MassHealth Managed Care Health Needs Questionnaire

PLEASE DO NOT FOLD.

Please take a few minutes to complete this survey. Your health assessment will help Fallon Health provide better health services and coordinate the care you receive. We will keep the information you provide private.
By submitting this form, you are giving us permission to share your information with the people involved in your care. Your answers will NOT affect your Masshealth/Medicaid benefits.

Answer all of the questions.
Mail it back to us.
Get a $10 gift card!

Survey Instructions:

1. Please fill out one assessment form for each new member.

2. You will need to have on hand:
   a. Your Fallon Health member ID number.
   b. The name, phone number, and address of your doctor or nurse.

3. Answer each of the questions by checking the appropriate box or filling 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.

5. This survey will take about 10 minutes to complete.

6. If you need help or have questions about completing this form, please call Fallon Customer Service at 1-800-341-4848 (TRS 711), Monday through Friday from 8 a.m. to 6 p.m.

Member information:

Q1 Member name (Last, First, MI)

Last name

First name

MI

Q2 Fallon MassHealth member ID number

Q3 Birth date (Example: 02112014)

14-677-030 Rev. 02 11/16

Q4 Gender

Male ☐

Female ☐

Q5 Address (number and street)

Number

Street

Q6 City/Town

Q7 State

Q8 Zip

Q9 Phone numbers

Home:

Cell:

Work:

Q10 Email address

Q11 Relationship (to member) of person completing this form:

Self ☐

Parent ☐

Spouse/Partner ☐

Family or relative ☐

Professional caregiver ☐

Authorized representative ☐

Information about you

Q12 Are there other phone numbers for Fallon to contact you about your health needs? If yes, please include area code first.

Yes (answer to the right) ☐

No ☐

Not sure ☐

Q13 Other phone numbers:

Home:

Cell:

Work:

Q14 Best time to call:

Morning ☐

Afternoon ☐

Q15 Preferred language spoken

- English ☐
- Spanish ☐
- Other ☐

If other, please specify

Q16 Are you currently homeless and/or don't have a stable living environment?

- Yes ☐
- No ☐
- Not sure ☐

Q17 Are you hearing impaired?

- Yes ☐
- No ☐
- Not sure ☐

Q18 Are you visually impaired?

- Yes ☐
- No ☐
- Not sure ☐

Q19 Do you currently get services from any of the state agencies listed in Question 20?

- Yes (choose below) ☐
- No ☐
- Not sure ☐

Q20 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 ☐

Information about your health

Q21 How would you describe your health now?

- Excellent ☐
- Good ☐
- Fair ☐
- Poor ☐

Q21a What is your height without shoes?

Example: 5 feet and 6 inches = 5'6"

Q21b What is your weight?

Example: Please enter "150" for 150 lbs

Q22 Do you have trouble doing any of the things listed in Question 23 because of your health?

- Yes (choose on next page) ☐
- No ☐
- Not sure ☐

Q23 If yes, please check as many as apply.

- Walking several blocks ☐
- Preparing meals ☐
- Eating ☐
- Bathing/Showering ☐
- Doing light household chores ☐
- Sleeping ☐
- Attending work/School ☐
- Exercising/Playing ☐

Q24 Do you currently take any prescription medications on a regular basis?

- Yes ☐
- No ☐
- Not sure ☐

Q25 If yes, how many medications are you currently taking?

- 1-2 ☐
- 3-4 ☐
- More than 4 medications ☐

Please list the medications you currently take.

Q26 Are you currently pregnant? (If not, skip to question 30.)

- Yes ☐
- No ☐
- Not sure ☐

If yes, when is your due date? (Example: 02112014)

Q27 If you are pregnant, do you have an OB/GYN doctor, nurse, or mid-wife who is providing care during this pregnancy?

- Yes (answer below) ☐
- No ☐
- Not sure ☐

If yes, provider's last name:

First name:

Street number:

Street name:

City/Town:

Phone:

Q28 If you are pregnant, do you have concerns about your pregnancy?

- Yes ☐
- No ☐
- Not sure ☐

Q29 If yes, would you like to speak to a prenatal care manager?

- Yes ☐
- No ☐

Q30 In the last 12 months, did you get care in an emergency room?

- Yes ☐
- No ☐
- Not sure ☐

Q31 If yes, how many times?

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

Q32 In the last 12 months, have you stayed overnight in a hospital?

- Yes ☐
- No ☐
- Not sure ☐

Q33 Does anyone in your family (mother, father, sister, brother, children) have any of the following health problems? Check all that apply.

- Asthma ☐
- Kidney disease ☐
- Chronic pain ☐
- HIV/AIDS ☐
- Obesity/weight problems ☐
- Diabetes ☐
- Depression ☐
- High blood pressure ☐
- Alcohol or substance abuse ☐
- Heart problems ☐
- High cholesterol ☐
- Cancer ☐
- Stroke ☐
- Other ☐

Q34 Are you being treated for any of the following health problems? Check all that apply.

- Asthma ☐
- Kidney disease ☐
- Chronic pain ☐
- HIV/AIDS ☐
- Obesity/weight problems ☐
- Diabetes ☐
- Depression ☐
- High blood pressure ☐
- Alcohol or substance abuse ☐
- Heart problems ☐
- High cholesterol ☐
- Cancer ☐
- Stroke ☐
- Congestive heart failure ☐
- Heart attack/bypass/stent placement ☐
- Lung problems or COPD ☐
- Other ☐

Q35 Have you been told by a doctor that you have or have had any of the following conditions? Check all that apply.

