

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:

- | | | |
|----------------------------------|-------------------------------------|------------------------------------|
| <input type="radio"/> Wheelchair | <input type="radio"/> Brace | <input type="radio"/> Lifts |
| <input type="radio"/> Cane | <input type="radio"/> Hospital Bed | <input type="radio"/> Vent |
| <input type="radio"/> Walker | <input type="radio"/> Feeding Aides | <input type="radio"/> Nebulizer |
| <input type="radio"/> Reacher | <input type="radio"/> Oxygen | <input type="radio"/> 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 Safety

*Do you keep your doors locked at night?

- Yes No N/A

*Do you keep emergency supplies in your home (such as a first aid kit and canned food)?

- Yes No N/A

Details: _____

*Do you/your child wear a seatbelt when traveling in a motor vehicle?

- Yes No N/A

*Do you talk or text on the phone while driving?

- Yes No N/A

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					Very sure
						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					Very sure
						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					Very sure
						sure					
0	1	2	3	4	5	6	7	8	9	10	