LOUISIANA DEPARTMENT OF HEALTH

Health Needs Assessment

Member's Name (First, Middle, Last)	Preferred Name	Member's Medicaid ID	Date of Birth

Preferred Pronouns	Date of form completion
☐ He/Him/His ☐ She/Her/Hers ☐ They/Them ☐ Other (describe) _____ ☐ Choose not to answer	

Is this assessment being completed by someone who is not the member?	☐ Yes ☐ No

Name of person completing/assisting with the completion of this assessment and their relationship to member

Member's Address Street	City	State	Zip

Phone Number 1	Phone Number 2	Email Address

Emergency Contact Name	Emergency Contact Phone	Emergency Contact Relationship

For those under 21, are you in foster care?	☐ Yes ☐ No

Which Race(s) are you? Check all that apply	Ethnicity
☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ White ☐ American Indian or Alaskan Native ☐ Other (describe) _____ ☐ Choose not to answer	☐ Hispanic ☐ Non-Hispanic ☐ Choose not to answer

Gender	Demographics Verified?
☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other (describe) _____ ☐ Choose not to answer	☐ Yes ☐ No

Assessment Method	Assessment Type
☐ Telephonic ☐ In-person ☐ Other	☐ Initial assessment ☐ Reassessment ☐ Change of health status

No.	Question	Response
1.	Do you speak a language other than English at home?	☐ Yes (describe) _____ ☐ No ☐ Choose not to answer
2.	Do you or your caregiver need translation services?	☐ Yes (describe) _____ ☐ No
3.	Do you or your caregiver ever need help reading hospital or clinic materials?	☐ Yes (describe) _____ ☐ No
4.	Do you or your caregiver have any of the following communication barriers?	☐ Hearing Impairment ☐ Visual Impairment ☐ Developmental Delays ☐ Non-verbal ☐ None ☐ Choose not to answer ☐ Other (describe) _____

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5.	Do you have any cultural or religious preferences related to your health?	☐ Cultural preferences ☐ Religion/Spiritual preferences ☐ Other (describe) _____ ☐ None ☐ Choose not to answer
6.	How do you describe your health?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
7.		☐ Heart Disease or Heart Failure ☐ Emphysema or COPD ☐ Asthma ☐ Diabetes ☐ High cholesterol ☐ Chronic Urinary Tract Infections (UTI) ☐ High blood pressure or hypertension ☐ Seizures ☐ Cancer (describe) _____ ☐ Chronic Pain (describe) _____ ☐ Hepatitis or liver disease ☐ HIV ☐ Trach or G-tube Dependent ☐ Substance use disorder ☐ Depression ☐ Tooth problems ☐ Other mental health diagnoses (describe) _____ ☐ Disability (describe) _____ ☐ Currently pregnant ☐ Chronic Lung Disease of Prematurity ☐ Developmental delay ☐ Autism ☐ None ☐ Other (describe) _____
8.	How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? (One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80 proof spirits.)	☐ Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or almost daily
9.	How many times in the past 12 months have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarettes or vaping)?	☐ Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or almost daily
10.	How many times in the past year have you used prescription drugs for non-medical reasons?	☐ Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or almost daily
11.	How many times in the past year have you used illegal drugs?	☐ Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or almost daily
12.	In the past 12 months, has your gambling been hard to cut back on; something you try to hide; or caused you financial trouble?	☐ Yes ☐ No ☐ Does not apply
13	When were your most recent medical, mental or behavioral health, and dental appointments or procedures?	☐ Medical (describe) _____ ☐ Mental/behavioral health (describe) _____ ☐ Dental (describe) _____
14.	Do you have any pending appointments or procedures for physical health, mental health or dental care?	☐ Yes (describe) _____ ☐ No

