Health Risk Assessment Screening

Please complete all sections that apply to you or your family member. The answers to these questions will help us see how we can best help you or your family member and will not affect your Medicaid benefits in any way. All answers are kept private. If you need help filling out this form, please call 1-866-769-3085. TDD/TTY users may call 1-855-742-0123.

*Indicates a required question

Member Information

Name of person filling out the form:

Relationship to Member:

☐ Self ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Child ☐ Other

*Member Name (Last,First):

*Medicaid ID: Date of Birth (MMDDYYYY):

*Gender: ☐ Female ☐ Male Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (List up to two):

☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ Unknown/Not Specified

*Spoken Language: ☐ English ☐ Spanish ☐ Other

Written Language: ☐ English ☐ Spanish ☐ Other

*What is the best telephone number to reach you?

What type of phone number is this? ☐ Home ☐ Cell ☐ Other

*Best Email address?

*How would you like us to contact you? ☐ Phone ☐ Mail ☐ Email ☐ Text ☐ Other

*Where do you live? ☐ Own/Rent ☐ Shelter ☐ Homeless ☐ Staying with family/friend ☐ Other

How many places have you lived in the past year? ☐ One ☐ Two ☐ Three or more

Do you feel safe at home?

☐ Yes, always ☐ Unsure ☐ Yes, sometimes ☐ No ☐ Choose not to answer

Do you have a reliable transportation to doctor visits?

☐ Always ☐ Sometimes ☐ Rarely or Never

Are you being treated for any of these conditions? (Check all that apply)

☐ Acquired Brain Disorder ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ HIV/AIDS

☐ Intellectual or Developmental Disability ☐ Lung Disease ☐ Sickle Cell Disease (not trait) ☐ Hepatitis

☐ Serious Physical Condition (such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures)

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Stroke Transplant Other (please explain)

Child Only

Juvenile Arthritis Developmental Issues Neonatal Abstinence Syndrome

Are you currently on IV antibiotics for more than 3 weeks? Yes No

Do you have constant pain? Yes No

If yes, how intense is the pain on a scale of 1 - 10 (10 being highest)

1 2 3 4 5 6 7 8 9 10

Have you ever experienced trauma or abuse? (e.g. being physically hurt by, humiliated, or emotionally abused by another person)?

Yes No

If you ever experienced trauma or abuse, would you like support (e.g. to talk with a counselor)?

Yes No

How often in the past 3 months were you worried that your food would run out?

Always Sometimes Rarely or Never

If completing for a child, does your child participate in any of the following?

Family Centered Early Supports and Services Special Medical Services Partners in Health None

Are you pregnant?

Yes No N/A

If yes, are there pregnancy complications (ex. diabetes, high blood pressure or multiples)?

Yes No N/A

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

Yes No N/A

Are you being treated for any of these Mental Health or Substance Use conditions?(Check all that apply)

ADHD Autism Bipolar Disorder Depression Eating Disorder(anorexia, bulimia, other)

Schizophrenia Serious Mental Illness Substance Use Problems None

Child Only Serious Emotional Disturbance

Other

Do you drink alcoholic beverages?

Yes No Choose not to answer

If yes, has anyone told you that your alcohol use is a problem?

Yes No Choose not to answer

Do you feel that you need help with drug or alcohol use?

Yes No Choose not to answer

Are you currently using street drugs (such as heroin, cocaine) or other drugs other than as prescribed?

☐ Yes ☐ No ☐ Choose not to answer

Have you had an overdose in the past 12 months?

☐ Yes ☐ No

Do you smoke cigarettes, use smokeless tobacco, or vape?

☐ Yes ☐ No ☐ Choose not to answer

Would you like to speak to someone about quitting?

☐ Yes ☐ No

Over the past 2 weeks, how often have you had little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Would you like to speak with someone about Mental Health/Substance use services?

☐ Yes ☐ No

Do you have difficulty doing the following activities by yourself? Check all that apply.

☐ Bathing ☐ Dressing ☐ Walking ☐ Eating ☐ Using the toiliet

☐ Getting in and out chair ☐ Preparing meals ☐ Managing Money ☐ Taking medication as prescribed

☐ Performing home chores ☐ Grocery Shopping ☐ Not applicable due to member's age

Have you used the emergency room 3 times or more in the last 3 months?

☐ Yes ☐ No

Have you been hospitalized for more than a 2-week period in the last 3 months?

☐ Yes ☐ No

If yes, was it for a new baby in the NICU (neonatal intensive care unit)?

☐ Yes ☐ No

Have you made a suicide attempt in the past 12 months?

☐ Yes ☐ No

Have you been released from jail or prison in the last 6 months?

☐ Yes ☐ No ☐ Choose not to answer

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

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?