Sentara® Health Plans

Instructions for Completing the Medicaid Member Health Risk Screening Form

Step 1: Please complete the fillable form and do not skip any questions. Fill all information in as completely as possible.

Step 2: Print out the completed Health Screening form and place it in an envelope.

Step 3: Copy the below address onto an envelope, attach a stamp, and mail the sealed envelope.

Sentara Health Plans
Attention: Member Onboarding/Outreach
PO Box 66189
Virginia Beach, VA 23466

Congratulations! You have completed the health risk screening process. If we have any questions, we will give you a call.

If you have any questions about your benefits or services, call 1-833-261-2367 (TTY: 711) or 757-552-8975, or visit sentarahealthplans.com.

Sentara® Health Plans

Health Risk Screening Form

Member Information

Last Name: _____ First Name: _____

*Medicaid ID #_____ Member ID # _____

Contact/Phone _____ Primary Care Provider_____

Primary Care Provider NPI _____ Date Screening Completed _____

*Fields will be validated and errors returned to health plan for correction

MCO Member Health Screening – **Please answer <u>EVERY</u> question on the form.**

PART 1 – Medically Complex Classification Questions:

Question 1: Has a doctor, nurse, or healthcare provider told you that you had/have any of the following (**please check all applicable boxes**):

- ☐ Cancer (active)
- ☐ COPD or emphysema
- ☐ Diabetes
- ☐ Heart disease, heart attack, heart failure (weak heart)
- ☐ HIV or 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 – **IF YES, Member Complexity Attestation must be completed**

Question 2: 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 ☐ Dressing ☐ Eating ☐ Using the bathroom ☐ Walking

- **Are you pregnant?** ☐ Yes ☐ No ☐ No Response Due Date: _____

Question 3: Has a doctor, nurse, or healthcare 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 – **IF YES, Member Complexity Attestation must be completed**

Question 4: Do any of the conditions you selected above keep you from doing everyday things?

☐ Yes ☐ No

Question 5: 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 well-being
☐ Self-care (bathing, grooming, eating)
☐ Travel/transportation (driving, taking the bus)

- **Are you currently seeing a behavioral healthcare provider?**

  ☐ Yes ☐ No ☐ No Response

PART 2 – Social Determinants of Health and Health Risk Assessment Triage Questions:

QUESTION 1: What is your housing situation today?

I have housing ☐ Yes ☐ No
I am worried about losing my housing ☐ Yes ☐ No
I do not have housing (**check all that apply**) ☐ Yes ☐ No

☐ 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

QUESTION 2(a): In the past **3 months**, did you worry whether your food would run out before you got money to buy more? ☐ Yes ☐ No

QUESTION 2(b): In the past **30 days**, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? (**check all that apply**)

- ☐ Prescription drugs or medicine
- ☐ Utilities
- ☐ Child care
- ☐ Clothing
- ☐ Phone
- ☐ Healthcare (doctor appointment, mental health services, addiction treatment)
- ☐ I choose not to answer this question

QUESTION 3: How many times have you been in the emergency room or a hospital in the last 90 days for one of the conditions you listed earlier?

_____ (enter number from 0–99)

QUESTION 4: How many times have you had a fall in the last 90 days and needed to visit a doctor, emergency room, or hospital because of the fall?

_____ (enter number from 0–99) **(Adult Population Question)**

QUESTION 5: 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

QUESTION 6: Caregiver status **(Adult Population Question)**

Do you live with at least one child under the age of 19, AND are you the main person taking care of this child? ☐ Yes ☐ No

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

QUESTION 7: What is the highest level of school that you have finished? **(Adult Population Question)**

- ☐ 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 degree
- ☐ Bachelor degree or higher
- ☐ I choose not to answer this question

QUESTION 8: Do you have a job? **(Adult Population Question)**

- ☐ 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

QUESTION 9: Do you like your current job? **(Adult Population Question)**

- ☐ Yes, I like my job
- ☐ I must work more than one job because I can't find a full-time job
- ☐ I work more than 40 hours per week at two or more part-time jobs
- ☐ I have been looking for a job for more than 3 months and I have not been offered a job
- ☐ I would like help finding a job that I like more or pays more money

QUESTION 10: 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

QUESTION 11: Do you have other important health issues or needs that you would like to discuss with someone? ☐ Yes ☐ No

QUESTION 12: Do you need assistance getting healthcare services, equipment, or medications from any of your providers? ☐ Yes ☐ No

QUESTION 13: 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