is the member currently pregnant? (If not, skip to question 24)

- Yes ☐
- No ☐
- Not sure ☐

a. If yes, what is the expected due date? (e.g., 09142018)

Q22 If the member is pregnant, does the member have an OB/GYN doctor, nurse or mid-wife who is providing care during this pregnancy?

- Yes ☐
- No ☐
- Not sure ☐

a. If yes, provider's name, address and phone number:

Last name

First name

Address

City/Town

Phone

Q23 If the member is pregnant, does the member have concerns about their pregnancy?

Yes☐
No☐
Not sure☐

a. If yes, would the member like to speak to a prenatal care manager?

Yes☐
No☐
Not sure☐

Q24 In the last 12 months, did the member get care in an emergency room?

Yes☐
No☐
Not sure☐

a. If yes, how many times?

1-3 times☐ 4-6 times☐ More than 6 times☐

Q25 In the last 12 months, has the member stayed overnight in a hospital?

Yes☐
No☐
Not sure☐

Q26 Does anyone in the member's immediate family (mother, father, sister, brother, children) have any of the following health problems. Check all that apply:

Asthma☐
Kidney disease☐
Chronic pain☐
HIV/AIDS☐
Obesity/weight problems☐
Chronic pain☐
Diabetes☐
Depression☐
High blood pressure☐
Alcohol or substance abuse☐
Heart problems☐
High cholesterol☐
Cancer☐
Stroke☐
Other☐

Q27 Is the member being treated for any of the following health problems? Check all that apply:

Asthma☐
Kidney disease☐
Chronic pain☐
HIV/AIDS☐
Obesity/weight problems☐
Diabetes☐
Depression☐
High blood pressure☐
Alcohol or substance abuse☐
Heart problems☐
High cholesterol☐
Cancer☐
Stroke☐
Congestive heart failure☐
Heart attack/bypass/stent placement☐
Lung problems or COPD☐
Other☐

Q28 Has the member been told by a doctor that they have or have had any of the following conditions? Check all that apply:

- Stroke ☐
- Tumor of the brain or spine ☐
- Genetic disorder ☐
- Spinal cord injury or disorder ☐
- Head or brain injury ☐
- Nerve or muscle disorder ☐

Information about the member's health needs

Q29 Does the member have a doctor or nurse who they usually go to for health care needs?

- Yes ☐
- No ☐
- Not sure ☐

a. If yes, provider's last name, first name, address, city/town and phone:

Last name

First name

Address

City/Town

Phone

Q30 Has the member seen their doctor in the last 12 months?

- Yes ☐
- No ☐
- Not sure ☐

a. If yes, what was the visit for?

- Well visit ☐
- Illness ☐
- Injury ☐

Q31 Does the member generally get a flu shot every year?

- Yes ☐
- No ☐
- Not sure ☐

Q32 When did the member last receive a colonoscopy?

- Within the past 10 years ☐
- More than 10 years ago ☐
- Never ☐
- Not sure ☐

Q33 Does the member currently use any medical equipment?

- Yes ☐
- No ☐
- Not sure ☐

a. If yes, please check all of the equipment the member uses:

- Wheelchair ☐
- Cane ☐
- Walker ☐
- Crutches ☐
- Other ☐

Questions 34 and 35 are for women only

Q34 When did the member last receive a mammogram?

- Within the past 2 years…… ☐
- More than 2 years ago…… ☐
- Never…… ☐
- Not sure…… ☐

Q35 When did the member last receive a PAP test?

- Within the past 2 years…… ☐
- More than 2 years ago…… ☐
- Never…… ☐
- Not sure…… ☐

Questions 36-39 are for children (pediatric) members ages 0-17 only

Q36 Does the member have any of the following behavioral health conditions?

- Attention Deficit Disorder…… ☐
- Autism spectrum…… ☐
- Anxiety disorder…… ☐
- Adjustment disorder…… ☐
- Depression…… ☐
- Conduct disorder…… ☐
- Learning disorder…… ☐
- Substance abuse disorder…… ☐
- Other (Please describer below)…… ☐

Q37 Does the member have any of the following medical diagnoses?

