MassHealth CarePlus Health Needs Assessment

celticare health™

You may also fill this form out online at **CeltiCareHealthPlan.com**

Questions? call **1-855-678-6975** (TDD/TTY: 1-866-614-1949) or visit **CeltiCareHealthPlan.com**

Please take a few minutes to complete this questionnaire. We will keep this information private. We will only use your answers to give you the best care possible. Your answers will NOT affect your health insurance benefits. Your answers can improve the health care services you get.

1. Please fill out one assessment form for each new member.
2. You will need to have on hand:
   a. Your CeltiCare Health CarePlus insurance card number
   b. The names, phone numbers, and addresses of your doctor or nurse
3. Answer each of the questions by checking off the box (Yes ☐ No ☐ Not Sure ☐) or filling in your response in the space provided.
4. You are sometimes told to skip over some questions in this survey. When this happens you will see a note that tells you what question to answer next.

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CeltiCareHealthPlan.com

Name of Person Completing This Form:

Member Name (Last, First, MI):

CeltiCare CarePlus Member ID: Birth Date (MMDDYYYY):

Gender: ☐ Male ☐ Female

Address (number and street):

City/Town: State: Zip Code:

Phone Number: - - ☐ Home ☐ Cell ☐ Work

E-mail Address:

Relationship of Person Completing This Form:

☐ Self ☐ Parent ☐ Spouse/Partner ☐ Family or Relative ☐ Professional Caregiver ☐ Authorized Representative

Information About You

1. Are there other phone numbers for CeltiCare Health to contact you about your health needs? If yes, please include area code first.

   ☐ Yes ☐ No ☐ Not Sure Phone Number: - - ☐ Home ☐ Cell ☐ Work

   Best time to call: ☐ AM ☐ PM

2. Preferred language spoken: ☐ English ☐ Spanish ☐ Other

   If other, please identify:

3. Are you currently homeless and/or don't have a stable living situation? ☐ Yes ☐ No ☐ Not Sure

4. Are you hearing impaired? ☐ Yes ☐ No ☐ Not Sure

5. Do you currently get services from any of the following state agencies? ☐ Yes ☐ No ☐ Not Sure

   ☐ 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

Information About Your Health

6. How would you describe your health now? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

7. Do you have trouble doing any of the following because of your health? ☐ Yes ☐ No ☐ Not Sure

   ☐ Walking several blocks ☐ Preparing meals ☐ Eating ☐ Bathing/Showering

   ☐ Doing light household chores ☐ Attending work/school ☐ Exercising/Playing ☐ Sleeping

8. 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:

9. Are you currently pregnant? *(if not, skip to question #12)* ☐ Yes ☐ No ☐ Not Sure

   If yes, when is your due date?

10. If you are 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: - -

11. If you are pregnant, do you have concerns about your pregnancy? ☐ Yes ☐ No ☐ Not Sure

If yes, would you like to speak to a prenatal care manager? ☐ Yes ☐ No

12. 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

13. In the last 12 months, have you stayed overnight in a hospital? ☐ Yes ☐ No ☐ Not Sure

14. Has anyone in your immediate family (mother, father, sister, brother, children) have any of the following health problems?

☐ Asthma	☐ Diabetes	☐ Heart Problems	☐ Cancer
☐ Kidney Disease	☐ Depression	☐ High Blood Pressure	☐ Chronic Pain
☐ High Cholesterol	☐ HIV/AIDS	☐ Alcohol or Substance Abuse	☐ Stroke
☐ Obesity/Weight Problems	☐ Other		

15. Are you being treated for any of the following health problems?

☐ Asthma	☐ Diabetes	☐ Heart Problems	☐ Cancer
☐ Kidney Disease	☐ Depression	☐ High Blood Pressure	☐ Chronic Pain
☐ High Cholesterol	☐ HIV/AIDS	☐ Alcohol or Substance Abuse	☐ Stroke
☐ Obesity/Weight Problems	☐ Other		

16. Do you have a doctor or nurse that you usually go for health care needs? ☐ Yes ☐ No ☐ Not Sure

If yes, doctor's name:

Address:

Phone: - -

17. 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

18. 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

19. Do you need help with managing your health care condition? ☐ Yes ☐ No ☐ Not Sure

If yes, would you like to speak with a care manager? ☐ Yes ☐ No

20. Do you need help with transportation to the doctor's office or clinic? ☐ Yes ☐ No ☐ Not Sure

If yes, some members may be eligible for transportation assistance. Please call CeltiCare Health member services for more information.

Information About Wellness and Lifestyle

21. 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

22. In the past month, do you have enough energy to 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

23. 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

24. 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

25. Do you drink alcohol? ☐ Yes ☐ No ☐ Not Sure

If yes, how often to you drink alcohol? ☐ 1-2 times per week ☐ 3-5 times per week

26. Do you buckle your seatbelt? ☐ Yes ☐ No ☐ Not Sure

If yes, how often: ☐ Always ☐ Sometimes ☐ Never

27. If you have children under age 8 in your household, do you use a car seat when driving? ☐ Yes ☐ No ☐ Not Sure

If yes, how often: ☐ Always ☐ Sometimes ☐ Never

28. Would you like to get information about other health topics? ☐ Yes ☐ No ☐ Not Sure

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

Information About Your Race and Ethnicity

29. How would you describe your race? Please check as many as apply. ☐ American Indian/Alaskan Native

☐ Black/African American ☐ White ☐ Asian ☐ Hispanic/Latino/Spanish ☐ Unknown/Not Specified

30. How would you describe your ethnic background? Please check as many as apply.

☐ African ☐ American ☐ Asian ☐ Chinese ☐ European ☐ Haitian ☐ Mexican ☐ Puerto Rican

☐ Russian ☐ South American ☐ Other, please specify: ________________ ☐ Unknown/Not Specified

Just a Few More Questions

31. In the past 2 weeks, have you been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No ☐ Not Sure

If yes, would you like to speak with a care manager? ☐ Yes ☐ No

32. Do you have an appointment scheduled with your PCP? ☐ Yes ☐ No ☐ Not Sure

If yes, please let us know the date of the appointment. (MMDDYY) ☐☐☐☐☐☐☐☐

33. Do you have a problem with any of your medications that prevent you from using them the way your doctor ordered them?

☐ Yes ☐ No ☐ Not Sure

34. Are you currently receiving home health care services? (for example: oxygen, home medical supplies)?

☐ Yes ☐ No ☐ Not Sure

Thank you for taking the time to fill out this assessment. CeltiCare Health will use the information on this form to help you get health care services. Your information will be kept private and confidential as required by State and Federal law. For more information, please see the Notice of Privacy section of Our Member Handbook or call us at **1-855-678-6975**, or TDD/TYY **1-866-614-1949**.