CARE NEEDS SCREENING FOR ADULTS 18 AND OLDER

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 ☐ Trained caregiver ☐ Other

Home Phone: _____

Cell Phone: _____

Email Address: _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Decline to answer

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

☐☐☐☐☐☐☐☐☐☐☐☐

Please indicate your 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

What is your preferred speaking 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
☐ Igbo
☐ Japanese
☐ Korean
☐ Khmer
☐ Kirundi
☐ Lithuanian
☐ Mandarin
☐ Nepali
☐ Pashto
☐ Portuguese
☐ Portuguese Creole
☐ Persian
☐ Polish
☐ Quechua
☐ Russian
☐ Spanish
☐ Somali
☐ Swahili
☐ Tamil
☐ Urdu
☐ Vietnamese
☐ Other

Do you need help to read or write in English?

☐ Yes ☐ No

Do you have any religious/spiritual/ cultural practices that you would like us to know about?

☐ Yes ☐ No

In general, how would you rate your overall health (physical and mental health)?

☐ Very Good
☐ Good
☐ Poor

Describe over health (Physical and mental health): _____

Please describe your current health conditions (physical and mental health)? Please select all that apply:

☐ Breathing problems
☐ Stroke
☐ Bones Problems
☐ Depression
☐ Thoughts of hurting yourself
☐ Trauma
☐ Other
☐ Cancer
☐ Seizures
☐ ADHD
☐ OCD
☐ Vision problems
☐ Diabetes
☐ Kidney problems
☐ Anxiety
☐ Schizophrenia
☐ Thoughts of hurting others
☐ Development Issues
☐ Heart Problems
☐ Bowel Problems
☐ Bipolar
☐ Substance Use
☐ High blood Pressure
☐ Hearing Problems

Please describe your past health history (physical and mental health): _____

Please list the medications you are currently taking (include prescriptions, OTC, supplements, etc.):

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 ■

Do you take the medications as prescribed by your provider (I.e..missing a dose or doubling up?)

☐ Yes ☐ No ☐ Sometimes ☐ 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

Are you currently receiving services from any of these state agencies? Please select all that apply:

☐ Department of Developmental Services (DDS)
☐ Executive office of Elder Affairs (EoEA)
☐ Department of Mental Health (DMH)
☐ Bureau of Substance Abuse Services (BSAS)
☐ Massachusetts Commission for the Blind (MCB)
☐ Massachusetts Commission for the Deaf and Hard of Hearing
☐ Massachusetts Rehabilitation Commission (MRC)
☐ Department of Children and Families (DCF)
☐ Department of Transitional Assistance (DTA)
☐ None of the above

Are you currently receiving any of these services? Please select all that apply:

☐ Adult Day Health Services
☐ Adult Foster Care Services
☐ Continuous Skilled Nursing Services (services more than 100 days)
☐ Group Adult Foster Care Services
☐ Nursing Facility Services (services more than 100 days)
☐ Inpatient and outpatient Chronic Disease Rehabilitation
☐ Hospital Services (services more than 100 days)
☐ Personal Care Attendant Services
☐ Home based Lab Services
☐ Home Health
☐ Live-In Caregiver
☐ Meals
☐ Medication Management
☐ Mental Health
☐ Day Habilitation Services
☐ Palliative Care
☐ Personal Care Attendant
☐ Respite Care
☐ Social Work
☐ Telemonitoring
☐ Therapies (PT, ST, OT)
☐ Transportation Services
☐ Visiting MD/NP
☐ Other, Please specify.
☐ None of these services

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 last 6 months have you been admitted to the hospital 2 or more times?
☐ Yes ☐ No ☐ Unsure

Have you been to the Emergency Room 3 or more times?
☐ Yes ☐ No ☐ Unsure

Do you have a primary doctor/physician?
☐ Yes ☐ No ☐ No, but need help finding a provider ☐ Unsure

Which statement best describes your current level of activity?
☐ I do not do physical activity or do not want to.
☐ I do not do physical activity and would like to be more active.
☐ I do physical activity.

