

# Care Needs Screening

13003652



**Important:** Please complete this health survey as best you can. This survey collects information about your health that we use to give you better care. Based on your answers, we may refer you to free programs to help improve your health or prevent disease.

## Survey instructions:



Complete this form for each member in your family. You can also complete it online at **wellsense.org**



Answer each question by checking the box or filling in your response in the space provided.



Once completed, please return your survey using the enclosed postage paid envelope.

## Please fill out below:

Name: \_\_\_\_\_ Member ID Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## We're here to help

If you need another form or have a question, call us at:

**888-566-0010 (MassHealth) | 855-833-8120 (Clarity plans, MA) | 855-833-8122 (Clarity plans, NH)**

Monday through Friday 8:00 a.m. to 6:00 p.m.

By completing this survey, you are giving us permission to reach out to share program information with you. Your personal results and information will be kept strictly confidential. You are not required to take this survey. If you do, your answers will only be shared with those who need to see them and will not affect your healthcare benefits or eligibility.

**wellsense.org**



**WellSense**  
HEALTH PLAN

**We revolve  
around you.**

# Member preferences

**1. What sex was assigned to you at birth?**

- Male
- Female
- Unknown

**2. Which of these best describes your current gender identity?** Complete if 18 years or older. Select one.

- Male
- Female
- Transgender man
- Transgender woman
- Genderqueer/gender nonconforming/non-binary
- Unknown
- Other \_\_\_\_\_

**3. What are your pronouns?** Select one.

- He/him
- She/her
- They/them
- Other, please specify \_\_\_\_\_

**4. Which of these best describes your current sexual orientation?** Complete if 18 years or older. Select One.

- Straight or Heterosexual
- Lesbian or Gay
- Bisexual
- Queer, Pansexual and/or questioning
- I don't know
- Other, please specify \_\_\_\_\_

**5. What is your race?** Check all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- I don't know
- Other

**6. Are you of Hispanic or Latino origin or descent?**

- Hispanic or Latino
- Not Hispanic or Latino
- I don't know

**7. What is your ethnicity?** You may provide two (for example, 'American' and 'Portuguese')

\_\_\_\_\_

**8. How well do you speak English?**

- Very well
- Well
- Not well
- Not at all

**9. What language do you feel most comfortable speaking with your doctor or nurse?**

\_\_\_\_\_

**10. In what language would you feel most comfortable reading medical or healthcare instructions?**

\_\_\_\_\_

**11. How old were you on your last birthday?**

\_\_\_\_\_

**12. What phone number should we use to contact you?**

\_\_\_\_\_

**13. What type of phone is this?** Select one.

- Home
- Mobile (text)
- Mobile (call)
- Office

**14. What email address should we use to contact you?**

\_\_\_\_\_

## Support services

15. Do you have transportation to doctor appointments?

- Always                       Usually  
 Sometimes                 Rarely or never

16. Would you like assistance to schedule transportation for medical appointments?

- Yes                               No

17. Do you have someone available to help you if you need and want help?

- Always                         Usually  
 Sometimes                 Rarely or never

18. Is your child currently receiving educational support services? For pediatric members only.

- Yes                               No

19. Have you been advised to seek educational support services for you child and would you like assistance in finding resources?

- Yes                               No

20. Do you currently get services from state agencies for the following? Check all:

- Blindness/Visual Impairment  
 Children, Youth and Family Services  
 Deafness/Hearing Impairment  
 Developmental Services  
 Early Intervention Program  
 Mental Health/Behavioral Health  
 Rehabilitation  
 Special Education  
 Other \_\_\_\_\_

21. Where do you live?

- Single family home  
 Apartment  
 Mobile home  
 Other \_\_\_\_\_

22. Are you currently experiencing homelessness or are you concerned about losing your housing in the near future?

- Yes                               No

23. How many people live in your home, including yourself?

\_\_\_\_\_

24. Do you feel safe at home?

- Yes                               No

25. Have you ever or are you currently experiencing trauma or abuse?

This includes being hurt by another person

- Yes                               No

26. If you are not currently receiving helpful support services, would you like WellSense to contact you with resources?

- Yes                               No

27. Do you usually have heat, hot water, electricity, and internet access?

- Yes                               No

28. Would you like assistance with utility resources?

- Yes                               No

29. Do you usually have access to enough food?

- Yes                               No

30. Are you employed (part-time or full-time)?

- Yes                               No

## Health history

**31. When did you last have a routine physical or wellness visit?**

- In the last year       3+ years ago  
 1-3 years ago       Not sure/Never

**32. Are you pregnant?** (Females only)

- No  
 Yes, currently pregnant  
 Yes, planning on becoming pregnant

**33. Are you currently having any pregnancy complications or have you in a previous pregnancy** (such as diabetes, high blood pressure, expecting multiple births, previous premature births)?

