HNE Be Healthy® Needs Assessment (HNA)

PLEASE TAKE A FEW MINUTES TO COMPLETE THIS SURVEY

Your health assessment will help HNE Be Healthy® provide better health services and coordinate the care you receive. We will keep the information you provide private. Your answers will NOT affect your MassHealth/ Medicaid benefits.

SURVEY INSTRUCTIONS

1. Please fill out one assessment form for each new member.

2. You will need to have on hand:

a. Your HNE Be Healthy® member insurance card number

b. The names, phone numbers, and addresses of your doctor or nurse

3. Answer each of the questions by checking off the box ❍ Yes ❍ No ❍ Not Sure, or filling in your response in the space provided.

4. You are sometimes told to skip over some questions in this survey. When this happens you will see a note that tells you what question to answer next.

5. This survey will take about 10 minutes to complete.

6. Please use enclosed mailing envelope and return to: One Monarch Place, Suite 1500, Springfield MA 01144.

Thank you for taking the time to fill out this assessment form. HNE Be Healthy® will review your responses to determine if there are care management programs, educational materials, or other resources that you may find helpful. If you have any questions about this health assessment, please call HNE Member Services at 413.788.0123 or 800.786.9999 (TTY 800.439.2730).

PERSONAL INFORMATION

Name of person completing this form:

Member Name (Last, First, MI)	MassHealth HNE Be Healthy® Member ID	Birth Date / /	Gender ❍ Male ❍ Female
Address (number and street)	City/Town	State	Zip code

Phone number:

❍ Home (_____)_____ ❍ Cell (_____)_____ ❍ Work (_____)_____

Email Address:

Relationship of person completing this form to the member:

❍ Self ❍ Parent ❍ Spouse/Partner ❍ Family/Relative ❍ Professional Caregiver ❍ Authorized Representative

INFORMATION ABOUT YOU

QUESTION	YES	NO	NOT SURE	ADDITIONAL ANSWER
1. Are there other phone numbers for HNE Be Healthy® to contact you about your health needs? If yes, please include area code first.	❍	❍	❍	❍ Home (_____)_____ ❍ Cell (_____)_____ ❍ Work (_____)_____ Best time to call: ❍ AM ❍ PM
2. Preferred language spoken				❍ English ❍ Spanish ❍ Other ***If other, please identify:*** _____
3. Are you currently homeless and/or don't have a stable living situation?	❍	❍	❍	
4. Are you hearing impaired?	❍	❍	❍	
5. Do you currently get services from any of the following state agencies?	❍	❍	❍	***If yes, please check as many as apply.*** ❍ Massachusetts Commission for the Blind ❍ Massachusetts Commission for the Deaf and Hard of Hearing ❍ Massachusetts Rehabilitation Commission ❍ Department of Mental Health ❍ Department of Developmental Services ❍ Division of Children and Families ❍ Special Education ❍ Early Intervention Program ❍ Other

INFORMATION ABOUT YOUR HEALTH

QUESTION	YES	NO	NOT SURE	ADDITIONAL ANSWER
6. How would you describe your health now?				❍ Excellent ❍ Good ❍ Fair ❍ Poor
7. Do you have trouble doing any of the following because of your health?	❍	❍	❍	❍ Walking several blocks ❍ Preparing meals ❍ Eating ❍ Bathing/Showering ❍ Doing light household chores ❍ Attending work/school ❍ Exercising/Playing ❍ Sleeping
8. Do you currently take any prescription medications on a regular basis?	❍	❍	❍	***If yes, how many medications are you currently taking?*** ❍ 1-2 ❍ 3-4 ❍ More than 4 medications Please list the medications you currently take _____ _____
9. Are you currently pregnant? (if not, skip to question #12)	❍	❍	❍	***If yes, when is your due date?*** ____/____/____
10. If you are pregnant, do you have an OB/GYN doctor, nurse, or mid-wife who is providing care during this pregnancy?	❍	❍	❍	***If yes, provider's name:*** _____ Address:_____ Phone: (____)_____
11. If you are pregnant, do you have concerns about your pregnancy?	❍	❍	❍	***If yes, would you like to speak to a prenatal care manager?*** ❍ Yes ❍ No
12. In the last 12 months, did you get care in an emergency room?	❍	❍	❍	***If yes, how many times?*** ❍ 1-3 times ❍ 4-6 times ❍ More than 6 times
13. In the last 12 months, have you stayed overnight in a hospital?	❍	❍	❍	

