

Health Needs Assessment

Please complete all sections that apply to you and each member in your family. The answers to these questions will help us see how we can best help you and will not affect you or your child's Medicaid benefits in any way. All answers are kept private. If you need help filling out this form, please call **877-957-1300**. TDD/TTY users may call 711.

Date: _____

Mailing Address: _____ Apt # _____
 (street)

 (city) (state) (zip)

Complete this survey for each family member on this health plan. Write "same" or " " when answers for additional members match answers for Member 1.

Name of person filling out the form for each member:

Member 1

Member 2

Member 3

Relationship to member:

- Self Grandparent
- Mother Foster parent
- Father Child
- Other _____

Relationship to member:

- Self Grandparent
- Mother Foster parent
- Father Child
- Other _____

Relationship to member:

- Self Grandparent
- Mother Foster parent
- Father Child
- Other _____

	Member 1	Member 2	Member 3
Member Name			
Member ID #			
Spoken Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____
Written Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____
Race (List up to two)			
Ethnicity (List up to two)			
Best phone number			
What type of phone number is this?	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other _____

	Member 1	Member 2	Member 3
Best email address			
How would you like us to contact you?	<input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> Other _____	<input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> Other _____	<input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> Text <input type="checkbox"/> Other _____
Where do you live?	<input type="checkbox"/> Own/Rent <input type="checkbox"/> Shelter <input type="checkbox"/> Homeless <input type="checkbox"/> Staying with family/friend <input type="checkbox"/> Other _____	<input type="checkbox"/> Own/Rent <input type="checkbox"/> Shelter <input type="checkbox"/> Homeless <input type="checkbox"/> Staying with family/friend <input type="checkbox"/> Other _____	<input type="checkbox"/> Own/Rent <input type="checkbox"/> Shelter <input type="checkbox"/> Homeless <input type="checkbox"/> Staying with family/friend <input type="checkbox"/> Other _____
How many places have you lived in the past year?	<input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three or more	<input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three or more	<input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three or more
Do you feel safe at home?	<input type="checkbox"/> Yes, always <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Unsure <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes, always <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Unsure <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes, always <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Unsure <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer
Do you have reliable transportation to doctor visits?	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or Never	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or Never	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or Never
Are you being treated for any of these conditions? Check all that apply.	<input type="checkbox"/> Acquired Brain Disorder <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV/AIDs <input type="checkbox"/> Intellectual or Developmental Disability <input type="checkbox"/> Lung Disease <input type="checkbox"/> Serious Physical Condition (such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures) <input type="checkbox"/> Sickle Cell Disease (not trait) <input type="checkbox"/> Stroke <input type="checkbox"/> Transplant <input type="checkbox"/> Other (please explain) _____ Child Only <input type="checkbox"/> Juvenile Arthritis <input type="checkbox"/> Developmental Issues <input type="checkbox"/> Neonatal Abstinence Syndrome	<input type="checkbox"/> Acquired Brain Disorder <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV/AIDs <input type="checkbox"/> Intellectual or Developmental Disability <input type="checkbox"/> Lung Disease <input type="checkbox"/> Serious Physical Condition (such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures) <input type="checkbox"/> Sickle Cell Disease (not trait) <input type="checkbox"/> Stroke <input type="checkbox"/> Transplant <input type="checkbox"/> Other (please explain) _____ Child Only <input type="checkbox"/> Juvenile Arthritis <input type="checkbox"/> Developmental Issues <input type="checkbox"/> Neonatal Abstinence Syndrome	<input type="checkbox"/> Acquired Brain Disorder <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV/AIDs <input type="checkbox"/> Intellectual or Developmental Disability <input type="checkbox"/> Lung Disease <input type="checkbox"/> Serious Physical Condition (such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures) <input type="checkbox"/> Sickle Cell Disease (not trait) <input type="checkbox"/> Stroke <input type="checkbox"/> Transplant <input type="checkbox"/> Other (please explain) _____ Child Only <input type="checkbox"/> Juvenile Arthritis <input type="checkbox"/> Developmental Issues <input type="checkbox"/> Neonatal Abstinence Syndrome

