# CARE NEEDS SCREENING FOR PARENTS & GUARDIANS OF CHILDREN AGES 0 TO 10 YEARS OLD

Steward Health Care Network
HEALTH CHOICE MASSACHUSETTS

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We want to get to know your child so we can support you and your child.
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 ■**

**Child's First Name:** _____ **Child's Last Name:** _____

**Street Address:** _____

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

**Home Phone:** _____ **Child's Date of Birth:** ____/____/____
Month Day Year

**Name of the adult completing this survey on behalf of the Child Member:**

**First Name:** _____ **Last Name:** _____

**What is your relation to the Child Member?**
☐ Parent ☐ Legal Guardian ☐ Trained caregiver ☐ Other

**Cell Phone:** _____

**Email address:** _____

**What is the Child's Steward Health Choice Identification Number?**
It is located on the Steward Health Choice Member ID card mailed to the Child's Home Address.

☐☐☐☐☐☐☐☐☐☐☐☐

**Child's Gender Identity:** ☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Decline to answer

**Please indicate the child's ethnicity / race below:**

☐ White – Caucasian
☐ Black – African-American
☐ Hispanic / Latino
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or Pacific Islander
☐ Caribbean
☐ Cape Verdean
☐ Multi-racial
☐ Other

| | Your preferred language? | Child's preferred language? |
|---|---|---|
| English | ☐ | ☐ |
| Arabic | ☐ | ☐ |
| Albanian | ☐ | ☐ |
| Amharic | ☐ | ☐ |
| American Sign Language | ☐ | ☐ |
| Bengali | ☐ | ☐ |
| Braille | ☐ | ☐ |
| Cambodian | ☐ | ☐ |
| Cantonese | ☐ | ☐ |
| Cape Verdean Creole | ☐ | ☐ |
| Chinese | ☐ | ☐ |
| French | ☐ | ☐ |
| Farsi | ☐ | ☐ |
| Fuzhou | ☐ | ☐ |
| German | ☐ | ☐ |
| Greek | ☐ | ☐ |
| Gujarati | ☐ | ☐ |
| Haitian Creole | ☐ | ☐ |
| Hebrew | ☐ | ☐ |
| Hindi | ☐ | ☐ |
| Hmong | ☐ | ☐ |
| Italian | ☐ | ☐ |

| | Your preferred language? | Child's preferred language? |
|---|---|---|
| Igbo | ☐ | ☐ |
| Japanese | ☐ | ☐ |
| Korean | ☐ | ☐ |
| Khmer | ☐ | ☐ |
| Kirundi | ☐ | ☐ |
| Lithuanian | ☐ | ☐ |
| Mandarin | ☐ | ☐ |
| Nepali | ☐ | ☐ |
| Pashto | ☐ | ☐ |
| Portuguese | ☐ | ☐ |
| Portuguese Creole | ☐ | ☐ |
| Persian | ☐ | ☐ |
| Polish | ☐ | ☐ |
| Quechua | ☐ | ☐ |
| Russian | ☐ | ☐ |
| Spanish | ☐ | ☐ |
| Somali | ☐ | ☐ |
| Swahili | ☐ | ☐ |
| Tamil | ☐ | ☐ |
| Urdu | ☐ | ☐ |
| Vietnamese | ☐ | ☐ |
| Other | ☐ | ☐ |

**Does your child need help to read or write in English?**
☐ Yes ☐ No ☐ N/A Child is not of reading age

**Does the/your child have any religious/spiritual/cultural practices that you would like us to know about?**
☐ Yes ☐ No

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

**Describe child's overall health (Physical and mental health):**

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**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 year, has the child been treated or is being treated for any of these?**
*Please select all that apply:*

| | Past Year | Currently |
|---|---|---|
| Asthma | ☐ | ☐ |
| Autism/Autism Spectrum Disorder | ☐ | ☐ |
| Behavioral health issue (like ADHD, depression, anxiety, substance abuse, etc.) | ☐ | ☐ |
| Birth defects | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Developmental issues (speech, motor skills, etc.) | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Down Syndrome | ☐ | ☐ |
| Epilepsy/Seizure disorder | ☐ | ☐ |
| Heart problems | ☐ | ☐ |
| Kidney disease | ☐ | ☐ |
| Learning disabilities | ☐ | ☐ |
| Liver disease | ☐ | ☐ |
| Sickle Cell Anemia | ☐ | ☐ |
| Transplant | ☐ | ☐ |
| Hearing Concerns | ☐ | ☐ |
| Vision Concerns | ☐ | ☐ |