14. Has anyone in your immediate family (mother, father, sister, brother, children) had any of the following health problems?				***Please check as many as apply.*** ❍ Asthma ❍ Diabetes ❍ Heart Problems ❍ Cancer ❍ Kidney Disease ❍ Depression ❍ High Blood Pressure ❍ Chronic Pain ❍ High Cholesterol ❍ HIV/AIDS ❍ Alcohol or Substance Abuse ❍ Stroke ❍ Obesity/Weight Problems ❍ Other
15. Are you being treated for any of the following health problems?				***Please check as many as apply.*** ❍ Asthma ❍ Diabetes ❍ Heart Problems ❍ Cancer ❍ Kidney Disease ❍ Depression ❍ High Blood Pressure ❍ Chronic Pain ❍ High Cholesterol ❍ HIV/AIDS ❍ Alcohol or Substance Abuse ❍ Stroke ❍ Obesity/Weight Problems ❍ Other

INFORMATION ABOUT YOUR HEALTH NEEDS

QUESTION	YES	NO	NOT SURE	ADDITIONAL ANSWER
16. Do you have a doctor or nurse that you usually go to for health care needs?	❍	❍	❍	***If yes, doctor's name:*** _____ Address:_____ Phone: (____)_____
17. Have you seen your doctor doctor in the last 12 months?	❍	❍	❍	***If yes, what was the visit for:*** ❍ Well-visit ❍ Illness ❍ Injury
18. Do you currently use any medical equipment?	❍	❍	❍	***If yes, please check all of the equipment you use.*** ❍ Wheelchair ❍ Cane ❍ Walker ❍ Crutches

QUESTION	YES	NO	NOT SURE	ADDITIONAL ANSWER
19. Do you need help with managing your health care condition?	❍	❍	❍	***If yes, would you like to speak to a care manager?*** ❍ Yes ❍ No
20. Do you need help with transportation to the doctor's office or clinic?	❍	❍	❍	***If yes, some members may be eligible for transportation assistance. Please call HNE Member Services for more information.***

INFORMATION ABOUT WELLNESS AND YOUR LIFE STYLE

QUESTION	YES	NO	NOT SURE	ADDITIONAL ANSWER
21. In the past month, have you felt sad or down?	❍	❍	❍	***If yes, how often?*** ❍ All of the time ❍ Most of the time ❍ Some of the time ❍ A little of the time
22. In the past month, have you had enough energy to do what you need to for work, school, or home?	❍	❍	❍	***If yes, how often?*** ❍ All of the time ❍ Most of the time ❍ Some of the time ❍ A little of the time
23. Do you exercise regularly?	❍	❍	❍	***If yes, how many times a week do you exercise?*** ❍ 1-2 times per week ❍ 3-5 times per week ❍ More than 6 times per week
24. Do you use tobacco products?	❍	❍	❍	***If yes, would you like written information about quitting smoking or using tobacco products?*** ❍ Yes ❍ No
25. Do you drink alcohol?	❍	❍	❍	***If yes, how often to you drink alcohol?*** ❍ 1-2 times per week ❍ 3-5 times per week
26. Do you buckle your seat belt?	❍	❍	❍	***If yes, how often:*** ❍ Always ❍ Sometimes ❍ Never

QUESTION	YES	NO	NOT SURE	ADDITIONAL ANSWER
27. If you have children under age 8 in your household, do you use a car seat when driving?	❍	❍	❍	***If yes, how often:*** ❍ Always ❍ Sometimes ❍ Never
28. Would you like to get information about other health topics?	❍	❍	❍	***If yes, please list the health topics you are interested in.*** _____ _____ _____

INFORMATION ABOUT YOUR RACE AND ETHNICITY

QUESTION	ADDITIONAL ANSWER		
29. How would you describe your race? Please check as many as apply.	❍ American Indian/ Alaska Native ❍ Asian ❍ Black/African American	❍ Native Hawaiian or other Pacific Islander ❍ White	❍ Other Race ❍ Unknown/not Specified
30. How would you describe your ethnic background? Please check as many as apply.	❍ African ❍ African American ❍ American ❍ Asian ❍ Asian Indian ❍ Brazilian ❍ Cambodian ❍ Cape Verdean ❍ Caribbean Islander ❍ Central American (not otherwise specified) ❍ Chinese ❍ Colombian ❍ Cuban ❍ Dominican	❍ Eastern European ❍ European ❍ Filipino ❍ Guatemalan ❍ Haitian ❍ Honduran ❍ Japanese ❍ Korean ❍ Laotian ❍ Mexican, Mexican American, Chicano ❍ Middle Eastern ❍ Portuguese ❍ Puerto Rican ❍ Russian	❍ Salvadoran ❍ South American (not otherwise specified) ❍ Vietnamese ❍ Other ethnicity ❍ Unknown/not specified