Fallon Health

Care Needs Screening Form

PLEASE DO NOT FOLD.

Please take a few minutes to complete this screening. Your Care Needs Screening will help Fallon Health provide better health services and coordinate the care you receive. We will keep the information you provide private. By submitting this form, you are giving us permission to share your information with the people involved in your care. Your answers will ***not*** affect your MassHealth/Medicaid benefits. Please note that this screening tool does ***not*** take the place of a medical evaluation with your Primary Care Provider. If you have any urgent medical or behavioral health needs, please schedule an appointment with your Primary Care Provider, or go to your nearest emergency care center.

Survey instructions:

1. Please fill out one screening form for each new member.
2. You will need to have on hand:
    a. Your plan member ID number
    b. The name, phone number and address of your doctor or nurse
3. Answer each of the questions by checking the appropriate box or filling in the space provided.
4. You are sometimes told to skip over some questions in this survey. When this happens, you will see a note that tells you what question to answer next.
5. This screening will take about 15 minutes to complete.
6. If you need help or have questions about completing this form, please call Customer Service at the number on the back of your member ID card, Monday through Friday from 8 a.m. to 6 p.m.

fallonhealth

Berkshire Fallon Health Collaborative

Q1 Name

Last Name:
First Name:
MI:

Q2 Fallon MassHealth ID number

Q3 Birth Date

(Example: 02/11/2014)

Q3a Please indicate your sex at birth:

- Male ☐
- Female ☐
- Intersex ☐
- Unspecified ☐
- Not listed ☐

Please specify.

3b Pronouns:

- He/Him/His ☐
- She/Her/Hers ☐
- They/They/Their ☐
- Other ☐

Please specify.

Q4a Gender Identity
Please check all that apply.

- Male ☐
- Female ☐
- Genderqueer/gender nonconforming; neither exclusively male nor female ☐
- Transgender Male/Trans Man ☐
- Transgender Female/Trans Woman ☐
- I do not know / I am not sure ☐
- I choose not to answer ☐
- My gender is not listed ☐

Please specify.

Q4b Sexual Orientation
Please check all that apply.

- Bisexual ☐
- Straight or heterosexual ☐
- Lesbian or homosexual ☐
- Gay or homosexual ☐
- Queer, pansexual, and/or questioning ☐
- I do not know / I am not sure ☐
- I choose not to answer ☐
- My sexual orientation is not listed ☐

Please specify.

5a How would you describe your race?
Please check as many as apply.

- American Indian/Alaskan Native ☐
- Asian ☐
- Black/African American ☐
- Native Hawaiian/Pacific Islander ☐
- White ☐
- Other race ☐
- I do not know / I am not sure ☐
- I choose not to answer ☐

5b Are you of Hispanic or Latino origin or decent?

- Hispanic or Latino ☐
- Not Hispanic or Latino ☐
- I do not know / I am not sure ☐
- I choose not to answer ☐

5c How would you describe your ethnic background? You may choose up to two options here. For example, "American" or "Mexican" or "Cuban and Puerto Rican". ***Please check all that apply.***

- African ☐
- African American ☐
- American ☐
- Asian ☐
- Asian Indian ☐
- Brazilian ☐
- Cambodian ☐
- Cape Verdean ☐
- Caribbean Island ☐
- Central American *(not otherwise specified)* ☐
- Chicano ☐
- Chinese ☐
- Columbian ☐
- Cuban ☐
- Dominican ☐
- Eastern European ☐
- European ☐
- Filipino ☐
- Guatemalan ☐
- Honduran ☐
- Japanese ☐
- Korean ☐
- Laotian ☐
- Mexican ☐
- Mexican American ☐
- Middle Eastern ☐
- Portuguese ☐
- Puerto Rican ☐
- Salvadoran ☐
- South American *(not otherwise specified)* ☐
- Vietnamese ☐
- My ethnicity is not listed ☐
- I do not know / I am not sure ☐
- I choose not to answer ☐

Q6a Address: Apartment/House Number and Street Name

Q6b City/Town

Q6c State

Q6d Zip code

Q7 Phone numbers

Primary:
Alternate:

Q8 E-mail address

Q9 Relationship (to member) of person completing this screening form

- Self
- Parent
- Spouse/Partner
- Family or relative
- Professional Caregiver
- Authorized representative

Q10 Preferred language

- English
- Spanish
- Other

Please specify.

Q11 Are you hearing impaired?

- Yes
- No
- Not sure

Q12 If yes, which is your preferred method of communication?

- American Sign Language Interpreter
- Assisted listening device
- Communication Access Real-Time Translations
- Text Telephone (TTY)
- Other

Please specify.

Q13a Are you visually impaired?

- Yes
- No
- Not sure

Q13b If yes, what is your preferred method of Communication?

- Large Print Publications
- Publications in Braille
- Publications in electronic format
- Other

Please specify.

13c. What language do you feel most comfortable speaking with your doctor or nurse?

