# CARE NEEDS SCREENING FOR CHILDREN 11-17

Steward Health Care Network
HEALTH CHOICE
MASSACHUSETTS

We want to get to know you so we can support you.
One way we can do this is by using your answers to the questions below.

Please return this completed survey in the self-addressed, postage-paid envelope.

To complete this survey by telephone, or if you have questions please call:
1-844-457-8945 Monday through Friday 9:00 AM – 8:00 PM EST.

Para completar esta encuesta en ESPAÑOL, por favor llame al: 1-844-457-8945.

**Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■**

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____
Month Day Year

**Are you completing this survey on behalf of the Member?**
☐ Yes, I am answering on the Member's behalf. ☐ No, I am the Member.

**If Yes, what is your relation to the Member?** ☐ Parent ☐ Spouse
☐ Legal Guardian ☐ Paid Caregiver ☐ Unpaid Caregiver ☐ Other

**Name of the person completing this survey on behalf of the Member:**
_____

Home Phone: _____

Cell Phone: _____

Email Address: _____

**What is your Steward Health Choice Identification Number?**
It is located on the Steward Health Choice Member ID card mailed to you.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

These questions help us make sure every patient receives the best possible care, and by knowing more about you, we will be able to do things like make sure information is sent in the right languages for you, and that the right services are available, and it helps us better serve other patients too. It is your choice if you do not want to answer any of these questions you can go on to the next one. The responses to these questions will be kept private, just like all of your other health information.

**How would you describe the child's race? Choose all that would apply**

☐ Asian ☐ Black or African American ☐ White-Caucasian ☐ American Indian or Alaska Native ☐ Native
☐ Hawaiian or Other Pacific Islander ☐ I am not sure/don't know ☐ I choose not to answer
☐ Other, please describe: _____

**Is the child of Hispanic or Latino origin or descent?** ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ I choose not to answer ☐ I am not sure/don't know.

**Which best describes the child's ethnicity?** Choose all that apply.

| | | | | |
|---|---|---|---|---|
| ☐ African | ☐ African American | ☐ Asian Indian | ☐ American | ☐ Asian Indian |
| ☐ Brazilian | ☐ Cambodian | ☐ Cape Verdean | ☐ Caribbean Islander | ☐ Central American |
| ☐ Chinese | ☐ Colombian | ☐ Cuban | ☐ Dominican | ☐ Eastern European |
| ☐ European | ☐ Filipino | ☐ Guatemalan | ☐ Haitian | ☐ Honduran |
| ☐ Japanese | ☐ Korean | ☐ Laotian/Lao | ☐ Mexican | ☐ Middle Eastern or North African |
| ☐ Portuguese | ☐ Puerto Rican | ☐ Russian | ☐ Other, please describe: _____ | |

**What language does the child prefer to speak in?** ☐ English ☐ Spanish ☐ Portuguese ☐ Cantonese
☐ Mandarin ☐ Haitian Sign Language, such as ASL ☐ French ☐ Vietnamese ☐ Russian ☐ Arabic
☐ Other, I choose not to answer ☐ I am not sure/don't know *If Other, please describe:* _____

**What was the child's sex assigned at Birth?** ☐ Male ☐ Female ☐ Unknown ☐ I choose not to answer

**How would you describe the child's gender identity?** ☐ Male ☐ Female ☐ Female-to Male (FTM)/Transgender
☐ Male/Trans Man ☐ Male-to Female (MTF)/Transgender ☐ Female/Trans Woman
☐ Genderqueer, neither exclusively male nor female ☐ Additional gender category or other ☐ I choose not to answer

**Additional gender category or other, please describe**: _____

**What is the child's preferred Pronouns?** ☐ She/Her ☐ He/His ☐ They/Their ☐ Ze/Zir ☐ I choose not to answer
*Something else, please describe*: _____

**What is the child's sexual orientation?** ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual
☐ I choose not to answer ☐ I am not sure/don't know *Something else, please describe:* _____

**Dose the child need help to read or write in English?** ☐ Yes ☐ No

**Dose the child have any religious/spiritual/cultural practices that you would like us to know about?**
☐ Yes ☐ No *If yes, please describe:* _____

**Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■**

**In general, how would you rate the child's overall health (physical and mental health)?**
☐ Very Good ☐ Good ☐ Poor

**Describe overall health (Physical and mental health):** _____

**In the past year, has the/your child been treated or is being treated for any of these?**
**Please select all that apply:** ☐ Asthma- Past year ☐ Asthma- Currently
☐ Autism/Autism Spectrum Disorder- Past year
☐ Autism/Autism Spectrum Disorder- Currently
☐ Behavioral Health Issues (like ADHD, Depression, Anxiety, Substance Abuse, etc.)- Past Year
☐ Behavioral Health Issues (like ADHD, Depression, Anxiety, Substance Abuse, etc.)- Currently
☐ Birth Defects -Past year ☐ Birth Defects- Currently ☐ Cancer- Past year ☐ Cancer- Currently
☐ Developmental issues (speech, motor skills, etc.)- Past year
☐ Developmental issues (speech, motor skills, etc.)- Currently
☐ Diabetes- Past year ☐ Diabetes- Currently ☐ Down Syndrome- Past year
☐ Down Syndrome- Currently ☐ Epilepsy/Seizure Disorder- Past year
☐ Epilepsy/Seizure Disorder- Currently ☐ Heart Problems- Past Year ☐ Heart Problems- Currently
☐ Kidney Disease- Past Year ☐ Kidney Disease- Currently ☐ Learning Disabilities- Past year

**Does the/your child currently take any medications (include prescription, OTC, Supplements, etc.)?**
☐ Yes ☐ No ☐ Unsure

**Dose the/your child see a behavioral health provider? (psychologist, therapist, psychiatrist, counselor)**
☐ Yes ☐ No ☐ Unsure

**Dose the/your child take the medications as prescribed by the/your child's provider (i.e. Missing a dose or doubling up?)**
☐ Yes ☐ No ☐ Sometimes ☐ Declines response

**What are the reasons the/your child dose not take your medications as prescribed by your provider?**
☐ Cannot afford all of my medications ☐ Cannot get to the pharmacy to get my medications
☐ Do not understand medications ☐ Forget to take my medications ☐ Too many pills to take
☐ Too many side effects ☐ Other ☐ Declines response

**How do you manage your medications (pill box, someone else helps, pill dispenser)?**_____

**Do you have any questions about your medications (i.e., Side effects, affordability)?**
☐ Yes ☐ No ☐ Unknown

**Is the/your child currently receiving services from any of these state agencies?**
**Please select all that apply:**
☐ Department of Developmental Services (DDS)
☐ Department of Mental Health (DMH)
☐ Massachusetts Commission for the Blind (MCB)
☐ Massachusetts Commission for the Deaf and Hard of Hearing (BLIND)
☐ Department of Children and Families (DYS)
☐ Department of Youth Services (DCF)
☐ None of the above

**Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■**

**In the past 6 months has the/your child been admitted to the hospital 2 or more times or been to the Emergency Room 3 or more times?** ☐ Yes ☐ No ☐ Unsure

**Is the/your child currently in school/daycare?** ☐ Yes ☐ No ☐ N/A

**If the child is not enrolled in the school/daycare do you need assistance in enrolling them?**
☐ Yes ☐ No ☐ N/A

**What is the/your child's current living arrangement?**
☐ Live with parent(s) guardian(s) ☐ Live with one parent or guardian
☐ Live with sibling(s) ☐ Live with other relative(s)
☐ Live with foster parent(s) ☐ Live with caregiver
☐ Live with roommate ☐ Other, please specify _____

**Have the/your child's doctor ever told you the child is overweight?**
☐ Yes and I agree with the doctor ☐ Yes and I do not agree with the doctor ☐ No

**Do you have any immediate health concerns for the/your child? (select all that apply)**
☐ The child's diet ☐ The child's sleeping issues
☐ The child's behavioral issues ☐ The child's medical issues
☐ The child's school/learning problems
☐ Other, please specify_____ ☐ None of the above

**Do you have any health goals for the/child? (select all that apply)**
☐ Improving the child's diet ☐ Improving the child's sleep
☐ Improving the child's behavioral issues ☐ Improving the child's medical issues
☐ Improving the child's school/learning problems ☐ Other, please specify _____
☐ None of the above