- Asthma…… ☐
- Juvenile diabetes…… ☐
- Seizure disorders…… ☐
- Congenital disorders (Please describer below)... ☐
- Other (Please describe below)…… ☐

Q38 How many adults are in the home?

Q39 Are there any specific health goals for the member?

- Yes…… ☐
- No…… ☐
- Not sure…… ☐

a. If yes, what are they?

Information about social well-being

Q40 In the past year, has the member been unable to get food when it was really needed?

- Yes……
- No……
- Not sure……
- I choose not to answer this question……

Q41 In the past year, has the member been unable to get clothing when it was really needed?

- Yes……
- No……
- Not sure……
- I choose not to answer this question……

Q42 In the past year, has the member been unable to access utilities (heat, electricity, etc.) when it was really needed?

- Yes……
- No……
- Not sure……
- I choose not to answer this question……

Q43 In the past year, has the member been unable to get medicine or any health care need (Medical, dental, mental health or vision) when it was really needed?

- Yes……
- No……
- Not sure……
- I choose not to answer this question……

Q44 What is the member's current housing situation?

- The member has housing……
- The member does not have housing……
  - Staying with others……
  - In a hotel……
  - In a shelter……
  - Living outside on the street……
  - Living on a beach……
  - Living in a park……
- Not sure……
- I choose not to answer this question……

Q45 Is the member worried about losing housing?

- Yes……
- No……
- Not sure……
- I choose not to answer this question……

Q46 Has lack of transportation kept the member from getting to medical appointments, school, or from getting things needed for daily living?

- Yes, it has kept the member from medical appointments or from getting their medications...
- Yes, it has kept the member from non-medical appointments, school, or getting things needed for daily living……
- No……
- Not sure……
- I choose not to answer this question……

Q47 Do you believe that the member feels emotionally and physically safe at home, school, and in the community?

- Yes……
- No……
- Not sure……
- I choose not to answer this question……

Q48 Is the member currently employed?

- Yes……☐
- No and I DO want help finding a job……☐
- No and I DO NOT want help finding a job……☐
- Not sure……☐
- I choose not to answer this question……☐

Q49 If the member is a child, are they attending school regularly?

- Yes……☐
- No……☐
- Not sure……☐
- I choose not to answer this question……☐

Q50 Does the member ever feel isolated from friends, family or anyone else in their life?

- Yes, the member does feel alone or isolated……☐
- No, the member does not feel alone or isolated..☐
- Not sure……☐
- I choose not to answer this question……☐

a. If yes, how often:

- Rarely……☐
- Sometimes……☐
- Often……☐
- Always……☐

Q51 Is the member interested in speaking to a member of our care team about their unmet needs?

- No, member does not have problems meeting their needs……☐
- Yes, member would like to speak with a member of the care team about additional resources/services……☐
- No, the member does not want to speak with a member of the care team……☐
- Not sure……☐
- I choose not to answer this question……☐

Information about wellness and the member's lifestyle

Q52 In the past month, has the member felt sad or down?

- Yes……☐
- No……☐
- Not sure……☐

Q53 Is stress or anger a problem for the member in handling such things as: The member's family or social relationships? The member's work or school?

- Yes……☐
- No……☐
- Not sure……☐

a. If yes, how often:

- All of the time……☐
- Most of the time……☐
- Some of the time……☐
- A little of the time……☐

Q54 In the past month, does the member have enough energy to do what needs t be done for work, school, or home?

- Yes……☐
- No……☐
- Not sure……☐

a. If yes, how often:

- All of the time……
- Most of the time……
- Some of the time……
- A little of the time……

Q55 In the past seven days, how many servings of fruits and vegetable was the member typically able to eat each day?

None……☐ 1-3……☐ More than 3……☐

Q56 In the past seven days, how many servings of high fiber or whole grain foods was the member typically able to eat each day?

None…….☐ 1-3……. ☐ More than 3..…☐

Q57 In the past seven days, how many servings of fried or high-fat foods did the member typically eat each day?

None…….☐ 1-3……. More than 3..…

Q58 In the past seven days, how many sugar-sweetened (not diet) beverages did the member typically drink each day?

None…….☐ 1-3……. More than 3..…

Q59 Does the member exercise regularly?

