TheHealthPlan

Assessment Date: _____

Your Full Name: _____

HID: _____ Medicaid ID: _____

Date of Birth: _____ (mm/dd/yyyy)

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: _____

What language do you speak at home?

☐ English ☐ Spanish ☐ Other: _____

Your primary care doctor:	Last seen:
Your dentist:	Last seen:
Your eye doctor:	Last seen:

Do you feel like you have problems getting care? ☐ Yes ☐ No

Explain: _____

Are you up to date on immunizations? ☐ Yes ☐ No ☐ I don't know

How would you rate your general physical health?

☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

How would you rate your general mental health?

☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

Are you pregnant? ☐ Yes, due date: _____ ☐ No ☐ Not applicable

Have you been hospitalized (medical or mental hospital) in the last 6 months?

☐ Yes ☐ No If yes, explain: _____

How many times have you been treated in the emergency department in the last 6 months?

☐ None ☐ Once or Twice ☐ Three Times or More

Do you take medicine? ☐ Yes ☐ No

Do you understand your medicine(s)? ☐ Yes ☐ No

Do you need an urgent refill for a medical or mental health medication? ☐ Yes ☐ No

Explain: _____

Do you receive any of these services?

☐ Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy

☐ Respiratory Therapy ☐ Nursing Services ☐ Home Health Aide

☐ Socially Necessary Services ☐Waiver Services ☐ SSI/SSDI

Do you use medical equipment?

☐ Wheelchair ☐ Oxygen

☐ Ventilator/CPAP/BiPAP ☐ Feeding pump/tube feeling supplies

☐ Special bed ☐ Insulin pump

☐ Hearing aid/cochlear implant ☐ Prosthetics/orthotics (artificial limbs/braces)

Walking Status? ☐ Walk unassisted ☐ Use a cane or walker

☐ Use a wheelchair or scooter ☐ Bed bound

Have you fallen in the last 12 months? ☐ Yes ☐ No

Do you have a hearing problem or do others think you have a hearing problem? ☐ Yes ☐ No

Do you have difficulty driving, watching TV, reading, or doing your daily activities because of your eyesight? ☐ Yes ☐ No

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

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

Do you have stable housing/a safe home environment? ☐ Yes ☐ No

Explain: _____

Do you have a dependable way to get to appointments and the store? ☐ Yes ☐ No

Have you had or do you currently have mental, physical or sexual abuse or have you been exposed to extreme violent behavior in your past?	☐ Yes ☐ No
Do you need counseling? Explain: _____	☐ Yes ☐ No
Are you employed?	☐ Yes ☐ No
Do you want help with life skills like getting child care, parenting classes, money management, obtaining personal documents like birth certificates/social security cards, or help with job training?	☐ Yes ☐ No
Do you smoke/use tobacco?	☐ Yes ☐ No
Do you want help quitting smoking/tobacco?	☐ Yes ☐ No
Do you have a problem with drugs or alcohol or do others think you have a problem with drugs or alcohol?	☐ Yes ☐ No

Over the past two weeks, how often have you been bothered by the following problems:

Little interest or pleasure in doing things

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed or hopeless

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

What is your normal pain level on a scale of 0 (no pain) to 10 (unbearable pain)?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person?

	I do not have difficulty	Yes, I have difficulty	I am not able to do this activity unassisted
Bathing	☐	☐	☐
Dressing and grooming	☐	☐	☐
Eating	☐	☐	☐
Using the toilet	☐	☐	☐
Getting in and out of bed or chairs	☐	☐	☐
Managing medications	☐	☐	☐
Managing money	☐	☐	☐
Household activities like food prep, laundry and housekeeping	☐	☐	☐
Shopping for groceries and clothes	☐	☐	☐
Getting places out of walking distance	☐	☐	☐

Do you have a Medical Power of Attorney? (Someone to make medical decisions for you in the event you are unable to).

☐ Yes. ☐ No, but I would like more information about medical power of attorney.

☐ No, and I do not wish to receive information about medical power of attorney.

Do you have a living will/advance directive? (Documents that make your health care wishes known if you are unable to voice them). ☐ Yes. ☐ No, but I would like more information about living will/advance directives. ☐ No, and I do not wish to receive information about living will/advance directives.
Please choose the answer that best describes your current status and related needs for each condition below:
I have breathing problems, like COPD (chronic obstructive pulmonary disease) or asthma. ☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help. ☐ Yes, and I would like a nurse to help me better manage this condition. ☐ No, I do not have this condition.
I have heart failure (CHF-congestive heart failure) or an enlarged heart. ☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help. ☐ Yes, and I would like a nurse to help me better manage this condition. ☐ No, I do not have this condition.
I have diabetes (blood sugar problems). ☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help. ☐ Yes, and I would like a nurse to help me better manage this condition. ☐ No, I do not have this condition.
I have chronic kidney disease. ☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help. ☐ Yes, and I would like a nurse to help me better manage this condition. ☐ No, I do not have this condition.
I am obese (with or without a diagnosis of pre-diabetes). ☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help. ☐ Yes, and I would like a staff member to help me better manage this condition. ☐ No, I do not have this condition.
I have a behavioral health condition like depression, anxiety, bipolar disorder, or schizophrenia. ☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help. ☐ Yes, and I would like a nurse to help me better manage this condition. ☐ No, I do not have this condition.
I am in active treatment for cancer. ☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help. ☐ Yes, and I would like a nurse to help me better manage this condition. ☐ No, I do not have this condition.
I have organ failure (in evaluation for transplant, listed for transplant or transplanted within the last year). ☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help. ☐ Yes, and I would like a nurse to help me better manage this condition. ☐ No, I do not have this condition.
I would like for a nurse from The Health Plan to contact me for help with something not identified on this screening. ☐ Yes ☐ No