- English
- Spanish
- Portuguese
- Chinese
- Haitian
- Sign Language, ASL
- French
- Vietnamese
- Russian
- Arabic
- I do not know / I am not sure
- I choose not to answer
- My language is not listed

Please specify.

13d. What language do you feel most comfortable when reading medical or health care instructions?

- English ☐
- Spanish ☐
- Portuguese ☐
- Chinese ☐
- Haitian ☐
- Sign Language, ASL ☐
- French ☐
- Vietnamese ☐
- Russian ☐
- Arabic ☐
- I do not know / I am not sure ☐
- I choose not to answer ☐
- My language is not listed ☐

Please specify.

Q14 Do you currently receive any services from any of the state agencies listed below?

Yes ☐ No ☐

Not sure ☐

Q15 If yes, please check all that apply.

- Massachusetts Commission for the Blind ☐
- Massachusetts Commission for the Deaf and Hard of Hearing ☐
- Massachusetts Rehabilitation Commission ☐
- Department of Mental Health ☐
- Department of Developmental Services ☐
- Division of Children and Families ☐
- Special Education ☐
- Department of Public Health ☐
- Executive Office of Elder Affairs ☐
- Bureau of Addiction Services ☐
- CARES for Kids ☐
- Justice Involvement ☐
- Other ☐

Please specify.

Q16a Do you currently get services from a Long-Term Service and Support (LTSS) Program?

Yes ☐ No ☐

Not sure ☐

Q16b If you answered yes to question 16a:

What is the name of the agency?

What services do you currently receive, and how many hours per week for each service?

Service	Hours/week

Are these services in your home or outside of the home?

In-home ☐

Outside the home ☐

Both: In home and outside the home ☐

Q17 How would you describe your health now?

Excellent ☐ Good ☐

Fair ☐ Poor ☐

Q18 Do you have any trouble completing any of the following tasks because of your health? *Please check all that apply.*

Walking ☐

Eating ☐

Bathing/showering/grooming ☐

Bowel/bladder control ☐

Shopping ☐

Getting and/or taking medications prescribed ☐

Preparing meals ☐

If you are pregnant, answer questions 19-22. *(If not, skip to Question 23A.)*

Q19 Are you currently pregnant?

Yes ☐ No ☐

Not sure ☐

If yes, when is your due date?

(Example: 02/11/2014)

Q20 If you are pregnant, do you have an OB/GYN doctor, nurse, or midwife who is providing care during this pregnancy?

Yes ☐ No ☐

Not sure ☐

If yes, provider's:

Last name
First name
Address
City/Town
Phone

Q21 If you are pregnant, do you have any concerns about your pregnancy?

Yes ☐ No ☐

Not sure ☐

Q22 If yes, would you like to speak to a prenatal care manager?

Yes ☐ No ☐

Q22a Have you delivered a child during the past 12 months? If yes, would you like to speak with a case manager for assistance?

Yes ☐ No ☐

Q23a In the last 12 months, did you get care in an emergency room?

Yes ☐ No ☐

Not sure ☐

Q23b If yes, how many times?

1-3 times ☐ 4-6 times ☐

More than 6 times ☐

Q24a In the last 12 months, have you stayed overnight in the hospital?

Yes ☐ No ☐

Not sure ☐

Q24b If yes, how many times?

1-2 times ☐ 3-4 times ☐

More than 5 times ☐

Information about your health needs

Q25a Do you have any of the following chronic illnesses?

Heart disease ☐

If yes, are you getting treatment for it?

Yes ☐ No ☐

COPD ☐

If yes, are you getting treatment for it?

Yes ☐ No ☐

Asthma ☐

If yes, are you getting treatment for it?

Yes ☐ No ☐

Diabetes ☐

If yes, are you getting treatment for it?

Yes ☐ No ☐

Q26a Do you have a Primary Care Doctor or Nurse Practitioner who you usually go to for health care needs?

Yes ☐ No ☐

Not sure ☐

If yes, provider's:

Last name
First name
Address
City/Town
Phone

26b Specialist

Last name
First name
Address
City/Town
Phone

26c Mental Health Provider
If yes, provider's:

Last name
First name
Address
City/Town
Phone

Q27a Do you have any concerns about your emotional or behavioral health that you want to speak with someone about?

Yes ☐ No ☐
Not sure ☐
I choose not to answer ☐

Q28 Do you have any concerns about your alcohol or drug use that you would you like to speak with someone about?

Yes ☐ No ☐
Not sure ☐
I choose not to answer ☐

Q29 How often do you feel lonely and isolated from those around you?

Never ☐
Rarely ☐
Sometimes ☐
Always ☐
I choose not to answer ☐

Q30a Do you currently use any medical equipment for your day-to-day needs?

Yes ☐ No ☐
I choose not to answer ☐

Q30b If yes, do you need help with any of the equipment?

Yes ☐ No ☐
I choose not to answer ☐

Q30c *Please check all equipment you need help with:*

Wheelchair ☐
Walker ☐
CPAP ☐
Nebulizer ☐
Other ☐

Please specify.

