Care Needs Screening

13003652

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.

Survey instructions:

Complete this form for each member in your family. You can also complete it online at **wellsense.org**

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.

Please fill out below:

Name: _____ **Member ID Number:** _____

Address: _____

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

We're here to help

If you need another form or have a question, call us at:

888-566-0010 (MassHealth) | 855-833-8120 (Clarity plans, MA) | 855-833-8122 (Clarity plans, NH)

Monday through Friday 8:00 a.m. to 6:00 p.m.

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. 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.

Member preferences

1. **What sex was assigned to you at birth?**
   - ☐ Male
   - ☐ Female
   - ☐ Unknown

2. **Which of these best describes your current gender identity?** Complete if 18 years or older. Select one.
   - ☐ Male
   - ☐ Female
   - ☐ Transgender man
   - ☐ Transgender woman
   - ☐ Genderqueer/gender nonconforming/ non-binary
   - ☐ Unknown
   - ☐ Other _____

3. **What are your pronouns?** Select one.
   - ☐ He/him
   - ☐ She/her
   - ☐ They/them
   - ☐ Other, please specify _____

4. **Which of these best describes your current sexual orientation?** Complete if 18 years or older. Select One.
   - ☐ Straight or Heterosexual
   - ☐ Lesbian or Gay
   - ☐ Bisexual
   - ☐ Queer, Pansexual and/or questioning
   - ☐ I don't know
   - ☐ Other, please specify _____

5. **What is your race?** Check all that apply.
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White
   - ☐ I don't know
   - ☐ Other

6. **Are you of Hispanic or Latino origin or descent?**
   - ☐ Hispanic or Latino
   - ☐ Not Hispanic or Latino
   - ☐ I don't know

7. **What is your ethnicity?** You may provide two (for example, 'American' and 'Portuguese')

   _____

8. **How well do you speak English?**
   - ☐ Very well
   - ☐ Well
   - ☐ Not well
   - ☐ Not at all

9. **What language do you feel most comfortable speaking with your doctor or nurse?**

   _____

10. **In what language would you feel most comfortable reading medical or healthcare instructions?**

    _____

11. **How old were you on your last birthday?**

    _____

12. **What phone number should we use to contact you?**

    _____

13. **What type of phone is this?** Select one.
    - ☐ Home
    - ☐ Mobile (text)
    - ☐ Mobile (call)
    - ☐ Office

14. **What email address should we use to contact you?**

    _____

Support services

15. Do you have transportation to doctor appointments?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely or never

16. Would you like assistance to schedule transportation for medical appointments?

- ☐ Yes
- ☐ No

17. Do you have someone available to help you if you need and want help?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely or never

18. Is your child currently receiving educational support services? For pediatric members only.

- ☐ Yes
- ☐ No

19. Have you been advised to seek educational support services for you child and would you like assistance in finding resources?

- ☐ Yes
- ☐ No

20. Do you currently get services from state agencies for the following? Check all:

- ☐ Blindness/Visual Impairment
- ☐ Children, Youth and Family Services
- ☐ Deafness/Hearing Impairment
- ☐ Developmental Services
- ☐ Early Intervention Program
- ☐ Mental Health/Behavioral Health
- ☐ Rehabilitation
- ☐ Special Education
- ☐ Other _____