**How long ago did the/your child last have a Well Visit (an appointment when the child was not sick)?**
☐ This month ☐ 1 month ago ☐ 2 months ago ☐ 3 months ago
☐ 4 months ago ☐ 5 months ago ☐ 6 months ago ☐ 7 months ago
☐ 8 months ago ☐ 9 months ago ☐ 10 months ago ☐ 11 months ago
☐ 12 months ago or more

**For all children who have not been seen for a Well Visit, why has the/your child not been seen for a well visit?(select all that apply)**
☐ Lack of transportation
☐ Unable to get time off of work
☐ Unable to get an appointment scheduled with doctor
☐ Other

**Does the/your child need more help than is expected of their age, for (1) or more of the following: (ADLs) Bathing, Eating, Dressing, Walking, using the bathroom? (select all that apply)**
☐ No, the child does not need more help ☐ Yes, the child needs the help and has all the help needed
☐ The child needs help with bathing ☐ The child needs help with eating
☐ The child needs help with dressing ☐ The child needs help with walking
☐ The child needs help with toileting
*Describe Equipment needs/status:* _____

**Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■**

**Which statement best describes the equipment needs of the/your child?**

☐ Yes, I have all the equipment I need ☐ No, I don't have all the equipment I need
☐ Unsure Describes the equipment needs of the/your child?_____

**Is the/your child currently experiencing pain?** ☐ Yes ☐ No

**Has the/your child experienced pain in the past few months?** ☐ Yes ☐ No
**Describe the pain(frequency, intensity, type, duration, what causes and relieves pain, any limitations pain causes):**_____

**Does the/your child follow a prescribed diet?** ☐ Yes ☐ No ☐ Unsure

**Has the/your child experienced weight gain or loss in the past 6 months?**

☐ Unintentional Weight Gain ☐ Unintentional Weight Loss
☐ Intentional Weight Gain ☐ Intentional Weight Loss ☐ No Change

**Has the/your child been seen by a dentist in the past twelve (12) months?**

☐ Yes ☐ No ☐ N/A child is under 1 year

**For children 3 years of age and older, during the past 7 days, on how many days was the/your child physically active for a total of at least 60 minutes per day?**_____

**Is the/your child currently pregnant or have you been pregnant in the last 12 months?**

☐ Currently Pregnant ☐ Pregnant in the last 12 months
☐ No ☐ N/A

**If pregnant, are you receiving prenatal care?** ☐ Yes ☐ No

**What is the/your child(s) housing situation today?**

☐ They do not have housing (They are Staying with others. Staying in a hotel. Staying in a shelter. Living outside on the street. Living on a beach. Living in a car. Living in a vacant building. Living in a bus or train station. Living in a park.)
☐ They have housing today but are worried about losing housing in the future.
☐ They have housing.

**If the/your child does not have housing, what is the housing situation today? (Select all that apply)**

☐ Staying with others ☐ Hotel ☐ Shelter ☐ Skilled Nursing Facility
☐ Living outside on the street ☐ Living on a beach ☐ Living in a park
☐ Living in an abandoned building ☐ Living in a bus or train station ☐ Other

**Have you moved three (3) or more times within the past year?** ☐Yes ☐No

**Think about the place the/your child live(s). Do you have problems with any of the following?**
**(check all that apply)**

☐ Infestation (bugs, mice, rats, etc.) ☐ Mold ☐ Lead paint or pipes
☐ Inadequate heat ☐ Oven or stove not working ☐ Water leaks
☐ Cigarette Smoke ☐ None of the above

**Are you receiving housing assistance for the/your child's home?**

☐ Yes ☐ No ☐ No, but interested in applying
☐ Interested in assistance-Already applying/applied ☐ N/A

**Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■**

**Is there something or someone in the/your child's home or community that make(s) them feel unsafe?**
☐ Yes ☐ No ☐ Unsure

**In the past 12 months, has the/your child had difficulty accessing medical, behavioral health or social services?** ☐ Yes ☐ No

**Has Transportation been a barrier for the/your child in meeting their needs? (i.e., school, medical appts., grocery stores)** ☐ Yes ☐ No

**In the past 12 months, did not have a ride cause the/your child to miss a health care visit(s)?**
☐ Yes ☐ No ☐ Sometimes