- Yes       No

**34. Have alcohol, prescription drugs or other substances been used during the pregnancy?**

- Yes       No

**35. How tall are you?** \_\_\_\_\_ (ft) \_\_\_\_\_ (in)

**36. How much do you weigh?** If pregnant, enter your pre-pregnancy weight. \_\_\_\_\_(lb)

**37. Are you satisfied with your weight? If not, how do you feel about working on weight loss?**

- I am satisfied with my weight.  
 I am already working on weight loss.  
 I intend to start working on weight loss within the next 30 days.  
 I intend to start working on weight loss within the next 6 months.  
 I have no plans to work on weight loss.

**38. Has a doctor ever told you that you have any of the following conditions?**

- Allergies  
 Anxiety  
 Arthritis  
 Asthma

- Attention deficit/hyperactivity disorder (ADHD)  
 Autism  
 Back pain  
 Bipolar disorder  
 Cancer  
 Chronic kidney disease  
 Chronic obstructive pulmonary disease (COPD, emphysema, chronic bronchitis)  
 Depression  
 Diabetes (other than during pregnancy)  
 Digestive problems  
 Heart disease (CAD, angina, heart attack)  
 Heart failure  
 High blood pressure (not during pregnancy)  
 High cholesterol  
 Migraines  
 Osteoporosis (bone loss)  
 Schizophrenia  
 Seizures  
 Sleep problems  
 Stroke  
 Substance abuse  
 None of the above

**39. Are you currently taking prescription medications for any of the following conditions?**

- Allergies  
 Anxiety  
 Arthritis  
 Asthma  
 Attention deficit/hyperactivity disorder (ADHD)  
 Autism  
 Back pain  
 Bipolar disorder  
 Cancer  
 Chronic kidney disease  
 Chronic obstructive pulmonary disease (COPD, emphysema, or chronic bronchitis)  
 Depression  
 Diabetes (other than during pregnancy)  
 Digestive problems

- Heart disease (CAD, angina, heart attack)
- High blood pressure (not during pregnancy)
- High cholesterol
- Migraines
- Osteoporosis (bone loss)
- Schizophrenia
- Seizures
- Sleep problems
- Stroke
- Substance abuse
- None of the above

**40. How many different prescription medications are you currently taking?**

- None
- 1-3
- 4-6
- 7 or more

**41. Do you have a vision impairment that requires special reading materials?**

- Yes
- No

**42. Do you have a hearing impairment that requires special equipment?**

- Yes
- No

**43. Are you blind or do you have serious difficulty seeing, even when wearing glasses?**

- Yes
- No
- I don't know

**44. Are you deaf or do you have serious difficulty hearing?**

- Yes
- No
- I don't know

**45. Do you have difficulty doing the following activities without help?** Complete if 6 years or older.

**Bathing:**

- No difficulty
- Yes difficulty
- Unable to do

**Dressing:**

- No difficulty
- Yes difficulty
- Unable to do

**Eating:**

- No difficulty
- Yes difficulty
- Unable to do

**Using the toilet:**

- No difficulty
- Yes difficulty
- Unable to do

**46. Do you have difficulty doing the following activities without help from another person?**

**Getting in or out of chairs:**

- No difficulty
- Yes difficulty
- Unable to do

**Preparing meals:**

- No difficulty
- Yes difficulty
- Unable to do

**Managing money:**

- No difficulty
- Yes difficulty
- Unable to do

**Taking medication as prescribed:**

- No difficulty
- Yes difficulty
- Unable to do

**47. Do you have serious difficulty walking or climbing stairs?** Complete if 6 years or older.

- Yes
- No
- I don't know

**48. Because of a physical, mental, or emotional condition, do you have difficulty doing errands such as visiting a doctor's office or shopping?** Complete if 16 years or older.

- Yes
- No
- I don't know

**49. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?** Complete if 6 years or older.

- Yes
- No
- I don't know

## Lifestyle

50. Have you had any trouble remembering or thinking clearly in the past month?

- Yes  No

51. Have you had trouble understanding written materials or counting?

- Yes  No

52. Have you had a flu shot in the past year?

- Yes  No

53. When did you last have a colonoscopy or sigmoidoscopy?

- In the last 10 years  
 More than 10 years ago  
 Not sure/never

54. When did you last have a Pap smear test and pelvic examination? (Females only)

- Does not apply to me  
 In the last year  
 1–3 years ago  
 More than 3 years ago  
 Not sure/never

55. When did you last have a mammogram (breast x-ray)? (Females only)

- Does not apply to me  
 In the last year  
 1–2 years ago  
 More than 2 years ago  
 Not sure/never

56. How many times have you been seen in a doctor's office, clinic, emergency room, or hospital for your health in the past 12 months, other than for pregnancy visits?