Q31a In the past 12 months, has the lack of transportation kept you from getting to medical appointments and/or medication pickup?

Yes ☐ No ☐

I choose not to answer ☐

Q31b In the past 12 months, has the lack of transportation kept you from meetings, work, or from getting things needed for daily living?

Yes ☐ No ☐

I choose not to answer ☐

Q32 Do you feel physically and emotionally safe where you currently live?

Yes, I do feel safe ☐

No, I do not feel safe ☐

I choose not to answer ☐

Q33 What is your current work situation?

Unemployed ☐

Part-time or temporary work ☐

Full time work ☐

Otherwise unemployed but not seeking work (e.g., student, retired, disabled, unpaid primary caregiver) ☐

I choose not to answer ☐

Q34a Within the past 12 months, were you worried that your food would run out before you got money to buy more?

Often true ☐

Sometimes true ☐

Never true ☐

I choose not to answer ☐

Q34b Within the past 12 months, did the food you bought run out or did not last, and you did not have money to get more?

Often true ☐

Sometimes true ☐

Never true ☐

I choose not to answer ☐

Q35a What is your current housing situation today?

I have housing ☐

I do not have housing (staying with others, in a hotel, in a shelter, living on the street, on a beach, in a car, or in a park) ☐

I choose not to answer ☐

Q35b Are you worried about losing your housing?

Yes ☐ No ☐

I choose not to answer ☐

Q36 Think about the place you live. Do you have problems with any of the following? *Please check all that apply.*

Pests, such as bugs, ants, or mice ☐

Mold ☐

Lack of heat ☐

Oven or stove not working ☐

Smoke detectors missing or not working ☐

I choose not to answer ☐

Q37 Within the past 12 months have you been worried about any of the following issues? *Please check all that apply.*

Finances (money) ☐
Heating and electricity ☐
Clothing ☐
Internet ☐
I choose not to answer ☐
Other ☐

Please specify.

Q38a Do you use tobacco products?

Yes ☐ No ☐
Not sure ☐
I choose not to answer ☐

Q38b If yes, would you be interested in quitting tobacco use within the next month?

Yes ☐ No ☐
Not sure ☐
I choose not to answer ☐

Q38c If yes, would you like information about quitting smoking or using tobacco products and would like to learn more about our Quit to Win program?

Yes ☐ No ☐

Q39 Do you have personal goals?

Yes ☐ No ☐
Not sure ☐
I choose not to answer ☐

Q40 Do you have any health goals?

Yes ☐ No ☐
Not sure ☐
I choose not to answer ☐

If yes, please specify.

The following questions are for pediatric members ages 0-18 only.

Q41 Is your child being treated for any of the following behavioral health conditions?

Adjustment disorder ☐
Anxiety disorder ☐
Attention Deficit Disorder ☐
Autism Spectrum ☐
Conduct disorder ☐
Depression ☐
Learning disorder ☐
Substance abuse disorder ☐
I choose not to answer ☐
Other ☐

Please specify.

Q42 Does your child have any of the following medical conditions?

Asthma ☐

If yes, are you getting treatment for it?

Yes ☐ No ☐

Obesity ☐

If yes, are you getting treatment for it?

Yes ☐ No ☐

Diabetes ☐

If yes, are you getting treatment for it?

Yes ☐ No ☐

Seizure disorders ☐

If yes, are you getting treatment for it?

Yes ☐ No ☐

Q43 Are your child's immunizations up to date?

Yes ☐ No ☐

Not sure ☐

I choose not to answer ☐

Q44 Who does the child live with in their primary residence?

☐

Q45a Does your child have any learning or developmental or speech conditions that you would like to speak with someone about?

Yes ☐ No ☐

Not sure ☐

I choose not to answer ☐

Q45b If yes, would you like information about school related resources or additional community supports?

Yes ☐ No ☐

Not sure ☐

I choose not to answer ☐

Q46 Is your child on a current 504 or IEP plan or receiving specialized services with their school?

Yes ☐ No ☐

Not sure ☐

Q47 If yes, do you need help with coordinating services with the school or other community supports?

Yes ☐ No ☐

Not sure ☐

I choose not to answer ☐

48 Do you have concerns about your child's emotional or behavioral health that you want to speak to someone about?

Yes ☐ No ☐

Not sure ☐

I choose not to answer ☐

Q49 Do have concerns about your child's alcohol or drug use that you would like to speak with someone about?

Yes ☐ No ☐

Not sure ☐

I choose not to answer ☐

Thank you!

Thank you for taking the time to fill out this screening form.

Berkshire Fallon Health Collaborative will review your responses to determine if there are care management programs, educational materials, or other resources that you may find helpful.

If you have any questions about this screening, please call Customer Service at the number on the back of your member ID card, Monday through Friday from 8 a.m. to 6 p.m.

Office use only:

Date Returned: _____

Date Reviewed: _____

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-855-203-4660 (TRS 711), Monday–Friday, 8 a.m.–6 p.m. The call is free.

Berkshire Fallon Health Collaborative

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