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15.	Have you visited the Emergency Room in the past 6 months? If yes, how many times and why?	☐ Yes – 1 time (describe) _____ ☐ Yes – 2 times (describe) _____ ☐ Yes – 3 times (describe) _____ ☐ Yes – 4 times (describe) _____ ☐ Yes – 5 times (describe) _____ ☐ Yes – more than 5 times (describe) _____ ☐ No
16.	Have you stayed overnight in the hospital in the past 6 months? If yes, how many times?	☐ Yes – 1 time (describe) _____ ☐ Yes – 2 times (describe) _____ ☐ Yes – 3 times (describe) _____ ☐ Yes – 4 times (describe) _____ ☐ Yes – 5 times (describe) _____ ☐ Yes – more than 5 times (describe) _____ ☐ No
17.	If you stayed overnight in the hospital in the past 6 months, did you ever stay fewer than 30 days from when you were discharged from another stay?	☐ Yes ☐ No
18.	Do you need assistance with any of the following?	☐ Dressing ☐ Bathing/grooming ☐ Eating ☐ Mobility ☐ Cooking/preparing meals ☐ Transfer ☐ Daily medications ☐ Using the restrooms ☐ None ☐ Other: _____
19.	Do you or your caregiver need help arranging your health services?	☐ Yes (describe) _____ ☐ No
20.	What is your living situation today?	☐ I have a steady place to live. ☐ I have a place to live today, but I am worried about losing it in the future. ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park (describe) _____
21.	Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY	☐ Pests such as bugs, ants, or mice ☐ Mold ☐ Lead paint or pipes ☐ Lack of heat ☐ Lack of AC ☐ Oven or stove not working ☐ Water leaks ☐ Smoke detectors missing or not working ☐ None
22.	In the last 12 months, did you ever eat less than you felt you should because there was not enough money for food?	☐ Yes ☐ No
23.	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? CHOOSE ALL THAT APPLY	☐ Yes, it has kept me from medical appointments or getting medications. ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need. ☐ No

No.	Question	Response
24.	In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	☐ Yes ☐ No ☐ Already shut off
25.	Have you or your caregiver ever been hit, kicked, punched, or otherwise hurt by someone in the past year? If so, by whom?	☐ Yes (describe) _____ ☐ No
26.	Do you or your caregiver feel safe in your current relationship(s)?	☐ Yes ☐ No
27.	Is there anyone from a previous relationship who is making you feel unsafe now?	☐ Yes ☐ No
28.	If you are over 16, do you want help finding or keeping work or a job?	☐ Yes, help finding work ☐ Yes, help keeping work ☐ I do not need or want help
29.	If you are over 16, do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.	☐ Yes ☐ No
30.	In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?	☐ Yes ☐ No ☐ Choose not to answer
31.	What community-based organization or agency, health related or non-health related, do you or your caregiver access often within your community?	☐ Health _____ ☐ Educational _____ ☐ Behavioral/mental health _____ ☐ Job-related _____ ☐ Housing _____ ☐ Other: _____
32.	For children under 21, do you exhibit worrisome behavior or has teacher reported concerning behavior at school?	☐ Yes (describe) _____ ☐ No

Auxiliary aids and services, free of charge, are available to you. **1-800-448-3810 (TTY: 711)**, Monday through Friday, from 7:00 a.m. to 7:00 p.m.

Humana Inc. and its subsidiaries comply with Section 1557 by providing free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Português (Portuguese): Ligue para o número acima para receber serviços gratuitos de assistência no idioma.

ພາສາລາວ (Lao): ໂທຫາເບີໂທລະສັບຂ້າງເທິງ ເພື່ອຮັບບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

اُردُو (Urdu): مفت لسانی اعانت کی خدمات موصول کرنے کے لیے درج بالا نمبر پر کال کریں۔

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

فارسی (Farsi): برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

ภาษาไทย (Thai): โทรไปที่หมายเลขด้านบนเพื่อรับบริการช่วยเหลือด้านภาษาฟรี

This notice is available at **Humana.com/LouisianaDocuments**.

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