TheHealthPlan
1110 Main Street
Wheeling, WV 26003-2704

– Child –
Health Screener

Enclosed is a health screener and pre-paid envelope. At your earliest convenience please complete the screener so that we may better understand your health care needs. Once you've completed the screener you can mail it back to us in the envelope provided.

Once we review the screener, a health navigator may call you to follow up on your health conditions and discuss any assistance we may be able to provide.

If you have any questions please feel free to contact an Outreach Representative at 1.855.577.7124 (TTY: 711).

Our hours of operation are 8:00 am to 5:00 pm, EST, Monday – Friday.

Assessment Date: _____ Child's Date of Birth: _____ (mm/dd/yyyy)

Child's Name? _____

HID: _____ Medicaid ID: _____

Gender at birth: ☐ Male ☐ Female ☐ I prefer not to say

Which of the following most accurately describes you now?
☐ Male ☐ Female Non-binary ☐ Transgender ☐ Intersex ☐ Other ☐ I prefer not to say

Race/Ethnicity:

☐ American Indian and Alaska Native, non-Hispanic
☐ Asian, non-Hispanic
☐ Black or African American, non-Hispanic
☐ Hispanic
☐ Native Hawaiian and Other Pacific Islander, non-Hispanic
☐ White, non-Hispanic
☐ Multiracial non-Hispanic
☐ Other race, non-Hispanic

Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Email: _____ My preferred method of contact is: _____

Name of legal guardian(s): _____

How is the child related to you? I am the:
☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Legal Guardian
☐ Other, explain: _____

What language do you speak at home? ☐ English ☐ Spanish ☐ Other: _____

Child's primary care doctor: _____ Last seen: _____

Child's dentist: _____ Last seen: _____

Child's eye doctor: _____ Last seen: _____

Do you feel like you have problems getting care for your child? ☐ Yes ☐ No
Explain: _____

Is the child up to date on immunizations? ☐ Yes ☐ No ☐ I don't know

How would you rate the child's general physical health? ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

How would you rate the child's general mental health? ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

Has a doctor told you the child has any of these problems?
☐ Asthma/Allergies ☐ Cystic Fibrosis ☐ High Blood Pressure ☐ Large Heart/Heart Issue ☐ Liver Problems
☐ Kidney Problems ☐ Birth Defect (problem present at birth) ☐ Cancer (in active treatment)
☐ History of Extreme Prematurity (delivered before 28 weeks of gestation) ☐ Seizures/Epilepsy
☐ Diabetes ☐ Blood Disorder (anemia/sickle cell/ hemophilia) ☐ Paralysis ☐ HIV/AIDS ☐ Growth Delay
☐ Pain (requiring pain management) ☐ Hearing Problem ☐ Vision Problem ☐ Developmental Delay
☐ ADHD/ADD ☐ Autism Spectrum ☐ Eating Disorder ☐ Depression Bipolar Disorder ☐ Schizophrenia
☐ Stress ☐ Substance Use/Substance Overdose ☐ My child does not have any of these problems

If you identified that your child has a problem or problems (above) would you like a nurse to contact you to help you understand this condition, manage symptoms of this condition, or access more care for this condition? ☐ Yes ☐ No ☐ Not applicable

Is the child pregnant? ☐ Yes, due date: _____ ☐ No ☐ Not applicable

Has the child been hospitalized (medical or mental hospital) in the last 6 months? ☐ Yes ☐ No

If yes, explain: _____

How many times has the child been taken to the emergency department in the last 6 months?

☐ None ☐ Once or Twice ☐ Three Times or More

Does the child take medicine? ☐ Yes ☐ No

Do you understand the child's medicine(s)? ☐ Yes ☐ No

Does the child need an urgent refill for a medical or mental health medication? ☐ Yes ☐ No

Does the child receive any of these services?

☐ Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy ☐ Respiratory Therapy

☐ Nursing Services ☐ Home Health Aide ☐ Socially Necessary Services ☐ Waiver Services

☐ Individual Educational Plan/IEP ☐ Autism Services/ABA

Does the child use medical equipment?

☐ Wheelchair ☐ Oxygen ☐ Special bed ☐ Insulin pump ☐ Prosthetics/orthotics (artificial limbs/braces)

☐ Ventilator/CPAP/BiPAP ☐ Hearing aid/cochlear implant ☐ Feeding pump/tube feeding supplies

Does lack of money ever make it hard for you to pay home related bills like water or heating? ☐ Yes ☐ No

Does lack of money ever make it hard to pay for medical, behavioral or dental expenses? ☐ Yes ☐ No

Does the child have difficulty getting to doctor or dentist appointments due to a lack of reliable transportation? ☐ Yes ☐ No

Does the child ever go hungry because there is not enough food in the home? ☐ Yes ☐ No

Does the child have stable housing/a safe home? ☐ Yes ☐ No

Explain: _____

Has the child had physical or sexual abuse or has she/he been exposed to extreme violent behavior in her/his home? ☐ Yes ☐ No

Does the child need counseling? ☐ Yes ☐ No

Explain: _____

Is the child potty trained? ☐ Yes ☐ No ☐ Not applicable due to age

Does the child go to school? ☐ Yes ☐ No ☐ Not applicable due to age

Has the doctor ever told you that the child needs to lose weight? ☐ Yes ☐ No

Height: _____ feet _____ inches Weight: _____ pounds ☐ Unsure

Is the child on a special diet? ☐ Yes ☐ No

Does the child smoke? ☐ Yes ☐ No

Does the family smoke in the home? ☐ Yes ☐ No

Does the child use street drugs or alcohol? ☐ Yes ☐ No

I would like for a nurse from The Health Plan to contact me for help with something not identified on this screening. ☐ Yes ☐ No

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