MassHealth Health Needs Assessment Form

Please take a few minutes to complete this questionnaire. Your health assessment will help MassHealth PCC Plan/Massachusetts Behavioral Health Partnership provide better health services and coordinate the care you receive. We will keep the information you provide private. Your answers will NOT affect your MassHealth/Medicaid benefits.

Survey Instructions:

1. Please fill out one form for each new Member.
2. You will need to have on hand:
    a. Your MassHealth PCC Plan/Massachusetts Behavioral Health Partnership member 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. When this happens you will see a note that tells you what question to answer next.
5. These questions will take about 10 minutes to complete.
6. If you need help or have questions about completing this form, please call MassHealth PCC Plan/Massachusetts Behavioral Health Partnership Member Services at 1-800-495-0086.
7. Please fax your completed form to (877) 334-9615 or mail it to MBHP at 200 State Street, Suite 305, Boston, MA 02109.

Name of Person Completing This Form:			
Member Name (Last, First, MI)	MassHealth Member ID	Birth Date	Gender □ Male □ Female
Address (number and street) _____City/Town _____State _____Zip Code _____ Phone Number ☐ Home _____ ☐ Cell _____☐ Work _____ E-mail Address _____			
Relationship to Person Completing this Form: □ Self ☐ Parent ☐ Spouse/Partner ☐ Family or Relative ☐ Professional Caregiver ☐ Authorized Representative			

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Information About You				
Question	**Yes**	**No**	**Not Sure**	**Additional Answer**
1. Are there other phone numbers for MassHealth PCC Plan/Massachusetts Behavioral Health Partnership to contact you about your health needs? If yes, please include area code first.	☐	☐	☐	☐ 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?	☐	☐	☐	
4. Are you hearing impaired?	☐	☐	☐	
5. Do you currently get services from any of the following state agencies?	☐	☐	☐	If yes, please check as many as apply. ☐ 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

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Information About Your Health				
Question	**Yes**	**No**	**Not Sure**	**Additional Answer**
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?	☐	☐	☐	☐ 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?	☐	☐	☐	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)*	☐	☐	☐	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?	☐	☐	☐	If yes, provider's name:_____ Address: _____ Phone:_____
11. If you are pregnant, do you have concerns about your pregnancy?	☐	☐	☐	If yes, would you like to speak to a prenatal care manager?
12. In the last 12 months, did you get care in an emergency room?	☐	☐	☐	If yes, how many times? ☐ 1-3 times ☐ 4-6 times ☐ more than 6 times

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Information About Your Health				
Question	**Yes**	**No**	**Not Sure**	**Additional Answer**
13. In the last 12 months, have you stayed overnight in a hospital?	☐	☐	☐	
14. Has anyone in your immediate family (mother, father, sister, brother, children) had any of the following health problems?	☐	☐	☐	If yes, please check as many as apply. ☐ 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?	☐	☐	☐	If yes, please check as many as apply. ☐ 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

Information About Your Health Needs				
Question	**Yes**	**No**	**Not Sure**	**Additional Answer**
16. Do you have a doctor or nurse that you usually go to for health care needs?	☐	☐	☐	If yes, doctor or nurse's name:_____ Address:_____ _____ Phone:_____ _____
17. Have you seen your doctor in the last 12 months?	☐	☐	☐	If yes, what was the visit for : ☐ Well-visit ☐ Illness ☐ Injury

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Information About Your Health Needs				
Question	**Yes**	**No**	**Not Sure**	**Additional Answer**
18. Do you currently use any medical equipment?	☐	☐	☐	If yes, please check all of the equipment you use. ☐ Wheelchair ☐ Cane ☐ Walker ☐ Crutches ☐ Other _____
19. Do you need help with managing your health care condition?	☐	☐	☐	If yes, would you like to speak with a care manager?
20. Do you need help with transportation to the doctor's office or clinic?	☐	☐	☐	If yes, some members may be eligible for transportation assistance. Please call MassHealth PCC Plan/Massachusetts Behavioral Health Partnership Member Services at 1-800-495-0086 for more information.

Information About Wellness and Your Lifestyle				
Question	**Yes**	**No**	**Not Sure**	**Additional Answer**
21. In the past month, have you felt sad or down?	☐	☐	☐	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, have you had enough energy to do what you need to do for work, school, or home?	☐	☐	☐	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?	☐	☐	☐	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?	☐	☐	☐	If yes, would you like written information about quitting smoking or use of tobacco products? ☐ Yes ☐ No
25. Do you drink alcohol?	☐	☐	☐	If yes, how often do you drink alcohol? ☐ 1-2 times per week ☐3-5 times per week ☐ Other _____
26. Do you buckle your seatbelt?	☐	☐	☐	If yes, how often: ☐ Always ☐ Sometimes

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Information About Wellness and Your Lifestyle				
Question	**Yes**	**No**	**Not Sure**	**Additional Answer**
27. If you have children under age 8 in your household, do they use a car seat when you or others are driving?	☐	☐	☐	If yes, how often: ☐ Always ☐ Sometimes
28. Would you like to get information about health topics?	☐	☐	☐	If yes, please list the health topics you are interested in. ☐ Healthy eating ☐ Exercise ☐ Kids' health ☐ Mental health and/or substance abuse ☐ Other _____

Information About Your Race and Ethnicity	
Question	**Additional Answer**
29. How would you describe your race? Please check all that apply.	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American (Non-Hispanic) ☐ Black or African American (Hispanic) ☐ Native Hawaiian or Other Pacific Islander ☐ White (Non-Hispanic) ☐ White (Hispanic) ☐ Multiracial (select all that apply above) ☐ Other _____
30. How would you describe your ethnic background? Please check all that apply.	☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Thank you for taking the time to fill out this form. Please fax your completed form to (877) 334-9615 or mail it to MBHP at 200 State Street, Suite 305, Boston, MA 02109. The MassHealth PCC Plan/MBHP 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 the MassHealth PCC Plan/MBHP at 1-800-495-0086.

MBHP complies with applicable federal civil rights laws and does not discriminate, exclude, or treat people differently because of race, color, national origin, ancestry, age, disability, religious creed, sex, sexual orientation, gender identity, gender stereotyping, genetic information, or veteran status. MBHP's notice of non-discrimination can be found at *http://www.masspartnership.com/member/NonDiscriminationNotice.aspx.*

You can get this information in other languages and other formats, such as large print or Braille.

Call us at 1-800-495-0086 from Monday to Thursday, 8 a.m. to 5 p.m. and Friday 9:30 a.m. to 5 p.m. The call is free! Call TTY 1-877-509-6981 if you are deaf, hard of hearing, or speech impaired.

Tenemos información en español. Servicio de intérpretes gratis!