Do you need someone to help you with Activities of Daily Living (ADLs)?
(bathing, eating, dressing, walking and using the bathroom)
☐ No, I do not need help ☐ Yes, I need help and I have all the help I need
☐ I need help with bathing ☐ I need help with eating
☐ I need help with dressing ☐ I need help with walking
☐ I need help with toileting

Do you need someone to help with one (1) or more of the following (ADLs): Shopping, Cooking, Housework, Laundry, Driving, Managing Finances?
☐ No, I do not need help ☐ Yes, I need help and I have all the help I need
☐ I need help with shopping ☐ I need help with cooking
☐ I need help with housework ☐ I need help with laundry
☐ I need help with managing finances ☐ I need help with transportation

Which statement best describes your medical equipment needs?
☐ Yes, I have all the equipment I need
☐ No, I do not have all the equipment I need
☐ Unsure

Are you currently experiencing pain?
☐ Yes ☐ No

Do you follow a prescribed diet?
☐ Yes ☐ No ☐ Unsure

Have you had weight gain or loss in the past 6 months?
☐ Unintentional Weight Gain ☐ Unintentional Weight Loss
☐ Intentional Weight Gain ☐ Intentional Weight Loss
☐ No Change

Are you interested in help managing your weight/diet?
☐ Yes ☐ No

Details (i.e., following a prescribed diet, weight management:_____

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 ■

How would you describe your oral health including your mouth, teeth/false teeth and dentures?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Details (i.e., following a prescribed diet, weight management: _____

For females only, are you currently pregnant?

☐ Yes ☐ No ☐ Unsure

What is your 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)

Have you ever experienced any of the following barriers to employment? Select all that apply.

☐ Criminal Record
☐ Lack of Childcare
☐ Mental Health Issues
☐ Lack of Training
☐ Medical/Physical Health Issues
☐ None of the Above

Tell us about your housing.

☐ 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

Have you moved three (3) or more times within the past year?

☐ Yes ☐ No

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

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

Are you receiving housing assistance?

☐ Yes ☐ No ☐ No, but interested in applying ☐ N/A

Do you have enough money to pay for housing?

☐ Yes ☐ No ☐ Not always ☐ Unsure

Are you up-to-date with your rent or mortgage?

☐ Yes ☐ No ☐ N/A

In the past 12 months, have you had difficulty accessing medical, behavioral health or social services?

☐ Yes ☐ No

Has Transportation been a barrier for you 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 you to miss health care visits?
☐ Yes ☐ No ☐ Sometimes

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

In the past 12 months, how often have you eaten smaller meals or skipped meals because you did not have enough food?
☐ Never ☐ Sometimes ☐ Often ☐ Very Often

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

Do you receive food assistance?
☐ Yes ☐ No ☐ No, but interested in applying ☐ N/A

Do you have trouble affording any of the following in general? (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

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

Are you interested in applying for financial assistance?
☐ Yes ☐ No

Other Social Determinants of Health Comments (including who contact for any SDOH concerns mentioned above):

Do you have any legal concerns?
☐ Yes ☐ No ☐ Unsure ☐ Declined to answer

Legal Comments (legal involvement, ever been incarcerated, custody agreement, etc)

Do you see a behavioral health provider? (psychologist, therapist, psychiatrist, consoler)
☐ 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 two (2) weeks, how often have you…	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	☐	☐	☐	☐

Have you 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
☐ Other, Please Specify _____
☐ Not used any of these substances

In the last 7 days have you taken any of the following? Select all that apply.

☐ Alcohol
☐ Amphetamines
☐ Cocaine/Crack
☐ Heroin
☐ LSD/Acid
☐ Marijuana/Hash
☐ Meth/Crystal Meth
☐ Opiates/Painkillers
☐ Tobacco
☐ Other, Please Specify _____
☐ Not used any of these substances

Would you like help to decrease or stop taking anything listed above?

☐ Yes ☐ No ☐ Unsure
☐ N/A ☐ Decline to answer

Is there something or someone in your home or community that make(s) you feel unsafe?

☐ Yes ☐ No ☐ Unsure

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 ■