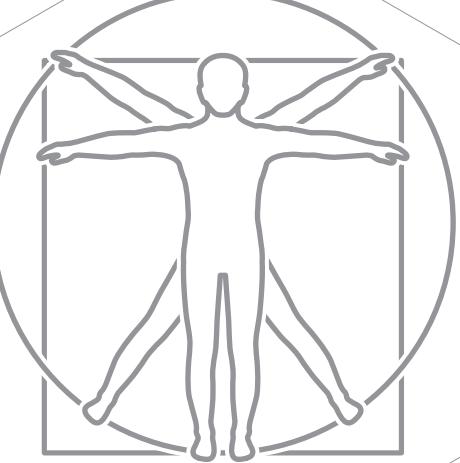




1110 Main Street
Wheeling, WV 26003-2704

- 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?

<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Nursing Services	<input type="checkbox"/> Home Health Aide	<input type="checkbox"/> Socially Necessary Services	<input type="checkbox"/> Waiver Services
<input type="checkbox"/> Individual Educational Plan/IEP		<input type="checkbox"/> 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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