General Health Information

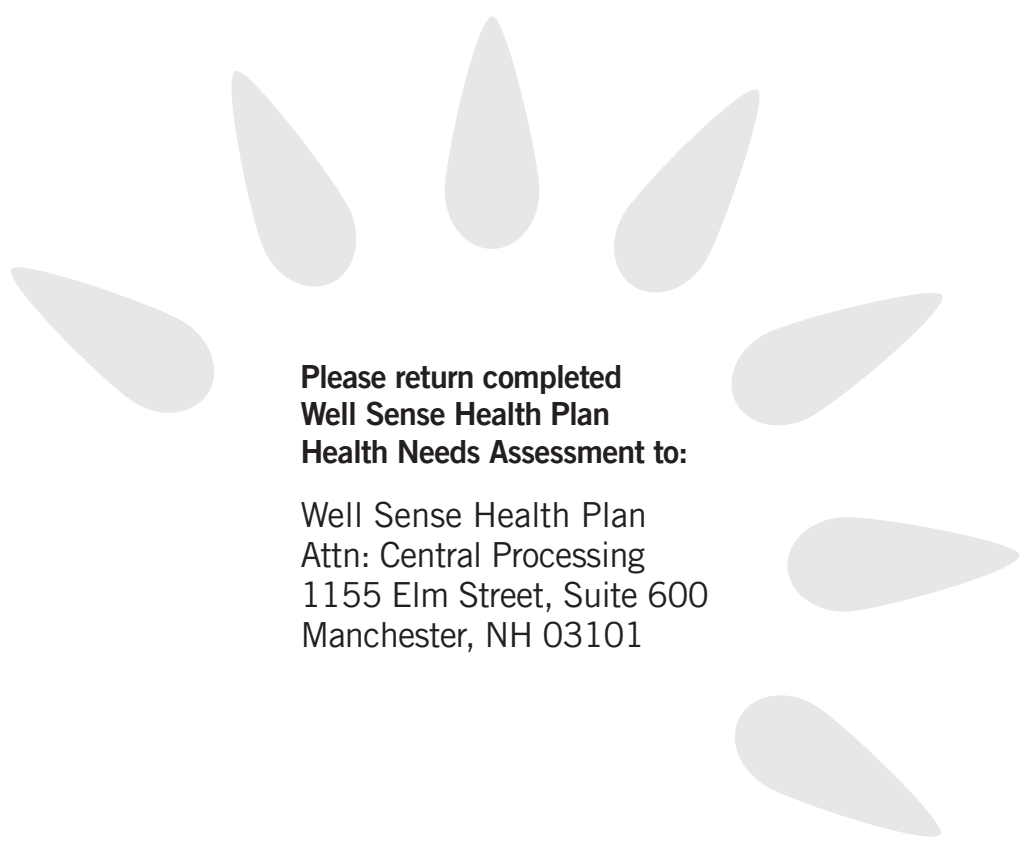
	Member 1	Member 2	Member 3
Are you currently on IV antibiotics for more than 3 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have constant pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how intense is the pain on a scale of 1 - 10 (10 being highest).	Pain Level: _____	Pain Level: _____	Pain Level: _____
Have you ever experienced trauma or abuse? (e.g. being physically hurt, humiliated, or emotionally abused by another person)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have ever experienced trauma or abuse, would you like support (e.g. to talk with a counselor)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often in the past 3 months were you worried that your food would run out?	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or Never	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or Never	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or Never
If completing for a child, does your child participate in any of the following?	<input type="checkbox"/> Family Centered Early Supports and Services <input type="checkbox"/> Special Medical Services <input type="checkbox"/> Partners in Health <input type="checkbox"/> None	<input type="checkbox"/> Family Centered Early Supports and Services <input type="checkbox"/> Special Medical Services <input type="checkbox"/> Partners in Health <input type="checkbox"/> None	<input type="checkbox"/> Family Centered Early Supports and Services <input type="checkbox"/> Special Medical Services <input type="checkbox"/> Partners in Health <input type="checkbox"/> None
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If yes, are there pregnancy complications (ex. diabetes, high blood pressure or multiples)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Have alcohol, prescription drugs or other substances been used during the pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

