MOLINA HEALTHCARE | Molina Complete Care

Reference#

Demographic Information

Medallion 4.0 Adult Member Health Screener

- Please fill in your responses like this using ONLY A BLUE OR BLACK PEN.
- Do NOT use GREEN INK.
- Please answer as many questions as you can.

Leave blank the question(s) you cannot or choose not to answer.

Member Last Name:

Member First Name:

Member Medicaid ID #:

Member ID # (Plan):

Member Contact/Phone:

Member Primary Care Provider:

Date Screening Completed: MM DD YYYY

Member Address:

Date of Birth: MM DD YYYY **Gender** Male Female

Welcome to Molina Complete Care (MCC)! We are glad to have you as a member and look forward to getting to know you. We'd like you to complete this form to tell us about your health so that we can help you in the ways you need. Please complete the form and return it to us in the enclosed postage-paid envelope.

We are excited to be your partner to help you live a healthy life! To help us provide you with the best service, please tell us about yourself. All information you provide will be kept private. We will use the information you provide with your health care providers to help make sure you have the health services that you need.

Please indicate your consent to complete this Health Screening to be used by MCC to help support your health and wellness needs.

Yes No

If you do not want this information shared, please check the box below. Race, language, and other information will be used to make sure your health needs are met.

I do not want this information shared.

Which option best describes your race?

Asian
White
Black/African American
I don't know
Hispanic/Latino
American Indian/Alaskan Native
Native Hawaiian/Other Pacific Islander
Declined

What language(s) do you speak?

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Medically Complex Classification Questions

These questions will help us determine if you are medically complex. Medically complex means that you have complex healthcare needs that typically require more intensive medical services coordinated across multiple providers.

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

- Cancer (active)
- Chronic Obstructive Pulmonary Disease (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

- Asthma
- High blood pressure
- High cholesterol
- Obesity or overweight
- Tuberculosis
- Hepatitis
- Other

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
- Eating
- Walking
- Dressing
- Using the bathroom

Question 3: Has a doctor, nurse or health care provider told you that you had/have any of the following **(please check all applicable boxes):**

- Alcoholism
- Bipolar Disorder or Mania
- Depression
- Post-Traumatic Stress Disorder (PTSD)
- Panic Disorder
- Schizophrenia or Schizoaffective Disorder
- Psychotic 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

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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
- Seeing things clearly
- Making decisions about your health or well-being
- Self-Care (bathing, grooming, eating)
- Travel/Transportation (driving, taking the bus)

Social Determinants of Health and Health Risk Assessment Triage Questions

Question 1: What is your housing situation today?

- I have housing
- I am worried about losing my housing
- I do not have housing (check all that apply)
  - 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: 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**.

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

Question 3:

a. 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)

b. How many times have you been in the Emergency Room or a hospital in the last 90 days for any reason? (enter number from 0-99)

Question 4: How many times have you fallen in the last 90 days? (enter number from 0-99)

Social Determinants of Health and Health Risk Assessment Triage Questions cont.

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 appointment or from getting my medications

Yes, it has kept me from non-medical meetings, appointments, work or from getting things that I need

No

I choose not to answer this question

Question 6: Caregiver Status

a. 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

b. 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?

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's degree

Bachelor's degree or higher

I choose not to answer this question

Question 8: Do you have a job?

I have a part-time or temporary job

I have a full time job

I choose not to answer this question

I do not have a job and am looking for one

I do not have a job and I am not looking for one

Question 9: Do you like your current job? (check all that apply)

Yes, I like my job

I work more than 40 hours per week at two or more part-time jobs

I must work more than one job because I can't find a full time job

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 any other unmet needs that you would like to discuss with a care coordinator?

Yes

No

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Social Determinants of Health and Health Risk Assessment Triage Questions cont.

Question 12: How quickly do you need to be contacted by a care coordinator who can help you with these needs?

1-30 days 31-60 days 61-90 days 91-120 days Do not contact me

Additional MCC Screening Questions:

Question 1: How much do you weigh? |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Question 2: How tall are you? |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Question 3: Are you currently pregnant?

Yes; if yes go to #4 No; if no skip to #5 I don't know Declined

Question 4: If pregnant:

a.) When is your due date? |_|_| |_|_| |_|_|_|_|
MM DD YYYY

b.) Does your doctor or do you have any concerns with this pregnancy?

Yes What are those concerns?_____

No I don't know Declined

Question 5: If not pregnant, are you planning to get pregnant?

Yes No I don't know Declined

Question 6: Do you have a primary care provider (PCP)? If not, do you have a doctor you would like to be your PCP?

Yes No What is the doctor's name?_____

Question 7: Are you seeing any specialists?

Yes No

a. If yes, what type?

Cardiology

Pulmonology

Neurology

Endocrinology

Oncology

Nephrology

GYN//OB

Other Specialist's Name:_____

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Additional MCC Screening Questions cont.

Question 8: Do you have surgery planned for the future?

Yes No

a. If yes, what type of surgery is that?____________________ Declined

b. What date? MM DD YYYY

Question 9: Are you currently receiving home care or home hospice care?

Yes No

Question 10: Are you currently receiving any physical therapy (PT), occupational therapy (OT) or speech therapy (ST)?

Yes No

Question 11: Are you receiving any durable medical equipment such as a walker or cane?

Yes No I don't know Declined

a. If yes, was it prescribed by a doctor?

Yes No I don't know Declined

Question 12: How many medications do you take each day? (Include prescriptions and over-the-counter)

None 1-3 4-7 8-11 12 or more I don't know

Declined

If yes, what are the medications used for:

Question 13: In the last 3 months, how often have you used medications not prescribed for you?

Daily Almost every day Sometimes Never I don't know

Declined

Question 14: Over the last 2 weeks, how often have you been bothered by the below?

a. Feeling sad, down, depressed or hopeless

Not at all Several days

More than ½ the days Nearly every day

I don't know Declined

b. Having little or no pleasure in doing things

Not at all Several days

More than ½ the days Nearly every day

I don't know Declined

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c. Feeling nervous, anxious or on edge

Not at all | Several days
More than ½ the days | Nearly every day
I don't know | Declined

d. Not being able to stop or control worrying

Not at all | Several days
More than ½ the days | Nearly every day
I don't know | Declined

Question 15: Do you use alcohol, drugs or medications which affect your mood or help you relax?

Daily | Almost every day | Sometimes | Rarely/Never | I don't know
Declined

Question 16: Are you currently being treated by a psychiatrist or psychologist?

Yes | No

Question 17: Do you currently use tobacco products (cigarettes, chewing tobacco, cigars, pipes)?

Yes | No, I quit within the last 6 months
No, I quit over 6 months ago | No, I have never used tobacco products
I don't know | Declined

Thank you for allowing us to learn more about you. We will use this information to help you live healthier.
If assistance is needed, please call 1-800-424-4518 (TTY 711) from 8 a.m. to 8 p.m. local time, Monday-Friday.