Health Needs Assessment Form

WellSense Medicare Advantage HMO and PPO Plans

WellSense HEALTH PLAN

Instructions: The following pages contain questions about your current health. The information provided will be treated confidentially and answers provided will not affect access to health benefits. Your results can help us determine the level of care, coordination or support you may need. Completion and submission of this form implies that you agree to have this information used for this purpose. Please respond as best you can.

Member Information

Date		
Member Name		
Member Date of Birth		
Street Address (mailing)		Apt. #
City	State	Zip Code
Telephone Number		

Health Questions

Are you being treated for any of these conditions?	Acquired Brain Disorder	☐ Yes	☐ No
	Asthma	☐ Yes	☐ No
	COPD/Emphysema	☐ Yes	☐ No
	Cancer	☐ Yes	☐ No
	Dementia/Alzheimer's	☐ Yes	☐ No
	Diabetes	☐ Yes	☐ No
	Heart Issue (irregular heartbeat, heart attack, or heart surgery	☐ Yes	☐ No
	Heart Failure or Enlarged Heart	☐ Yes	☐ No
	High Blood Pressure	☐ Yes	☐ No
	Kidney Disease	☐ Yes	☐ No
	Osteoporosis	☐ Yes	☐ No
	Mobility/Fall Risk	☐ Yes	☐ No
	Serious Physical Condition (such as cerebral palsy, multiple sclerosis, Lupus, Gout, Fibromyalgia, Rheumatoid Arthritis)	☐ Yes	☐ No
	Stroke	☐ Yes	☐ No
	Transplant	☐ Yes	☐ No

	Other	☐ Yes	☐ No
		If other is yes, please describe:	
Do you have any of the following issues that impact your health?	Pain	☐ Yes	☐ No
	Sleep	☐ Yes	☐ No
	Bowel	☐ Yes	☐ No
	Bladder	☐ Yes	☐ No
	Other	☐ Yes	☐ No
		If other is yes, please describe:	
How many different medications do you take each day (including prescriptions and over the counter medication)?		☐0-3 ☐4-6 ☐7 or more ☐None ☐Other If other, please describe:	
Have you been able to get all of the medications ordered by your doctor at the pharmacy?		☐ Yes	☐ No
Are you being treated for any of these Mental Health or Substance Use conditions?	Anxiety	☐ Yes	☐ No
	Bipolar Disorder	☐ Yes	☐ No
	Depression	☐ Yes	☐ No
	PTSD	☐ Yes	☐ No
	Schizophrenia	☐ Yes	☐ No
	Serious Mental Illness	☐ Yes	☐ No
	Substances Use Problems	☐ Yes	☐ No
	Other	☐ Yes	☐ No
		If other is yes, please describe:	
Do you use any of the following special equipment or assistive devices?	Cane	☐ Yes	☐ No
	Walker	☐ Yes	☐ No
	Wheelchair	☐ Yes	☐ No
	Motorized Wheelchair	☐ Yes	☐ No
	Hoyer Lift	☐ Yes	☐ No
	Hospital Bed	☐ Yes	☐ No

Do you have difficulty doing the following activities by yourself?	Bathing	☐ Yes	☐ No
	Dressing	☐ Yes	☐ No
	Walking	☐ Yes	☐ No
	Eating	☐ Yes	☐ No
	Using the toilet	☐ Yes	☐ No
	Getting in and out of chairs	☐ Yes	☐ No
	Preparing meals	☐ Yes	☐ No
	Managing Money	☐ Yes	☐ No
	Taking medication as prescribed	☐ Yes	☐ No
	Performing home chores (Laundry, basic cleaning	☐ Yes	☐ No
	Grocery shopping	☐ Yes	☐ No
	Driving/Transportation to Doctor Appointments	☐ Yes	☐ No
	Other	☐ Yes	☐ No
		If other is yes, please describe:	
Do you have a caregiver that helps you with your healthcare and personal care needs?		☐ Always ☐ Most of the time ☐ Sometimes ☐ Never	
In the past 12 months, have you been to the Emergency Room?		☐ None ☐ 1-2 times ☐ 3 or more times	
In the past 12 months have you been hospitalized?		☐ None ☐ 1-2 times ☐ 3 or more times	

Please return this completed survey in the enclosed postage-paid envelope, or mail to:
WellSense Health Plan
Attn: Central Processing
100 City Square, Suite 200
Charlestown, MA 02129