Indiana Care Select Health Risk Screening

Please note that this information pertains to you and/or your dependent's health care. (one form per person)

Section 1: Background Information

Name of member: _____ DOB: ___/___/____ Medicaid ID#: _____

Member's current address: _____ City: _____
St: ____ ZIP: _____

Home Number: _____ Work Number: _____ Cell Number: _____ ☐ No Phone

E-mail Address: _____ Language other than English: _____

Who is completing the assessment? ☐ Member ☐ Other

If someone other than the member is completing the assessment, please answer the following:

What is the name of the person completing the assessment? _____

What is the relationship of the person completing the assessment to the member: ☐ spouse ☐ domestic partner ☐ father or mother ☐ son or daughter ☐ other relative _____ ☐ other _____

Why is someone other than the member completing the assessment: ☐ member is a child ☐ member is cognitively impaired or intellectual disabled ☐ member has emotional or behavioral problems ☐ member is hospitalized (acute care, psychiatric, etc.) ☐ member is deceased ☐ other _____

Section 2: Health Services

Do you (or the member) have a Primary Medical Provider (PMP)? ☐ Yes ☐ No

Do you (or the member) have a medical problem that requires one or more specialist doctors? ☐ Yes ☐ No

If yes, name specialists: _____

Are you (or the member) enrolled in one of the following waiver programs:

☐ Aged and Disabled Waiver ☐ Autism Waiver ☐ Developmental Disable Waiver
☐ Support Services Waiver ☐ Traumatic Brain Injury Waiver ☐ Waiver waiting list
☐ Not on a waiver program

If yes, provide the case managers name and phone number:

Name: _____

Phone: _____

Have you (or the member) been admitted to the hospital or inpatient behavioral health facility in the past 3 months? ☐ Yes ☐ No

If yes, provide reason(s) for admission: _____

Have you (or the member) been seen in the emergency room within the past 3 months? ☐ Yes ☐ No

If yes, provide reason(s) for going to the emergency room: _____

How would you describe the health of your teeth and gums?

☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Are you (or the member) currently receiving any of the following services? Please check all that apply.

☐ Area Agency on Aging (AAA) ☐ Rehabilitative ☐ Dialysis ☐ Chemotherapy/Radiation Therapy
☐ Speech Therapy ☐ Physical Therapy ☐ Occupational Therapy ☐ Behavioral/Mental Health Services
☐ Home Health Agency Services ☐ Substance Abuse Services ☐ 24-hour supports from a Medicaid Waiver Provider

Do you (or the member) have or use any of the following medical equipment or supplies?

☐ Wound Supplies ☐ Oxygen ☐ Feeding Pump ☐ Mechanical Lift (Hoyer Lift)
☐ Wheelchair ☐ Specialty Bed ☐ Breathing Machine (CPAP, BiPAP, Ventilator)
☐ Other: _____

Are you (or the member) waiting for any of your equipment or supplies? ☐ Yes ☐ No

Do you (or the member) know how to use this equipment or supplies? ☐ Yes ☐ No

Do you (or the member) need to use medical care, mental health, home health, or other health services at least once every three months?

☐ Yes ☐ No

Do you (or the member) need or get treatment or counseling for any kind of mental health, substance abuse/alcohol or emotional problem?

☐ Yes ☐ No

Do you (or the member) currently need or use medicine prescribed by a doctor (other than vitamins)? ☐ Yes ☐ No

Section 3: Health Status

In general, compared to other people your (or the member's) age, would you say that your (his/her) health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you (or the member) have any of the following conditions? If so, please check all that apply:

☐ Asthma	☐ Dementia	☐ Hepatitis C	
☐ Behavioral/Mental Health Needs	☐ Depression	☐ Diabetes	☐ HIV/Aids
☐ Breathing Problems	☐ Digestive Problems	☐ High blood pressure	☐ Stroke
☐ Cancer, Type: _____	☐ Epilepsy/seizures	☐ Kidney Failure	
☐ Congestive Heart Failure	☐ Heart Disease	☐ Multiple Sclerosis	
☐ COPD	☐ Hepatitis B	☐ Quadriplegia	
☐ Other _____		☐ Schizophrenia/psychosis	

Have you (or the member) ever had an organ transplant ☐ No ☐ Yes If so, type:_____
Date of transplant: _____

Are you (or the member) currently pregnant: ☐ No ☐ Yes If so, when is your due date: _____
Have you (or the member) see a doctor for this pregnancy? ☐ Yes ☐ No
Who is the doctor you (or the member) is seeing for this pregnancy? _____ Phone: _____