**In the past 12 months, did not have a ride cause the/your child to miss school, meeting or other things needed for daily living?**
☐ Yes ☐ No ☐ Sometimes

**In the past 12 months, the food you bought just didn't last for the/your child. You didn't have money to get more?** ☐ Never ☐ Sometimes ☐ Often ☐ Very Often

**In the past 12 months, have you worried that they/your child's food would run out before you had money to buy more?** ☐ Never ☐ Sometimes ☐ Often ☐ Very Often

**Do you have trouble affording any of the following in general for the/your child? (select all that apply)**
☐ Clothing ☐ Utilities ☐ Medical Supplies ☐ Child Care ☐ Child Supplies
☐ Other ☐ None of the above ☐ Decline to answer

**In the past 12 months, have any utility firms/companies said they would shut off services in your home? This could be electric, gas, oil, or water.**
☐ Yes ☐ No ☐ Already shut off ☐ N/A

**In the past 12 months, did you receive fuel assistance?**
☐ Yes ☐ No ☐ No, but interested in applying ☐ N/A

**Are you interested in applying for financial assistance for the/your child?** Yes ☐ No ☐

| **In the past two (2) weeks, how often has the/your child..** | **Not at All** | **Several days** | **More than half (1/2) the days** | **Nearly every day** |
|---|---|---|---|---|
| Felt nervous, anxious, or on the edge | ☐ | ☐ | ☐ | ☐ |
| Not been able to stop worrying or control your worrying | ☐ | ☐ | ☐ | ☐ |
| Felt down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| Felt little interest or pleasure in doing things? | ☐ | ☐ | ☐ | ☐ |

**How often is stress a problem for the/your child?**
☐ All the time ☐ Most of the time
☐ Some of the time ☐ Never

**How often is stress a problem for the/your child handling school?**
☐ All the time ☐ Most of the time
☐ Some of the time ☐ Never

**Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correc ■**

**How often is stress a problem for the/your child handling family or other relationships?**
☐ All the time ☐ Most of the time ☐ Some of the time ☐ Never

**How often is stress a problem for the/your child handling friends?**
☐ All the time ☐ Most of the time ☐ Some of the time ☐ Never

**How often is stress a problem for the/your child handling work?**
☐ All the time ☐ Most of the time ☐ Some of the time ☐ Never

**In the past six (6) months how true is "The child has had one or more good friends"?**
☐ Certainty True ☐ Somewhat True ☐ Not True

**In the past six (6) months how true is "Other people the child's age often like the child"?**
☐ Certainty True ☐ Somewhat True ☐ Not True

**Has the/your child ever taken any of the following? Select all that apply.**
☐ Alcohol ☐ Amphetamines ☐ Cocaine/Crack ☐ Heroin
☐ Marijuana/Hash ☐ Meth/Crystal Meth ☐ Opiates/Painkillers ☐ Not used any of these substances
☐ Tobacco ☐ LSD/Acid ☐ Other, Please Specify: _____

**In the last 7 days has the/your child taken any of the following? Select all that apply.**
☐ Alcohol ☐ Amphetamines ☐ Cocaine/Crack ☐ Heroin
☐ Marijuana/Hash ☐ Meth/Crystal Meth ☐ Opiates/Painkillers ☐ Not used any of these substances
☐ Tobacco ☐ LSD/Acid ☐ Other, Please Specify: _____

**Would you like help to decrease or stop taking anything listed above?**
☐ Yes ☐ No ☐ Unsure ☐ N/A ☐ Decline to answer

**What is your (the guardians) current work status?**
☐ Out of work and seeking work ☐ Out of work and no longer looking due to obstacles
☐ Part-time or temporary work (and seeking work) ☐ Part-time or temporary work (and satisfied)
☐ Full-time work ☐ Out of work by choice (student, retired, disabled, full time parent)

**What is your (the guardian's) source of income? (check all that apply)**
☐ Out of work and seeking work ☐ Out of work and no longer looking due to obstacles
☐ Part-time or temporary work (and seeking work) ☐ Part-time or temporary work (and satisfied)
☐ Full-time work ☐ Out of work by choice (student, retired, disabled, full time parent)

**Thank you for taking the time to complete this survey!**
**Your answers will help us make a better health plan so you can access things like wellness programs, support and services that you may need.**

**Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■**