Care Needs Screening

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.

To get a custom health report right away, you can log in to the members-only section of **www.bmchp.org** or **www.wellsense.org** and take this survey online. Your report will tell you what you can do to get and stay healthy.

PLEASE FILL OUT BELOW

Name: _____

Member ID Number: _____

Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

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. If you need another form or have a question, call us at **888-566-0010 (MassHealth members)**, **855-833-8120 (Qualified Health Plan members)** or **877-957-1300 (Well Sense members**), Monday through Friday 8:00 a.m. to 6:00 p.m.

SURVEY INSTRUCTIONS:

Complete this paper form or online survey for each member in your family.

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.

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.

BOSTON MEDICAL CENTER HEALTHNet PLAN

Please return completed BMC HealthNet Plan Care Needs Screening to:

BMC HealthNet Plan
Attn: Central Processing
529 Main Street, Suite 500
Charlestown, MA 02129

WELL SENSE HEALTH PLAN

Please return completed Well Sense Health Plan Care Needs Screening to:

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

Take this survey online

bmchp.org or wellsense.org

1. **Are you male or female?**
   - ☐ Male
   - ☐ Female

2. **How old were you on your last birthday (years)?**

   _____

3. **What is your race? You may choose up to two options here.**
   - ☐ Alaska Native
   - ☐ American Indian
   - ☐ Asian
   - ☐ Black/African American
   - ☐ Hispanic/Latino (Black)
   - ☐ Hispanic/Latino (White)
   - ☐ Hispanic/Latino (Other)
   - ☐ Hawaiian or Pacific Islander
   - ☐ White/Caucasian
   - ☐ Other

4. **What is your ethnic background?** ***You may provide two ethnicities here. For example 'American' and 'Portuguese'.***

   _____

   _____

5. **What is your primary spoken language?**

   _____

6. **What is your primary written language?**

   _____

7. **What phone number should we use to contact you? For example: 555-555-5555 ext. 55.**

   _____

8. **What type of phone is this? Please select one.**
   - ☐ Home
   - ☐ Mobile (text)
   - ☐ Mobile (call)
   - ☐ Office

9. **What e-mail address should we use to contact you?**

   _____

10. **Do you have transportation for doctor appointments?**
    - ☐ Always
    - ☐ Sometimes
    - ☐ Usually
    - ☐ Rarely or never

11. **Do you have someone available to help you if you need and want help?**
    - ☐ Always
    - ☐ Sometimes
    - ☐ Usually
    - ☐ Rarely or never

12. **Do you currently get services from any state agencies for the following? If yes, please check all that apply:**
    - ☐ Blindness/Visual Impairment
    - ☐ Deafness/Hearing Impairment
    - ☐ Rehabilitation
    - ☐ Mental Health/Behavioral Health
    - ☐ Developmental Services
    - ☐ Children, Youth and Family Services
    - ☐ Special Education
    - ☐ Early Intervention Program
    - ☐ Other

13. **Where do you live?**
    - ☐ Single family home
    - ☐ Apartment
    - ☐ Mobile home
    - ☐ Other

14. **Do you have lack of stable housing? (ex. Homelessness or risk of losing housing)**
    - ☐ Yes
    - ☐ No

15. **How many people live in your home (including yourself)?**

    _____

16. **Do you feel safe with who you live with?**
    - ☐ Yes
    - ☐ No

17. **Have you ever or are you currently experiencing trauma or abuse? (ex. Being hurt by another person)**
    - ☐ Yes
    - ☐ No

18. **Are you employed (either part-time or full-time)?**
    - ☐ Yes
    - ☐ No

19. **When did you last have a routine physical or wellness visit?**
    - ☐ In the last year
    - ☐ 1–3 years ago
    - ☐ More than 3 years ago
    - ☐ Not sure/Never

20. **Are you pregnant? (Females only)**
    - ☐ No
    - ☐ Yes, currently pregnant
    - ☐ Yes, planning on becoming pregnant

21. **How tall are you?** _____ (ft) _____ (in)

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

23. **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.

24. **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

24. **Continued: Has a doctor ever told you that you have any of the following conditions?**
    - ☐ High blood pressure (hypertension, other than during pregnancy)
    - ☐ High cholesterol
    - ☐ Migraines
    - ☐ Osteoporosis (bone loss)
    - ☐ Schizophrenia
    - ☐ Seizures
    - ☐ Sleep problems
    - ☐ Stroke
    - ☐ Substance abuse
    - ☐ None of the above

25. **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 (hypertension) other than during pregnancy
    - ☐ High cholesterol
    - ☐ Migraines
    - ☐ Osteoporosis (bone loss)
    - ☐ Schizophrenia
    - ☐ Seizures
    - ☐ Sleep problems
    - ☐ Stroke
    - ☐ Substance abuse
    - ☐ None of the above

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

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

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

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

30. **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
- ☐ Yes difficulty

Managing money:

- ☐ No difficulty
- ☐ Yes difficulty
- ☐ Unable to do

Taking medication as prescribed:

- ☐ No difficulty
- ☐ Yes difficulty
- ☐ Unable to do

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

- ☐ Yes
- ☐ No

32. **Have you had trouble understanding written materials or counting?**

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

34. **When did you last have a colonoscopy or sigmoidoscopy?**

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

35. **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

36. **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

37. **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
- ☐ 1-3
- ☐ 4-6
- ☐ 7 or more

38. **How often do you eat foods high in unhealthy fats (Examples include red meats, fried foods, bakery goods, and high-fat dairy products like ice cream or cheese)?**

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

39. **How often do you eat foods that are high in fiber (Examples include fruits, vegetables, beans, and whole-grain breads and pasta)?**

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

40. **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.

41. **On average, how often do you engage in moderate physical activity for 30 minutes or more (Examples include brisk walking, cycling, vacuuming, and gardening)?**

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

42. **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.

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

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

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

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

45. **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

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

_____(packs)

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

- ☐ None
- ☐ Once
- ☐ More than once

50. **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.

51. **How often do you use marijuana (pot, hash oil, THC/marijuana oil)?**

- ☐ Never
- ☐ Sometimes
- ☐ Weekly
- ☐ Almost every day

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

- ☐ Never
- ☐ Sometimes
- ☐ Weekly
- ☐ Almost every day

53. **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

54. **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
- ☐ Sometimes
- ☐ Weekly
- ☐ Almost every day

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

- ☐ None
- ☐ Low
- ☐ Moderate
- ☐ High

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

_____ days per months

57. **To what degree have you experienced major life changes in the last 12 months (Examples include someone close dying, a relationship ending, or money problems)?**

- ☐ None
- ☐ Low
- ☐ Moderate
- ☐ High

58. **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

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

- ☐ Yes
- ☐ No

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