	Member 1	Member 2	Member 3
<p>Are you being treated for any of these Mental Health or Substance Use conditions?</p> <p>Check all that apply.</p>	<input type="checkbox"/> ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorder (anorexia, bulimia, other) <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Serious Mental Illness <input type="checkbox"/> Substance Use Problems <input type="checkbox"/> Other _____ <input type="checkbox"/> None Child Only <input type="checkbox"/> Serious Emotional Disturbance	<input type="checkbox"/> ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorder (anorexia, bulimia, other) <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Serious Mental Illness <input type="checkbox"/> Substance Use Problems <input type="checkbox"/> Other _____ <input type="checkbox"/> None Child Only <input type="checkbox"/> Serious Emotional Disturbance	<input type="checkbox"/> ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorder (anorexia, bulimia, other) <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Serious Mental Illness <input type="checkbox"/> Substance Use Problems <input type="checkbox"/> Other _____ <input type="checkbox"/> None Child Only <input type="checkbox"/> Serious Emotional Disturbance
Do you drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer
If yes, has anyone told you that your alcohol use is a problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer
Do you feel that you need help with drug or alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer
Are you currently using street drugs (such as heroin, cocaine) or other drugs other than as prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer
Have you had an overdose in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke cigarettes, use smokeless tobacco, or vape?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer
Would you like to speak to someone about quitting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Over the past 2 weeks, how often have you had little interest or pleasure in doing things?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half of the days <input type="checkbox"/> Nearly every day	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half of the days <input type="checkbox"/> Nearly every day	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half of the days <input type="checkbox"/> Nearly every day

	Member 1	Member 2	Member 3
Over the past 2 weeks, how often have you felt down, depressed, or hopeless?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half of the days <input type="checkbox"/> Nearly every day	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half of the days <input type="checkbox"/> Nearly every day	<input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half of the days <input type="checkbox"/> Nearly every day
Would you like to speak with someone about Mental Health/Substance use services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty doing the following activities by yourself? Check all that apply.	<input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Walking <input type="checkbox"/> Eating <input type="checkbox"/> Using the toilet <input type="checkbox"/> Getting in and out of chairs <input type="checkbox"/> Preparing meals <input type="checkbox"/> Managing money <input type="checkbox"/> Taking medication as prescribed <input type="checkbox"/> Performing home chores <input type="checkbox"/> Grocery shopping <input type="checkbox"/> Not applicable due to member's age	<input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Walking <input type="checkbox"/> Eating <input type="checkbox"/> Using the toilet <input type="checkbox"/> Getting in and out of chairs <input type="checkbox"/> Preparing meals <input type="checkbox"/> Managing money <input type="checkbox"/> Taking medication as prescribed <input type="checkbox"/> Performing home chores <input type="checkbox"/> Grocery shopping <input type="checkbox"/> Not applicable due to member's age	<input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Walking <input type="checkbox"/> Eating <input type="checkbox"/> Using the toilet <input type="checkbox"/> Getting in and out of chairs <input type="checkbox"/> Preparing meals <input type="checkbox"/> Managing money <input type="checkbox"/> Taking medication as prescribed <input type="checkbox"/> Performing home chores <input type="checkbox"/> Grocery shopping <input type="checkbox"/> Not applicable due to member's age
Have you used the emergency room 3 times or more in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you made a suicide attempt in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been hospitalized for more than a 2 week period in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, was it for a new baby in the NICU (neonatal intensive care unit)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been released from jail or prison in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to answer

	Member 1	Member 2	Member 3
Would you like a care manager to reach out to you to assist you with health concerns, community resources or other questions or issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Thank you for taking the time to answer these questions. Is there anything else you think we should know about you, your child, or family?



**Please return completed
Well Sense Health Plan
Health Needs Assessment to:**

Well Sense Health Plan
Attn: Central Processing
1155 Elm Street, Suite 600
Manchester, NH 03101