- None  4–6  
 1–3  7 or more

57. How often do you eat foods high in unhealthy fats? Includes red meats, fried foods, bakery goods, and high-fat dairy products like ice cream or cheese

- Several times a day  
 Once a day  
 Several times a week  
 Once a week  
 Less than once a week

58. How often do you eat foods that are high in fiber? Includes fruits, vegetables, beans, and whole-grain breads and pasta

- Several times a day  
 Once a day  
 Several times a week  
 Once a week  
 Less than once a week

59. Are you satisfied with your eating habits? If not, how do you feel about making changes?

- I am satisfied with my eating habits.  
 I am already making changes to my eating habits.  
 I intend to start making changes to my eating habits within the next 30 days.  
 I intend to start making changes to my eating habits within the next 6 months.  
 I have no plans to change my eating habits.

60. On average, how often do you engage in moderate physical activity for 30 minutes or more? Includes brisk walking, cycling, vacuuming, and gardening

- Never  4 days per week  
 1 day per week  5 days per week  
 2 days per week  6 days per week  
 3 days per week  Every day

**61. Are you satisfied with your physical activity? If not, how do you feel about making changes?**

- I am satisfied with my physical activity.
- I am already increasing my physical activity.
- I intend to start increasing my physical activity within the next 30 days.
- I intend to start increasing my physical activity within the next 6 months.
- I have no plans to increase my physical activity.

**62. How many days last year were you too sick to work or complete your usual activities?**

- None
- 1-3
- 4-6
- 7 or more

**63. How would you rate your health compared to other people your age?**

- Excellent
- Very good
- Good
- Fair
- Poor

**64. If poor, would you like a care manager to reach out to you to assist you with health concerns, community resources or other questions or issues?**

- Yes
- No

**65. Do you smoke cigarettes or smokeless tobacco?**

- No, I have never smoked
- No, I used to smoke but don't now
- Yes, some days
- Yes, every day

**66. How many packs of cigarettes do you smoke per day?**

\_\_\_\_\_ (packs)

**67. Would you like to speak to someone about quitting tobacco use?**

- Yes
- No

**68. Do you ever drink alcoholic beverages?**

- Yes
- No

**69. How many times in the past month did you have five or more drinks in 2 hours or less?**

- More than once
- Once
- None

**70. Are you satisfied with your use of alcohol? If not, how do you feel about making changes?**

- I am satisfied with my use of alcohol.
- I am already making changes to my alcohol use.
- I intend to start making changes to my alcohol use within the next 30 days.
- I intend to start making changes to my alcohol use within the next 6 months.
- I have no plans to change my alcohol use.

**71. How often do you use marijuana?** Includes pot, hash oil, THC/marijuana oil

- Never
- Sometimes
- Weekly
- Almost every day

**72. How often do you use other street drugs such as cocaine, LSD, PCP, ecstasy, speed, methamphetamine, or heroin?**

- Never
- Sometimes
- Weekly
- Almost every day

**73. How often do you use prescription medications such as Oxycontin, Vicodin, or Ritalin that were not prescribed for you by your healthcare provider?**

- Never
- Sometimes
- Weekly
- Almost every day

**74. How often do you use drugs or medications that affect your mood or help you relax?**

Do NOT count medications you use according to your healthcare provider's instructions.

- Never
- Weekly
- Sometimes
- Almost every day

**75. How would you describe the stress in your daily life?**

- High
- Low
- Moderate
- None

**76. How often did you miss an entire work or school day because of problems with your physical or mental health?**

\_\_\_\_\_ days per months

**77. To what degree have you experienced major life changes in the last 12 months?** This

includes someone close dying, a relationship ending, or money problems

- None
- Moderate
- Low
- High

**78. Do any of the following apply to the way you have felt in the past 2 weeks?** Please check all that apply or select "None of the above."

- I have felt downhearted, low, or sad.
- I haven't enjoyed the things I used to.
- I have been gaining or losing a significant amount of weight.
- I have been sleeping too much or too little.
- I have experienced a change in activity level.
- I have been feeling tired and lacking in energy.
- I have felt worthless or guilty.
- I have had trouble concentrating and making decisions.
- I have had recurrent thoughts of death or suicide.
- None of the above.

**79. Would you like to speak with someone about Behavioral Health or Substance Use services?**

- Yes
- No



**Next steps:**

Once completed, please return your survey using the enclosed postage paid envelope.



**WellSense**  
HEALTH PLAN

WellSense may collect and use information like race, ethnicity, language, gender identity, sexual orientation, sexual preference, religious beliefs, citizenship or immigration status to help improve your healthcare. We may also share this information with your healthcare provider so that they can give you better care. In line with federal and state laws, WellSense takes many steps to protect your information, including physical and electronic safeguards such as encryption and access controls. WellSense will not use this information for underwriting, rate setting or benefit determination. Providing this information is voluntary and will not impact your coverage or benefits with WellSense. For more details, visit <https://www.wellsense.org/about-us/health-equity> or contact our Member Service Team.