Do you (or the member) have pain that affects your daily activities? ☐ Yes ☐ No
If yes,
How much bodily pain have you (he/she) had in the past 4 weeks?
☐ None ☐ Very Mild ☐ Moderate ☐ Quite A Bit ☐ Severe ☐ Very Severe ☐ Don't Know ☐ Refused
During the past 4 weeks, how much did pain interfere with your (his/her) general activities?
☐ Not at All ☐ A Little Bit ☐ Moderately ☐ Quite A Bit ☐ Extremely ☐ Don't Know ☐ Refused

Do you (or he/she) smoke? ☐ Yes ☐ No

What is your (his/her) weight? _____
What is your (his/her) height? _____

Are you currently receiving pain management services to help you (or him/her) manage your pain? ☐ Yes ☐ No

Section 4: Activities of Daily Living

The next questions ask about difficulties you (he/she) may have doing certain activities because of a health problem. By "health problem" we mean any long-term physical, mental or emotional problem or illness. Please tell me whether you (he/she) have "No difficulty", "Some Difficulty", "A lot of Difficulty", or "You can't do them at all"?

Managing money [such as keeping track of expenses or paying bills]?
O No Difficulty O Some O A Lot O Can't Do At All O Don't know O Refused

Preparing meals?
O No Difficulty O Some O A Lot O Can't Do At All O Don't know O Refused

Keeping track of your (his/her) medicines and taking them on time?
O No Difficulty O Some O A Lot O Can't Do At All O Don't know O Refused

Dressing yourself (himself/herself), including tying shoes, working zippers, and doing buttons?
O No Difficulty O Some O A Lot O Can't Do At All O Don't know O Refused

Going from one room to another on the same level, either walking or with a wheel chair or walker?
O No Difficulty O Some O A Lot O Can't Do At All O Don't know O Refused

Using the toilet, including getting there?
O No Difficulty O Some O A Lot O Can't Do At All O Don't know O Refused

Getting in and out of bed?
O No Difficulty O Some O A Lot O Can't Do At All O Don't know O Refused

Eating, like holding a fork, cutting food, or drinking from a glass?
O No Difficulty O Some O A Lot O Can't Do At All O Don't know O Refused

Who helps you (him/her) with these activities? Please check all that apply.
☐ No one helps ☐ Husband or wife ☐ Father or mother ☐ Son or daughter ☐ Other relative ☐ Friend or Neighbor
☐ Person from an agency or organization (such as home health agency, mental health center, center for independent living, etc.)

Do you (he/she) need more help than you are getting right now?
O Yes O No O Don't know O Refused

Do you (he/she) have difficulty with speech or understanding others when speaking to you?

O No Difficulty O Some O A Lot O Very Difficult O Don't know O Refused

Do you (he/she) have difficulty hearing that interferes with your daily activities?

O No Difficulty O Some O A Lot O Very Difficult O Don't know O Refused

If yes, do you (he/she) wear hearing aids? ☐ Yes ☐ No

Do you (he/she) have vision problems? ☐ Yes ☐ No

If yes, is this vision problem correctable by glasses? ☐ Yes ☐ No

If yes, do you (he/she) have glasses? ☐ Yes ☐ No

Section 5: Mental Health

Have you (he/she) been consistently depressed or down, most of the day, nearly every day, for the past two weeks?
○ Yes ○ No ○ Don't know ○ Refused

During the past two weeks, have you (he/she) been much less interested in most things, or much less able to enjoy things you (he/she) used to enjoy most of the time?
○ Yes ○ No ○ Don't know ○ Refused

Over the past week how much have you (he/she) thought that people were spying on you (him/her), or that someone was plotting against you (him/her), or trying to hurt you (him/her)?
○ Not at all ○ A little ○ Moderately ○ Markedly ○ Extremely ○ Don't know ○ Refused

Over the past week how much have you (he/she) heard things other people couldn't hear, such as voices or how much have you (he/she) heard a voice commenting on your (his/her) thoughts or behaviors or did you (he/she) hear two or more voices talking to each other?
○ Not at all ○ A little ○ Moderately ○ Markedly ○ Extremely ○ Don't know ○ Refused

Over the past week how much did you (he/she) want to harm yourself (himself/herself):
○ Not at all ○ A little ○ Moderately ○ Markedly ○ Extremely ○ Don't know ○ Refused

Have you (he/she) ever felt you (he/she) should cut down on your (his/her) drinking or use of street drugs?
○ Yes ○ No ○ Don't know ○ Refused

Have people annoyed you (him/her) by criticizing your (his/her) drinking or use of street drugs?
○ Yes ○ No ○ Don't know ○ Refused

Section 6: Miscellaneous

Do you (or the member) have a condition or illness that you feel is not under control or needs urgent treatment? ☐ No ☐ Yes

If yes, please explain: _____