HEALTH NEEDS ASSESSMENT FORM

IMPORTANT: Please complete this questionnaire. This will help us provide better health services and coordinate the care you receive. **This information will not affect your MassHealth/Medicaid benefits or eligibility and will only be shared with those authorized to see it.** If you need another form or have a question, call Member Services at **888-566-0010**.

SURVEY INSTRUCTIONS:

1. Complete one form for each BMC HealthNet Plan member.
2. Answer each of the questions by checking off the box (yes, no) or filling in your response in the space provided.
3. Once completed, please return your survey using the enclosed postage-paid envelope:

   BMC HealthNet Plan
   Attn: Central Processing
   Two Copley Place, Suite 600
   Boston, MA 02116

Name of Person Completing this Form: _____

Relationship of Person Completing This Form: ☐ Self ☐ Parent ☐ Spouse/Partner ☐ Family or Relative ☐ Professional Caregiver ☐ Authorized Representative

If completing on behalf of a member, please complete the following questions based on the member's information.

Member Information (Please print information clearly)

Member Last Name: _____

Member First Name: _____

Middle Initial: _____

Member ID#: _____

Date of Birth: _____

Gender ☐ MALE ☐ FEMALE

Address:

City/Town:

State:

Zip Code:

Best Contact Information

Cell phone: _____

Home phone: _____

Work phone: _____

Email address: _____

Are there other phone numbers for us to contact you about your health needs? ☐ YES ☐ NO ☐ NOT SURE

If yes, include area code: _____

Best time to call: ☐ AM ☐ PM

Preferred language spoken:

☐ ENGLISH ☐ SPANISH ☐ OTHER:_____

Preferred language written:

☐ ENGLISH ☐ SPANISH ☐ OTHER:_____

Are you currently homeless and/or don't have a stable living situation? ☐ YES ☐ NO ☐ NOT SURE

If yes, what is the best way to reach you?

☐ PHONE ☐ MAIL ☐ OTHER: _____

Are you hearing impaired?

☐ YES ☐ NO ☐ NOT SURE

If yes, please check as many as apply:

☐ I use a hearing aide ☐ I use TDD/TTY services

Do you currently get services from any of the following state agencies?

☐ YES ☐ NO ☐ NOT SURE

If yes, please check as many as apply

☐ Massachusetts Commission for the Blind

What services are you receiving?_____

☐ Massachusetts Commission for the Deaf and Hard of Hearing

What services are you receiving?_____

☐ Massachusetts Rehabilitation Commission

What services are you receiving?_____

☐ Department of Mental Health

What services are you receiving?_____

☐ Department of Developmental Services

What services are you receiving?_____

☐ Division of Children and Families

What services are you receiving?_____

☐ Special Education

What services are you receiving?_____

☐ Early Intervention Program

What services are you receiving?_____

☐ Other: _____

Do you have a case manager or social worker?

☐ YES ☐ NO ☐ NOT SURE

If yes, please give the following information about your case manager or social worker:

Name: _____

Phone Number: _____

How would you describe your health now?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have trouble doing any of the following because of your health?

Walking several blocks	☐ YES	☐ NO
Preparing meals	☐ YES	☐ NO
Eating	☐ YES	☐ NO
Bathing/Showering	☐ YES	☐ NO
Sleeping	☐ YES	☐ NO
Doing light household chores	☐ YES	☐ NO
Attending work/school	☐ YES	☐ NO
Exercising/Playing	☐ YES	☐ NO

Do you currently take any prescription medications on a regular basis?

☐ YES ☐ NO ☐ NOT SURE

If yes, how many medications are you currently taking?

☐ 1-2 ☐ 3-4 ☐ more than 4 medications

Please list the medications you currently take: _____

_____

Are you currently pregnant? (If no, skip to next page)

☐ YES ☐ NO ☐ NOT SURE

If yes, when is your due date?_____

If you're pregnant, do you have an OB/GYN doctor, nurse, or mid-wife who is providing care during this pregnancy?

☐ YES ☐ NO ☐ NOT SURE

If yes, provider's name: _____

Address: _____

Phone: _____

If you're pregnant, do you have any concerns about your pregnancy?

