LOUISIANA DEPARTMENT OF HEALTH

Pediatric 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 someone other than the member completing this assessment?	☐ Yes ☐ No	Relationship to the member?	
Name of person completing/assisting with this assessment:			

Member's Address Street	City	State	Zip

Phone Number 1	Phone Number 2	Email Address

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	☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Choose not to answer ☐ Other (describe): _____

Assessment Method	Assessment Type
☐ Telephonic ☐ In-person ☐ Virtual ☐ Web-based ☐ Print/Paper	☐ Initial assessment ☐ Reassessment ☐ Change in health status

#	Question	Response
1.	What is your preferred language for communication?	Preferred Language: _____
2.	Do you or the child need translation services, including but not limited to American Sign Language, braille?	☐ Yes (describe): _____ ☐ No
3.	Do you or the child ever need help reading health information given to you by the hospital, your doctor, or pharmacist?	☐ Yes (describe): _____ ☐ No
4.	Do you or the child have communication barriers?	☐ No ☐ Choose not to answer ☐ Yes. If "yes", check all that apply ☐ Hearing Impairment If Hearing Impairment present, does member wear hearing aids? ☐ Left Ear ☐ Right Ear ☐ Both ☐ Non-verbal ☐ Developmental Delays ☐ Visual Impairment. If Visual Impairments present, does member wear glasses? ☐ Yes ☐ No ☐ Other (describe): _____

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5.	Does the child have any health conditions currently or in the past?	☐ No ☐Yes. If "Yes", check all that apply: ☐ Anxiety ☐ Asthma ☐ Autism ☐ Behavioral concerns (describe): _____ ☐ Cancer (Type): _____ ☐ Congenital abnormalities ☐ Dental/Tooth problems ☐ Depression ☐ Developmental delay ☐ Diabetes ☐ Disability (describe): _____ ☐ G-tube Dependent ☐ HIV ☐ History of NICU stay (Length of stay): _____ ☐ Mental health diagnoses (describe): _____ ☐ Pregnant ☐ Seizures ☐ Substance use disorder ☐ Trach ☐ Other (describe): _____
6.	Does the child take prescription medications?	☐ No ☐ Yes If yes, how many? ☐ 1 – 4 ☐ 5 – 10 ☐ 11 or more (state number): _____ Does the child have problems taking their medications? ☐ No ☐ Yes, due to difficulty (check all that apply): ☐ Reading the label ☐ Picking up from the pharmacy ☐ Purchasing ☐ Swallowing ☐ Other: _____
7.	Is the child seeing a Primary Care Provider/Pediatrician at least once per year?	☐ No ☐ Yes. If yes, who is the child seeing? ☐ PCP: _____Date of visit: _____
8.	Has the child visited the Emergency Room in the past 6 months?	☐ No ☐ Yes. If yes, how many times and why? ☐ 1 time (describe): _____ ☐ 2 times (describe): _____ ☐ 3 times (describe): _____ ☐ 4 times (describe): _____ ☐ 5 times (describe): _____ ☐ more than 5 times (describe): _____
9.	Has the child stayed overnight in the hospital in the past 6 months?	☐ No ☐ Yes. If yes, how many times and why? ☐ 1 time (describe): _____ ☐ 2 times (describe): _____ ☐ 3 times (describe): _____ ☐ 4 times (describe): _____ ☐ 5 times (describe): _____ ☐ more than 5 times (describe): _____ Was the child home for less than 30 days before going back to the hospital to stay overnight? ☐ No ☐ Yes

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10.	Does the child need assistance with basic self-care activities outside of age-appropriate activities?	☐ No ☐ Yes. If yes, check all that apply: ☐ Bathing ☐ Grooming ☐ Daily medications ☐ Dressing ☐ Eating ☐ Cooking/Preparing Meals ☐ Mobility ☐ Transfer ☐ Using the bathroom ☐ None ☐ Other: _____
11.	What is the child's living situation today?	☐ The child has a steady place to live ☐ The child/caregiver has a place to live today, but is worried about losing it in the future, (describe): _____ ☐ The child does not have a steady place to live. The child is staying (check all that apply): ☐ with others ☐ in a hotel ☐ in a shelter ☐ on the street ☐ on a beach ☐ in a car ☐ abandoned building ☐ bus or train station ☐ in a park ☐ other (describe): _____
12.	Do you and the child feel safe in current living situation?	☐ Yes ☐ No, (describe): _____
13.	In the last 3 months, have you or the child ever… (check all that apply)	☐ Eaten less than you felt you should because there was not enough money for food? ☐ Lacked reliable transportation that kept you from medical appointments, meetings, work or from getting things needed for daily living? ☐ Had your electric, gas, oil, or water company threaten to shut off services to your home? ☐ Had anyone or anything make you feel unsafe? Describe: _____ ☐ None of the above
14.	Do you have any other concerns regarding the child or yourself that we did not talk about today?	Describe: _____ _____

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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