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