- Stroke ☐
- Tumor of the brain or spine ☐
- Genetic disorder ☐
- Spinal cord injury or disorder ☐
- Head or brain injury ☐
- Nerve or muscle disorders ☐

Information about your health needs

Q36 Do you have a doctor or nurse who you usually go to for health care needs?

- Yes (answer below) ☐
- No ☐
- Not sure ☐

If yes, provider's last name:

First name:

Street number:

Street name:

City/Town:

Phone:

Q37 Have you seen your doctor in the last 12 months?

- Yes ☐
- No ☐
- Not sure ☐

Q38 If yes, what was the visit for?

- Well-visit ☐
- Illness ☐
- Injury ☐

Q38a Do you generally get a flu shot every year?

- Yes ☐
- No ☐
- Not sure ☐

Q38b When did you last receive a colonoscopy?

- Within the past 10 years ☐
- More than 10 years ago ☐
- Never ☐
- Not sure ☐

Questions 38c and 38d are for women only

Q38c When did you last receive a mammogram?

- Within the last 2 years ☐
- More than 2 years ago ☐
- Never ☐
- Not sure ☐

Q38d When did you last receive a PAP test?

- Within the last 2 years ☐
- More than 2 years ago ☐
- Never ☐
- Not sure ☐

Q39 Do you currently use any medical equipment?

- Yes ☐
- No ☐
- Not sure ☐

Q40 If yes, please check all of the equipment you use.

- Wheelchair ☐
- Cane ☐
- Walker ☐
- Crutches ☐
- Other ☐

Q41 Do you need help with managing your health care condition?

- Yes ☐
- No ☐
- Not sure ☐

Q42 If yes, would you like to speak with a care manager?

- Yes ☐
- No ☐

Q43 Are you interested in speaking to a social worker about managing mental health or alcohol/substance use concerns?

- Yes ☐
- No ☐
- Not sure ☐

Please provide details related to your concerns.

Q44 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 Fallon Customer Service for more information.)**

- Yes ☐
- No ☐
- Not sure ☐

Information about wellness and your lifestyle

Q45 In the past month, have you felt sad or down?

- Yes ☐
- No ☐
- Not sure ☐

Q45a Is stress or anger a problem for you in handling such things as:

Your health?
Your finances?
Your family or social relationships?
Your work?

- Yes ☐
- No ☐

Q45b If yes, how often?

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

Q46 In the past month, do you have enough energy to do what you need to for work, school, or home?

- Yes ☐
- No ☐
- Not sure ☐

Q47 If yes, how often?

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

Q47a In the past seven days, how many servings of fruits and vegetables were you typically able to each day?

- None ☐
- 1-3 ☐
- More than 3 ☐

Q47b In the past seven days, how many servings of high fiber or whole grain foods were you typically able to eat each day?

- None ☐
- 1-3 ☐
- More than 3 ☐

Q47c In the past seven days, how many servings of fried or high-fat foods did you typically eat each day?

- None ☐
- 1-3 ☐
- More than 3 ☐

Q47d In the past seven days, how many sugar-sweetened (not diet) beverages did you typically drink each day?

- None ☐
- 1-3 ☐
- More than 3 ☐

Q48 Do you exercise regularly?

- Yes ☐
- No ☐
- Not sure ☐

Q49 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 ☐

Q50 Do you use tobacco products?

- Yes ☐
- No ☐
- Not sure ☐

Q50a Would you be interested in quitting tobacco use within the next month?

- Yes ☐
- No ☐
- Not sure ☐

Q51 If yes, would you like written information about quitting smoking or using tobacco products?

- Yes ☐
- No ☐

Q52 Do you drink alcohol?

- Yes ☐
- No ☐
- Not sure ☐

Q53 If yes, how often do you drink alcohol?

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

Q54 Do you buckle your seat belt?

- Yes ☐
- No ☐
- Not sure ☐

Q55 If yes, how often?

- Always ☐
- Sometimes ☐
- Never ☐

Q56 If you have children under age 8 in your household, do you use a car seat when driving?

- Yes ☐
- No ☐
- Not sure ☐

Q57 If yes, how often?

- Always ☐
- Sometimes ☐
- Never ☐

Q58 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

Q59 How would you describe your race? Please check as many as apply.

- American Indian/Alaska Native ☐
- Asian ☐
- Black/African American ☐
- Hispanic/Latino/Spanish ☐
- Native Hawaiian or other Pacific Islander ☐
- White ☐
- Other race ☐
- Unknown/Not specified ☐

Q60 How would you describe your ethnic background? You may choose up to two options here. For example "American" or "Mexican" or "Cuban and Puerto Rican."

- African ☐
- African American ☐
- American ☐
- Asian ☐
- Asian Indian ☐
- Brazilian ☐
- Cambodian ☐
- Cape Verdean ☐
- Caribbean Island ☐
- Central American (not otherwise specified) ☐
- Chicano ☐
- Chinese ☐
- Colombian ☐
- Cuban ☐
- Dominican ☐
- Eastern European ☐
- European ☐
- Filipino ☐
- Guatemalan ☐
- Honduran ☐
- Japanese ☐
- Korean ☐
- Laotian ☐
- Mexican ☐
- Mexican American ☐
- Middle Eastern ☐
- Portuguese ☐
- Puerto Rican ☐
- Russian ☐
- Salvadoran ☐
- South American (not otherwise specified) ☐
- Vietnamese ☐
- Other ethnicity ☐
- Unknown/Not specified ☐

Thank you!

Thank you for taking the time to fill out this assessment form. Fallon 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 Fallon Customer Service at 1-800-341-4848 (TRS 711), Monday through Friday from 8 a.m. to 6 p.m.

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Office use only:

Date returned:_____

Date reviewed:_____