☐ YES ☐ NO ☐ NOT SURE

If yes, would you like to speak to a prenatal care manager?

☐ YES ☐ NO

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

☐ YES ☐ NO ☐ NOT SURE

If yes, how many times?

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

In the last 12 months, have you stayed overnight in a hospital?

☐ YES ☐ NO ☐ NOT SURE

Has anyone in your immediate family had any of the following? (Please check as many as apply)

Asthma	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Heart Problems	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Kidney Disease	☐ YES	☐ NO
Depression	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Chronic Pain	☐ YES	☐ NO
High Cholesterol	☐ YES	☐ NO
HIV/AIDS	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Alcohol or Substance Abuse	☐ YES	☐ NO
Obesity/Weight Problems	☐ YES	☐ NO
Other:	☐ YES	☐ NO

Are you being treated for any of the following? (Please check as many as apply)

Asthma	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Heart Problems	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Kidney Disease	☐ YES	☐ NO
Depression	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Chronic Pain	☐ YES	☐ NO
High Cholesterol	☐ YES	☐ NO
HIV/AIDS	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Alcohol or Substance Abuse	☐ YES	☐ NO
Obesity/Weight Problems	☐ YES	☐ NO
Other:	☐ YES	☐ NO

Do you have a doctor or nurse that you usually go to for health care needs?

☐ YES ☐ NO ☐ NOT SURE

If yes, doctor's name: _____

Address: _____

Phone: _____

Have you seen your doctor in the last 12 months?

☐ YES ☐ NO ☐ NOT SURE

If yes, what was the visit for?

☐ Well-visit ☐ Illness ☐ Injury

Do you currently use any medical equipment?

☐ YES ☐ NO ☐ NOT SURE

If yes, please check all of the equipment you use:

☐ Wheelchair ☐ Cane ☐ Walker ☐ Crutches

Do you need help managing your health care condition?

☐ YES ☐ NO ☐ NOT SURE

If yes, would you like to speak with a care manager?

☐ YES ☐ NO

Do you need help with transportation to the doctor's office or clinic?

☐ YES ☐ NO ☐ NOT SURE

If yes, you may be eligible for transportation assistance. Please call us at 888-566-0010 for more information.

In the past month, have you felt sad or down?

☐ YES ☐ NO ☐ NOT SURE

If yes, how often?

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

In the past month, do you have enough energy to do what you need to for work, school, or home?

☐ YES ☐ NO ☐ NOT SURE

If yes, how often?

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

Would you like to speak with a care manager from Behavioral Health Services?

☐ YES ☐ NO

Do you exercise regularly?

☐ YES ☐ NO ☐ NOT SURE

If yes, how many times a week do you exercise?

☐ 1-2 times per week ☐ 3-5 times per week
☐ more than 6 times per week

Do you use tobacco products?

☐ YES ☐ NO ☐ NOT SURE

If yes, would you like written information about quitting smoking or using tobacco products?

☐ YES ☐ NO

Do you drink alcohol?

☐ YES ☐ NO ☐ NOT SURE

If yes, how often do you drink alcohol?

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

Do you buckle your seatbelt?

☐ YES ☐ NO ☐ NOT SURE

If yes, how often?

☐ Always ☐ Sometimes

If you have children under age 8 in your household, do they use a car seat when driving?

☐ YES ☐ NO ☐ NOT SURE

If yes, how often?

☐ Always ☐ Sometimes

Would you like to get information about other health topics?

☐ YES ☐ NO

If yes, please list the health topics you are interested in:

_____

Please go to the Health Education Center at bmchp.org for information on a variety of health topics.

How would you describe your race? (You may choose up to two options)

☐ Alaskan Native
☐ American Indian
☐ Asian
☐ Black/African American
☐ Hispanic/Latino – Black
☐ Hispanic/Latino – White
☐ Hispanic/Latino – Other
☐ Native Hawaiian or other Pacific Islander
☐ White/Caucasian

How would you describe your ethnic background? (You may provide two ethniticies, i.e. "American" and "Portuguese")

1. _____

2. _____

Thank you for taking the time to fill out this assessment form. We 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 us at 888-566-0010.