Yes……..……..…. ☐
No……..……..…. ☐
Not sure…….…. ☐

a. If yes, how many times a week does the member exercise:

1-2 times per week…….... ☐
3-5 times per week…….... ☐
More than 6 times per week…….... ☐

Q60 Does the member use tobacco products?

Yes……..……..…. ☐
No……..……..…. ☐
Not sure…….…. ☐

a. If yes, would the member be interested in quitting tobacco use within the next month?

Yes……..……..... ☐
No……..……..... ☐
Not sure……..……..... ☐

b. If yes, would the member like written information about quitting smoking or using tobacco products?

Yes……..……..... ☐
No……..……..... ☐
Not sure……..……..... ☐

Q61 Does the member drink alcohol?

Yes……..……..…. ☐
No……..……..... ☐
Not sure…….…. ☐

a. If yes, how often do you drink alcohol?

1-2 times per week……..... ☐
3-5 times per week…….....… ☐

Q62 Does the member have any personal goals?

Yes……..……..…. ☐
No……..……..... ☐
Not sure…….…. ☐

a. If yes, what are they?

Q63 Does the member buckle their seat belt?

Yes……..……..…. ☐
No……..……..... ☐
Not sure…….…. ☐

a. If yes, how often?

Always……..……..... ☐
Sometimes……..……..... ☐
Never…….…. ☐

Q64 Who else lives in the home with the member? Please select as many as apply or select N/A:

Spouse/significant other…….…. ☐
Child/step-child……..……..... ☐
Extended family……..……..…. ☐
Sibling……..……..... ☐
Grandparent…….…. ☐
Aunt/uncle…….…. ☐
Friend of family……..... ☐
Parent……..……..... ☐
Roommate……..……..... ☐
N/A……..……..... ☐
Other……..……..... ☐

Q65 If the member has children under age 8 in the household, does the member use a car seat when driving?

Yes☐
No☐
Not sure☐

a. If yes, how often?

Always☐
Sometimes☐
Never☐

Q66 Would the member like to get information about other health topics?

Yes☐
No☐
Not sure☐

a. If yes, please list specific topics:

Q67 Does the member need help with managing their health care condition?

Yes☐
No☐
Not sure☐

a. If yes, would the member like to speak with a care manager?

Yes☐
No☐
Not sure☐

Q68 Is the member interested in speaking to a social worker about managing mental health or alcohol/substance use concerns?

Yes☐
No☐
Not sure☐

a. If yes, please provide details of your concerns?

Race and ethnicity

Q69 How would you describe the member's race? Please check as any as apply:

American Indian/Alaskan Native☐
Asian☐
Black/African American☐
Hispanic/Latino/Spanish☐
Native Hawaiian/Pacific Islander☐
White☐
Other race☐
Unknown/not specified☐

Q70 How would you describe the member's ethnic background? You may choose up to two options here (For example, "American" and "Mexican", or "Cuban" and "Puerto Rican") :

African☐
African American☐
American☐
Asian☐
Asian Indian☐
Brazilian☐
Cambodian☐
Cape Verdean☐
Caribbean Island☐
Central American (not otherwise specified)☐
Chicano☐
Chinese☐
Colombian☐
Cuban☐
Dominican☐
Eastern European☐
European☐
Filipino☐
Guatemalan☐
Honduran☐

Japanese……..…… ☐
Korean…… ☐
Laotian…… ☐
Mexican……..... ☐
Mexican American…… ☐
Middle Eastern…….. ☐
Portuguese……..... ☐
Puerto Rican……..…….…….. ☐
Russian…… ☐
Salvadoran…….. ☐
South American (not otherwise specified)… ☐
Vietnamese…… ☐
Other ethnicity……..... ☐

Unknown/Not Specified……..…… ☐

Thank you!

Thank you for taking the time to fill out this assessment form. Fallon will review your responses to determine if there are care management programs, educational materials or other resources that you may find helpful.

If you have any questions about this health assessment, please call Customer Service at the number on the back of the member's ID card, Monday through Friday from 8 a.m. to 6 p.m.

Office use only:

Date returned:_____

Date reviewed:_____