21. Where do you live?

- ☐ Single family home
- ☐ Apartment
- ☐ Mobile home
- ☐ Other _____

22. Are you currently experiencing homelessness or are you concerned about losing your housing in the near future?

- ☐ Yes
- ☐ No

23. How many people live in your home, including yourself?

_____

24. Do you feel safe at home?

- ☐ Yes
- ☐ No

25. Have you ever or are you currently experiencing trauma or abuse?
This includes being hurt by another person

- ☐ Yes
- ☐ No

26. If you are not currently receiving helpful support services, would you like WellSense to contact you with resources?

- ☐ Yes
- ☐ No

27. Do you usually have heat, hot water, electricity, and internet access?

- ☐ Yes
- ☐ No

28. Would you like assistance with utility resources?

- ☐ Yes
- ☐ No

29. Do you usually have access to enough food?

- ☐ Yes
- ☐ No

30. Are you employed (part-time or full-time)?

- ☐ Yes
- ☐ No

Health history

31. When did you last have a routine physical or wellness visit?

- ☐ In the last year
- ☐ 1-3 years ago
- ☐ 3+ years ago
- ☐ Not sure/Never

32. Are you pregnant? (Females only)

- ☐ No
- ☐ Yes, currently pregnant
- ☐ Yes, planning on becoming pregnant

33. Are you currently having any pregnancy complications or have you in a previous pregnancy (such as diabetes, high blood pressure, expecting multiple births, previous premature births)?

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

35. How tall are you? _____ (ft) _____ (in)

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

37. 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.

38. 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
- ☐ High blood pressure (not during pregnancy)
- ☐ High cholesterol
- ☐ Migraines
- ☐ Osteoporosis (bone loss)
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sleep problems
- ☐ Stroke
- ☐ Substance abuse
- ☐ None of the above

39. 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 (not during pregnancy)
- ☐ High cholesterol
- ☐ Migraines
- ☐ Osteoporosis (bone loss)
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sleep problems
- ☐ Stroke
- ☐ Substance abuse
- ☐ None of the above

40. How many different prescription medications are you currently taking?

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

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

43. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- ☐ Yes
- ☐ No
- ☐ I don't know

44. Are you deaf or do you have serious difficulty hearing?

- ☐ Yes
- ☐ No
- ☐ I don't know

45. Do you have difficulty doing the following activities without help? Complete if 6 years or older.

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

46. 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

Managing money:

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

Preparing meals:

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

Taking medication as prescribed:

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

47. Do you have serious difficulty walking or climbing stairs? Complete if 6 years or older.

- ☐ Yes
- ☐ No
- ☐ I don't know

48. Because of a physical, mental, or emotional condition, do you have difficulty doing errands such as visiting a doctor's office or shopping? Complete if 16 years or older.

- ☐ Yes
- ☐ No
- ☐ I don't know

49. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? Complete if 6 years or older.

- ☐ Yes
- ☐ No
- ☐ I don't know

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

- ☐ Yes
- ☐ No

51. Have you had trouble understanding written materials or counting?

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

53. When did you last have a colonoscopy or sigmoidoscopy?

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

54. 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

55. 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

56. 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

Lifestyle

57. How often do you eat foods high in unhealthy fats? Includes red meats, fried foods, bakery goods, and high-fat dairy products like ice cream or cheese

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

58. How often do you eat foods that are high in fiber? Includes fruits, vegetables, beans, and whole-grain breads and pasta

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

59. 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.

60. On average, how often do you engage in moderate physical activity for 30 minutes or more? Includes 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

61. 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.

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

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

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

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

64. If poor, 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

65. 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

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

_____ (packs)

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

- ☐ Yes
- ☐ No

68. Do you ever drink alcoholic beverages?

- ☐ Yes
- ☐ No

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

- ☐ More than once
- ☐ Once
- ☐ None

70. 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.

71. How often do you use marijuana? Includes pot, hash oil, THC/marijuana oil

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

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

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

73. 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

74. 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

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

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

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

_____ days per months

77. To what degree have you experienced major life changes in the last 12 months? This includes someone close dying, a relationship ending, or money problems

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

78. 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.

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

- ☐ Yes
- ☐ No

Next steps:
Once completed, please return your survey using the enclosed postage paid envelope.

WellSense HEALTH PLAN

WellSense may collect and use information like race, ethnicity, language, gender identity, sexual orientation, sexual preference, religious beliefs, citizenship or immigration status to help improve your healthcare. We may also share this information with your healthcare provider so that they can give you better care. In line with federal and state laws, WellSense takes many steps to protect your information, including physical and electronic safeguards such as encryption and access controls. WellSense will not use this information for underwriting, rate setting or benefit determination. Providing this information is voluntary and will not impact your coverage or benefits with WellSense. For more details, visit **https://www.wellsense.org/about-us/health-equity** or contact our Member Service Team.