nh healthy families

Health Needs Assessment

You may also fill this form out online at **NHhealthyfamilies.com**

Questions?

call **1-866-769-3085**
(TDD/TTY: 1-855-742-0123) or
visit **NHhealthyfamilies.com**

Please take a few minutes to complete this questionnaire. We will keep this information private. We will only use your answer to give you the best care possible. Your answers will NOT affect your health insurance benefits. Your answers can improve the health care services you get.

One Member per Form ***Required Field**

Member Last Name: First Name:

Member ID*: Member Date of Birth (mmddyyyy):

1. Compared to others your age, how would you describe your health now? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. In the past 2 weeks, have you been bothered by:

a. Little interest or pleasure in doing things: ☐ Yes ☐ No b. Feeling down, depressed or hopeless: ☐ Yes ☐ No

3. Do you have a regular doctor or nurse who you usually go to for health care needs – sometimes called a Primary Care Provider (PCP)?

☐ Yes ☐ No

If **YES**, please provide the following information about your PCP:

Name: Phone Number: – –

Address:

If YES, have you seen your PCP in ☐ Less than 3 months: ☐ More than 3 months ago; ☐ Never

Do you have an appointment scheduled with your PCP ☐ Yes or ☐ No

IF yes insert date of appointment. (mmddyyyy)

4. Are you pregnant? ☐ Yes ☐ No If YES, when is your due date?

If you are pregnant, who is your OB/GYN provider, or a regular doctor, nurse, or midwife who is providing your pregnancy care?

Name: Phone Number: – –

Address:

5. Are **YOU** currently being treated, or have you ever been treated, for any of the following? **Please check as many as apply:**

- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Asthma
- ☐ Alcohol use or drug use
- ☐ Cancer
- ☐ Chronic Pain
- ☐ COPD
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Development/ Intellectual Disabilities
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Liver disease
- ☐ Mental Health Condition
- ☐ Migraines/headaches
- ☐ Obesity/ Weight problems
- ☐ Stress
- ☐ Tobacco Use
- ☐ Transplant
- ☐ Trouble breathing

Other Health Conditions:

6. Has anyone in your IMMEDIATE FAMILY ever suffered from any of the conditions listed above? ☐ Yes ☐ No

(Your immediate family includes your mother, father, sister, brother, or your children — blood relatives only.)

If yes, please list which ones:

7. Are you having a problem with any of your medications that prevent you from using them the way your doctor ordered them?

☐ Yes ☐ No

8. In the last 12 months, how many times did you go to the emergency room?

☐ Never ☐ 1-3 times ☐ 4-6 times ☐ more than 6 times

9. In the last 12 months, have you stayed overnight in a hospital? ☐ Yes ☐ No

If yes, insert reason for admission: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

10. In the last 12 months have you missed a doctor's appointment? ☐ Yes ☐ No

11. Have you been to the emergency room (ER) more than once in the last six (6) months? ☐ Yes ☐ No

12. Do you have trouble doing any of the following because of your health? **Please check as many as apply:**

☐ Bathing/Showering
☐ Eating
☐ Preparing meals
☐ Walking several blocks without stopping
☐ Doing light household chores, such as vacuuming
☐ Exercising or playing
☐ Sleeping
☐ Going to work or school

13. Are you hearing impaired? ☐ Yes ☐ No

14. Do you use a wheelchair? ☐ Yes ☐ No

15. Do you currently receive any of the following services?

☐ Equipment to help you walk
☐ Home medical equipment
☐ Home medical supplies
☐ Oxygen in the home
☐ Home health care

16. Do you use tobacco products? ☐ Yes ☐ No

If YES, would you like to get information about quitting smoking or tobacco use? ☐ Yes ☐ No

17. Would you like to get information about alcohol and/or substance use? ☐ Yes ☐ No

18. Are you currently getting any services from any other agencies?

(Your answers to this question will NOT affect your Medicaid benefits. Your answers can help us coordinate all the services you get and serve you better in future.)

Please list below:

PERSONAL INFORMATION

19. Your current mailing address:

City: State: Zip Code:

I am currently homeless

20. Your gender: Female Male

21. What telephone numbers are best for us to contact you about your health needs?

Call this number first (with area code): – –

Call this number second (with area code): – –

Text me at this number (with area code): – –

22. What is your email address?

23. How would you describe your race? You may choose up to two options.

- American Indian/Alaska Native
- Black/African American
- White
- Asian
- Hispanic/Latino/Spanish
- Unknown/Not Specified

Other Race:

24. How would you describe your ethnic background?

(For example, "African" "American", Asian", "Chinese", "Cuban", "European", "Haitian", "Mexican", "Puerto Rican", "Russian", "South American", or "Other/Unknown/Not Specified")

25. What language would you prefer that we use to communicate with you? **(Please choose one):**

- Cambodian
- Chinese
- English
- Haitian Creole
- Laotian
- Portuguese
- Russian
- Spanish
- Vietnamese
- Braille
- Sign Language
- Other

26. What language do you use for reading, and writing?

- Cambodian
- Chinese
- English
- Haitian
- Creole
- Laotian
- Portuguese
- Russian
- Spanish
- Vietnamese
- Braille
- Sign Language
- Other

26. Please indicate how you are submitting this form?

- Website
- Mail
- Fax
- Health Plan Staff
- NurseWise

27. If you had someone help you fill out this form, please tell us the name of the person that helped you:

What is your relationship to the person that helped you fill out this form?

- ☐ Parent
- ☐ Friend
- ☐ Other
- ☐ Guardian
- ☐ Lawyer
- ☐ Spouse
- ☐ Provider

New Hampshire Health Families will use the information on this form to help you get health care services. Your information will be kept private and confidential as required by State and Federal law.

For more information, please see the Notice of Privacy section of your member handbook or call us at **1-866-769-3085**, or TDD/TYY **1-855-742-0123**.