Child Health Assessment

Please complete this form and send it back in the pre-paid envelope. Or you can complete this form online at www.MCCofFL.com. If you need help filling out this form, please call us at 800-327-8613 (TTY 711).

Magellan Complete Care, your health plan, wants to help you or your child feel better and enjoy a healthy life.

These health questions will help us to better understand how you or your child is feeling. It will help us know what services and resources you will need to stay healthy and feel well. The questions will take you about 15 minutes to complete.

As your or your child's health plan it is key that we work very closely with your doctors. We will make sure you get the care you need. If you give us the OK, we can share this information with your or your child's doctors. This will make sure you or your child gets good care and help your (your child's) doctors talk to each other. Without your OK, we will not share any information with anyone.

Do you agree for us to share this information with your doctors? ○ Yes ○ No

Fields mark with an * are required. Date completed: ___________________

About You/Your Child

*Enrollee's Name		*Medicaid ID #
*Date of Birth	Age	
What language do you, your family, or caregiver speak?		Race/Ethnicity
*Sex: Male Female	*Date of Enrollment	Guardian
*Address		
*Home Phone #	Cell Phone #	Email

Other Insurance:

○ Medicare ○ Long Term Care ○ Waiver Program ○ Veteran Benefits ○ Other

*Do you/your child have reliable transportation to appointments? ○ Yes ○ No ○ Unsure

*Best day/time to reach you (to go over information about your child)? ______________________________

*Where do you (or your child) currently live? (select all that apply)

○ House
○ Apartment
○ Assisted living: Name: ___________________________ Contact: _____________________________
○ Shelter: Name:____
○ Other: ____
○ Homeless
○ SIPP

*Who do you (or your child) live with? (select all that apply)

○ Mother
○ Father
○ Both parents
○ Relative/friend
○ Protective custody
○ Foster care
○ Other

Do you /(Does your child) have a caregiver or someone we can contact if we can't reach you? ○ Yes ○ No

If yes is selected, please give details: Name: _______________ Contact information: ________________

If yes, do you give Magellan Complete Care permission to give information to this person? ○ Yes ○ No
Details:____
____

About You/Your Child's Physical Health

*How tall (inches) are you (your child)? _____________
* How much do you (your child) weigh (lbs)? ___________
*Do you have any concerns about your (your child's) overall health? ○ Yes ○ No ○ Unsure

In the past 4 weeks, how many days did you (your child) miss from work or school because of problems with your/their physical or mental health? (Please include only days missed for your own/your child's health, not someone else's health.)

○ None ○ 1 to 2 times ○ 3 to 4 times ○ 5 or more times

During the past 7 days, how much did your (the child's) physical or mental health affect you/your child being able to do things at work or at school?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

Do you (your child) have any of the following:

○ Asthma
○ Anxiety
○ Cancer
○ Cerebral Palsy
○ Cystic Fibrosis
○ Depression
○ Diabetes
○ Down Syndrome
○ Epilepsy/Seizure disorder
○ Heart Problems
○ Hearing Impaired
○ Hemophilia
○ Hepatitis C
○ High Blood Pressure
○ HIV/AIDS
○ Kidney Disease
○ Learning Disabilities
○ Liver Disease
○ Schizophrenia
○ Sickle Cell Anemia
○ Transplant
○ Visually Impaired
○ Other: ________________

Are you (your child) currently pregnant? ○ Yes ○ No ○ Unsure Estimated due date:____________

A case manager will be reaching out to you to give more information about our Maternity program.

About Care You/Your Child Receives

*How many times have you (has your child) been seen in the Emergency Room in the last 3 months?

○ 0 ○ 1 ○ 2 ○ More than 2

*How many times have you/ (has your child) stayed overnight in a hospital room in the past 3 months?

○ 0 ○ 1 ○ 2 ○ More than 2

*Have you (your child) had any major falls or injuries in the last 6 months? ○ Yes ○ No ○ Unsure

*Do you/ (does your child) use any medical equipment? ○ Yes ○ No ○ Unsure

If yes, select type:

○ Wheelchair	○ Brace	○ Lifts
○ Cane	○ Hospital Bed	○ Vent
○ Walker	○ Feeding Aides	○ Nebulizer
○ Reacher	○ Oxygen	○ Other: ________________

Do you (the child) get assistance with Activities of Daily Living such as dressing, feeding, bathing?

○ Yes ○ No ○ Unsure

If yes, give details:____

What number best describes how much, during the past week, pain has affected with your (your child's) general activity?

Does not affect — **Completely affects**

0 1 2 3 4 5 6 7 8 9 10

*How many different prescriptions/medications (other than vitamins) do you (does your child) take?

○ None ○ 1 – 3 ○ 4 – 7 ○ 8 – 11 ○ 11 or more

*What is the name of your (your child's) primary care provider?

PCP Name:________________________ ○ N/A

*What is the name of your (your child's) primary behavioral health provider?

PBHP Name: ____ ○ N/A

*What is the name of your (your child's) dentist?

Dentist Name:________________________________ ○ N/A

Do you/ (Does your child) see any other healthcare providers? If so what are their names and what do you (does your child) see them for? ____

Have you/(Has your child) had any of the following health screenings in last 12 months? Please document the date of the last exam for each of the items that apply.

○ **Routine Physical Exam (CHCUP)**
Date: ________________________________
Provider Name: ________________________
Office Location: _______________________

○ **Tetanus Vaccination** (*ages 10-13 only*)
Date: ________________________________
Provider Name: ________________________
Office Location: _______________________

○ **Dental Exam**
Date:________________________________
Provider Name: _________________________
Office Location: _______________________

○ **HPV Vaccination** (*ages 8 and older only*)
Date Series initiated: ____________________
Vaccination Series Complete? ○ Yes ○ No
Office Location: _______________________

○ **Meningococcal Vaccination** (*ages 11-13 only)*
Date: ___________________________
Provider Name: _________________________
Office Location: _______________________

About Your/Your Child's Lifestyle

*How many meals do you (your child) eat on a regular day?
○ Fewer than 3 ○ 3 ○ 4 to 6 ○ More than 6

*How often do you (does your child) eat fast food, processed foods (such as chicken nuggets, hot dogs, bologna) or fried foods?
○ Daily ○ Almost every day ○ Sometimes ○ Never

*How would you describe your (the child's) physical activity/exercise level?
○ High ○ Moderate ○ Low

*On average how many hours of sleep do you (your child) get per night?
○ Less than 5 ○ More than 5 but less than 7 ○ 7 to 8 hours ○ More than 8 hours

*Do you (your child) currently use tobacco products? ○ Yes ○ No ○ Unsure

*Are there any substance use concerns for you (your child)? ○ Yes ○ No ○ Unsure

About Your/Your Child's Emotional Health

Over the past 2 weeks, how often have you (has your child) been bothered by any of the following problems?

*Little interest or pleasure in doing things?
○ Not at all ○ Several days ○ More than half days ○ Nearly every day

*Feeling down, depressed or hopeless?
○ Not at all ○ Several days ○ More than half days ○ Nearly every day

About Your/Your Child's Future Health

*How important is it to you/your child to make a change to your health right now?

Not sure					**Somewhat sure**					**Very sure**
0	1	2	3	4	5	6	7	8	9	10

*How confident are you/your child about making a change to your health right now?

Not sure					**Somewhat sure**					**Very sure**
0	1	2	3	4	5	6	7	8	9	10

*How ready are you/your child to make a change to your health right now?

Not sure					**Somewhat sure**					**Very sure**
0	1	2	3	4	5	6	7	8	9	10