None of the above ☐

**Is the child currently taking any prescription medications?**
☐ Yes ☐ No

**Does the child have a pediatrician or family practice physician?**
☐ Yes ☐ No ☐ Unsure

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

**Does 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

**How do you manage the/your child's medications (pill box, someone else helps, pill dispenser)?**

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**Do you have any questions about the/your child's medications (i.e., side effects, affordability)?**
☐ Yes ☐ No ☐ Unknown

**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 the child getting services from any of these state agencies?**
*Please select all that apply:*

☐ Department of Developmental Services (DDS)
☐ Massachusetts Commission for the Blind (MCB)
☐ Department of Children and Families (DCF)
☐ Department of Youth Services (DYS)
☐ Department of Mental Health (DMH)
☐ Massachusetts Commission for the Deaf and Hard of Hearing
☐ None of the above

**In the past 6 months has the/your child been admitted to the hospital 2 or more times for been to the Emergency Room 3 or more times?**

☐ Yes ☐ No ☐ Unsure

**Is your child currently in school/daycare?**

☐ Yes ☐ No ☐ N/A

**What is your child's current living arrangement?**

☐ Live with parent(s)/guardian(s)
☐ Live with sibling(s)
☐ Live with foster parent(s)
☐ Live with roommate
☐ Live with one parent or guardian
☐ Live with other relative(s)
☐ Live with caregiver
☐ Other

**Has the child's doctor ever told you the child is overweight?**

☐ Yes ☐ No

**Do you have any immediate health concerns for the child?** *Please 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
☐ None of the above

**Do you have any health goals for your child?** *Please select all that apply:*

☐ Improving the child's diet
☐ Improving the child's behavioral issues
☐ Improving the child's school/learning problems
☐ Improving the child's sleep
☐ Improving the child's medical issues
☐ Other
☐ None of the above

**How long ago did the 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

**Does the child need someone to help him/her with Activities of Daily Living (ADL's)? (bathing, eating, dressing, walking and using the bathroom)**

☐ No, the child does not need help
☐ Yes, the child needs help and he/she has all the help he/she needs
☐ 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

**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 do not have all the equipment I need
☐ Unsure

**Describe the equipment needs/status for the/your child?**

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

**Has your child had weight gain or loss in the past 6 months?**
☐ Unintentional Weight Gain ☐ Unintentional Weight Loss
☐ Intentional Weight Gain ☐ Intentional Weight Loss
☐ No Change

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

**Has the child been seen by a dentist in the last twelve (12) months?**
☐ Yes ☐ No ☐ N/A Child is under 1 year old

**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?** _____ Days

**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 6 months, how TRUE is the statement below.**
The child enjoys playing or interacting with others ☐ Certainty True ☐ Somewhat True ☐ Not True

**What is the/your child(s) housing situation today?**
☐ They do not have housing (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 worried about losing it in the future
☐ They have housing

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

**Think about the place your child lives. 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 your child's home?**
☐ Yes ☐ No ☐ No, but interested in applying ☐ N/A

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

**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 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 having a ride cause your child to miss health care visits?**
☐ Yes ☐ No ☐ Sometimes

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

**Within the past 12 months, the food you bought just didn't last for the child. You didn't have money to get more.**
☐ Often true ☐ Sometimes true ☐ Never true

**Within the past 12 months, you worried that your child's food would run out before you could buy more.**
☐ Often true ☐ Sometimes true ☐ Never true

**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 child's 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

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

**What is your (the guardian's) source of income?**
☐ Employment ☐ Unemployment ☐ No income ☐ Social Security
☐ Retirement/pension ☐ SSI ☐ SSDI ☐ TAFDC (or cash assistance)
☐ EAEDC (or cash assistance) ☐ Child support ☐ Other

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