WellSense HEALTH PLAN

Health Needs Assessment

This survey will help us understand if we have special programs available to help you achieve your health goals. Your answers will not affect your access to benefits and all answers are kept private. If you need help filling out this form, call the Member Services phone number on the back of your WellSense member ID card. Please complete all questions that apply.

Date:	**Mailing Address** Street:		Apt #:
	City:	State:	Zip:

Complete this survey for each family member on this health plan. Please call Member Services if you need additional copies.

Name of person filling out the form for each member: _____ _____

Relationship to Member 1:

☐ Self ☐ Mother
☐ Father ☐ Grandparent
☐ Foster parent

Relationship to Member 2:

☐ Self ☐ Mother
☐ Father ☐ Grandparent
☐ Foster parent

General Information	**Member 1**	**Member 2**
Member Name		
Member ID #		
Spoken Language	☐ English ☐ Spanish ☐ Other: _____	☐ English ☐ Spanish ☐ Other: _____
Written Language	☐ English ☐ Spanish ☐ Other: _____	☐ English ☐ Spanish ☐ Other: _____
Race (List up to two)		
Ethnicity (List up to two)		
Best phone number		
What type of phone is this?	☐ Home ☐ Cell ☐ Other: _____	☐ Home ☐ Cell ☐ Other: _____
Best email address		

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

General Information	Member 1	Member 2
Are you currently on IV antibiotics for more than 3 weeks?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have constant pain?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, how intense is the pain on a scale of 1 - 10 (10 being highest).	Pain Level: _____	Pain Level: _____
Have you ever experienced trauma or abuse? (e.g. being physically hurt, humiliated or emotionally abused by another person)	☐ Yes ☐ No	☐ Yes ☐ No
If you have ever experienced trauma or abuse, would you like support (e.g. to talk with a counselor)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you afraid of anyone or is anyone hurting you?	☐ Yes ☐ No	☐ Yes ☐ No
Is anyone using your money without your ok?	☐ Yes ☐ No	☐ Yes ☐ No
Is anyone using your medication?	☐ Yes ☐ No	☐ Yes ☐ No
Is anyone taking your belonging without your ok?	☐ Yes ☐ No	☐ Yes ☐ No
How often in the past 3 months were you worried that your food would run out?	☐ Always ☐ Sometimes ☐ Rarely or Never	☐ 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	☐ Family Centered Early Supports and Services ☐ Special Medical Services ☐ Partners in Health ☐ None
Are you pregnant?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

General Information	Member 1	Member 2
If yes, are there pregnancy complications (ex. diabetes, high blood pressure or multiples)?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Have alcohol, prescription drugs or other substances been used during the pregnancy?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Are you being treated for any of these Mental Health or Substance Use conditions? **Check all that apply.**	☐ ADHD ☐ Anxiety ☐ Autism ☐ Bipolar Disorder ☐ Depression ☐ Eating Disorder (anorexia, bulimia, other) ☐ PTSD ☐ Schizophrenia ☐ Serious Mental Illness ☐ Substance Use Problems ☐ Other: _____ ☐ None **Child Only** ☐ Serious Emotional Disturbance	☐ ADHD ☐ Anxiety ☐ Autism ☐ Bipolar Disorder ☐ Depression ☐ Eating Disorder (anorexia, bulimia, other) ☐ PTSD ☐ Schizophrenia ☐ Serious Mental Illness ☐ Substance Use Problems ☐ Other: _____ ☐ None **Child Only** ☐ Serious Emotional Disturbance
Do you drink alcoholic beverages?	☐ Yes ☐ No ☐ Choose not to answer	☐ 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	☐ Yes ☐ No ☐ Choose not to answer
Do you feel that you need help with drug or alcohol use?	☐ Yes ☐ No ☐ Choose not to answer	☐ 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	☐ Yes ☐ No ☐ Choose not to answer
Have you had an overdose in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No

General Information	Member 1	Member 2
Do you smoke cigarettes, use smokeless tobacco or vape?	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer
Would you like to speak to someone about quitting?	☐ Yes ☐ No	☐ 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	☐ 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	☐ 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	☐ Yes ☐ No
Do you have difficulty doing the following activities by yourself? **Check all that apply.**	☐ Bathing ☐ Dressing ☐ Walking ☐ Eating ☐ Using the toilet ☐ Getting in and out of chairs ☐ Preparing meals ☐ Managing money ☐ Taking medication as prescribed ☐ Performing home chores ☐ Grocery shopping ☐ Not applicable due to member's age	☐ Bathing ☐ Dressing ☐ Walking ☐ Eating ☐ Using the toilet ☐ Getting in and out of chairs ☐ Preparing meals ☐ Managing money ☐ Taking medication as prescribed ☐ Performing home chores ☐ Grocery shopping ☐ Not applicable due to member's age
If you are age 65 or older, how often do you feel too tired to do basic activities (e.g. eat, shower, get dressed)?	☐ Always ☐ Most of the time ☐ Sometimes ☐ Never	☐ Always ☐ Most of the time ☐ Sometimes ☐ Never

General Information	Member 1	Member 2
If you are age 65 or older, do you have any difficulty walking up 10 steps without resting (by yourself and not using aids)?	☐ Yes ☐ No	☐ Yes ☐ No
If you are age 65 or older, have you fallen or had any near falls in the past 3 months?	☐ Yes ☐ No	☐ Yes ☐ No
Have you used the emergency room 3 times or more in the last 3 months?	☐ Yes ☐ No	☐ Yes ☐ No
Have you made a suicide attempt in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
Have you been hospitalized for more than a 2-week period in the last 3 months?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, was it for a new baby in the NICU (neonatal intensive care unit)?	☐ Yes ☐ No	☐ Yes ☐ No
Have you been released from jail or prison in the last 6 months?	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer
Would you like a care manager to reach out to assist with your health concerns, community resources or other questions ?	☐ Yes ☐ No	☐ 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?

_____

_____

_____

_____

_____

Please return completed survey to:

Well Sense Health Plan
Attn: Central Processing
1155 Elm Street, Suite 500
Manchester, NH 03101

WellSense
HEALTH PLAN