CARE NEEDS SCREENING FOR PARENTS & GUARDIANS OF CHILDREN AGES 11 TO 17 YEARS OLD

Steward Health Care Network
HEALTH | CHOICE
MASSACHUSETTS

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

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

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

Describe overall health (Physical and mental health):

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 (include prescriptions, OTC, supplements, etc.)?
☐ Yes ☐ No

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

Is the child actively seeing a behavioral health provider?
☐ Yes ☐ No ☐ No, but need help finding a provider

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)?

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

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

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 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/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 child? *Please select all that apply:*

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

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
☐ None of the above
☐ Improving the child's sleep
☐ Improving the child's medical issues
☐ Other

How long ago did the/your child have a Well Visit (an appointment when the child was not sick)?

☐ This month
☐ 3 months ago
☐ 6 months ago
☐ 9 months ago
☐ 12 months ago or more
☐ 1 months ago
☐ 4 months ago
☐ 7 months ago
☐ 10 months ago
☐ 2 months ago
☐ 5 months ago
☐ 8 months ago
☐ 11 months ago

Does the child need more help than is expected of their age, for one (1) or more of the following (ADLs): Bathing, Eating, Dressing, Walking, using the bathroom? *Please select all that apply:*

☐ No, the child does not need help
☐ The child needs help with bathing
☐ The child needs help with dressing
☐ The child needs help with toileting
☐ Yes, the child needs help and he/she has all the help he/she needs
☐ The child needs help with eating
☐ The child needs help with walking

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

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 ■

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

Is the/your child currently experiencing pain?

☐ Yes ☐ No

Does the child follow a prescribed diet?

☐ Yes ☐ No ☐ Unsure

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

Has the child been seen by a dentist in the last twelve (12) months?

☐ Yes ☐ No

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

For a female child only, is the child now pregnant?

☐ Yes ☐ No ☐ Unsure

Please answer following questions about your child's home:

☐ 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.)

☐ Have housing today, but worried about losing it in the future

☐ 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

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

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, 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

In the past two (2) weeks, how often has the child…	**Not at all**	**Several days**	**More than half (1/2) the days**	**Nearly every day**
Felt nervous, anxious, or on 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 child in handling…	**All the time**	**Most of the time**	**Some of the time**	**Never**
Health	☐	☐	☐	☐
School	☐	☐	☐	☐
Family or other relationships	☐	☐	☐	☐
Friends	☐	☐	☐	☐
Work	☐	☐	☐	☐

In the past 6 months, how TRUE are the statements below?

	Certainty True	**Somewhat True**	**Not True**
The child has had one or more good friends	☐	☐	☐
Other people the child's age often like the child	☐	☐	☐

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 ■

Has the/your child ever taken any of the following? Select all that apply.

☐ Alcohol ☐ Amphetamines ☐ Cocaine/Crack
☐ Heroin ☐ LSD/Acid ☐ Marijuana/Hash
☐ Meth/Crystal Meth ☐ Opiates/Painkillers ☐ Tobacco
☐ Not used any of these substances
☐ 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 ☐ LSD/Acid ☐ Marijuana/Hash
☐ Meth/Crystal Meth ☐ Opiates/Painkillers ☐ Tobacco
☐ Not used any of these substances
☐ 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 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 ■