Member Health Screening

Dear Member,

To ensure you're getting the best care, we'd like to ask some questions about your health, including questions related to race, ethnicity, language, gender identity and sexual orientation. We gather this information to ensure we are addressing each member's whole health. The information will remain confidential. We want to address every need with a resource. We provide the screening with sensitivity and privacy for all members. Please answer the questions to the best of your ability. Your answers won't affect your plan benefits. This should take about five minutes.

Sincerely,

Humana Healthy Horizons® in Virginia

Member last name _____ Member first name _____

Member ID # (Humana Plan ID) H _____

*Member Medicaid ID # _____

Member contact/phone _____

Member primary care provider (PCP) _____

Member PCP National Provider Identifier (NPI) _____

*Date Screening Completed (mm/dd/yyyy): _____

Part 1 - Medically Complex Classification

Has a doctor, nurse, or health care provider told you that you had/have any of the following? (Please check all applicable boxes)

- ☐ Cancer (Active)
- ☐ Chronic obstructive pulmonary disease (COPD) or emphysema
- ☐ Diabetes
- ☐ Heart disease, heart attack, heart failure (weak heart)
- ☐ Human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)
- ☐ Kidney failure or end stage renal disease (ESRD)
- ☐ Parkinson's disease
- ☐ Sickle cell disease
- ☐ Stroke, brain injury, or spinal injury
- ☐ Transplant or on a transplant wait list
- ☐ Other chronic (long-term) disabling condition

Do any of the chronic conditions you checked above impact your ability to do everyday things and require you to receive assistance with any of the following: (Please check all applicable boxes)

☐ Bathing	☐ Eating	☐ Walking
☐ Dressing	☐ Using the bathroom	

Has a doctor, nurse or health care provider told you that you had/have any of the following: (Please check all applicable boxes)

- ☐ Alcoholism
- ☐ Bipolar disorder or mania
- ☐ Depression
- ☐ Panic disorder
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Psychotic Disorder
- ☐ Schizophrenia or schizoaffective disorder
- ☐ Substance use disorder or addiction
- ☐ Other chronic (long-term) mental health condition.

Do any of the conditions you selected above keep you from doing everyday things?
☐ Yes ☐ No

(females) Are you or could you be currently pregnant?

- ☐ Yes
- ☐ Possible, but I do not know
- ☐ No

Do you have an intellectual or developmental disability and require help with any of the following: (Please check all applicable boxes)

- ☐ Learning or problem-solving
- ☐ Listening or speaking
- ☐ Living on your own
- ☐ Making decisions about your health or wellbeing
- ☐ Self-care (bathing, grooming, eating)
- ☐ Travel/transportation (driving, taking the bus)

Part 2 - health related social needs and health risk assessment triage

What is your housing situation today?

☐ I have housing

I am worried about losing my housing ☐ Yes ☐ No

☐ I do not have housing (check all that apply)

- ☐ Staying with others
- ☐ Living in a hotel
- ☐ Living in a shelter
- ☐ Living outside (on the street, on a beach, in a car, or in a park)
- ☐ I choose not to answer this question

In the past three (3) months, did you worry whether your food would run out before you got money to buy more?

☐ Yes ☐ No

In the past thirty (30) days, have you or any family members you live with been unable to get any of the following when it was really needed? (Select all that apply.)

☐ Yes ☐ No Prescription drugs or medicine

☐ Yes ☐ No Utilities

☐ Yes ☐ No Clothing

☐ Yes ☐ No Child care

☐ Yes ☐ No Phone

☐ Yes ☐ No Health care (doctor appointment, mental health services, addiction treatment)

☐ Yes ☐ No I choose not to answer this question

How many times have you been in the emergency room (ER) or a hospital in the last ninety (90) days for one (1) of the conditions you listed earlier?

_____ (Enter Number from 0 to 99)

How many times have you had a fall in the last ninety (90) days and needed to visit a doctor, Emergency Room, or hospital because of the fall?

_____ (Enter Number from 0 to 99)

Caregiver Status

Adult population question: Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Check all that apply)

- ☐ Yes, it has kept me from medical appointments or from getting my medications
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- ☐ No
- ☐ I choose not to answer this question

Adult population question: Do you live with at least one (1) child under the age of nineteen (19), **and** are you the main person taking care of this child?

☐ Yes ☐ No

Adult population question: Do you live with and are you the primary caretaker of an adult who requires assistance with bathing, dressing, walking, eating, or using the bathroom?

☐ Yes ☐ No

Adult population question: What is the highest level of school that you have finished?

- ☐ Some high school but no diploma
- ☐ High school diploma or equivalency (GED)
- ☐ Some college but no degree
- ☐ Workforce credential or industry certification after high school
- ☐ Associate's degree
- ☐ Bachelor's degree or higher
- ☐ I choose not to answer this question

Adult population question: Do you have a job?

- ☐ I have a part time or temporary job
- ☐ I have a full time job
- ☐ I do not have a job and am looking for one
- ☐ I do not have a job and I am not looking for one
- ☐ I choose not to answer this question

Adult population question: Do you like your current job?

Yes, I like my job ☐ Yes ☐ No

I must work more than one job because I can't find a full time job ☐ Yes ☐ No

I work more than forty (40) hours per week at two (2) or more part time jobs ☐ Yes ☐ No

I have been looking for a job for more than three (3) months and I have not been offered a job ☐ Yes ☐ No

I would like help finding a job that I like more or pays more money ☐ Yes ☐ No

In the past year have you been afraid of your partner, ex-partner, family member, or caregiver (paid or unpaid)?

☐ Yes ☐ No ☐ Unsure ☐ I choose not to answer this question

Do you have other important health issues or needs that you would like to discuss with someone?

☐ Yes ☐ No

How soon do you want to be contacted by someone to discuss your health issues or needs?

☐ 1-30 Days

☐ 31-60 Days

☐ 61-90 Days

☐ 91-120 Days

☐ Do not contact me

Member: I acknowledge that the information is accurate and completed to the best of my knowledge. The assessment will be confirmed by a Humana Associate to ensure that you receive the best coordination to meet your needs.

☐ Yes ☐ No