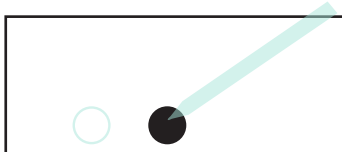
MOLINA HEALTHCARE | Molina Complete Care

Reference#

Medallion 4.0 Child Health Screener

Demographic Information



- 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.

Child's Last Name:

Child's First Name:

Child's Medicaid ID #:

Child's ID # (plan):

Parent/Caregiver Contact/Phone:

Child's Primary Care Provider:

Date Screening Completed: M M D D Y Y Y Y

Child's Address:

Child's Date of Birth M M D D Y Y Y Y **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 partner with you to help your child live a healthy life! To help us provide your child with the best service, please tell us about your child. All information you provide will be kept private. We will use the information you provide with your child's health care providers to help make sure your child has the health services that he or she needs.

Please indicate your consent to complete this Health Screening to be used by MCC to help support your child's 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 child's health needs are met.

◯ I do not want this information shared.

For members under the age of 18, please tell us who is completing this survey?

◯ Health representative ◯ Parent

Which option best describes your child's 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) does your child 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 your child had/has any of the following **(please check all applicable boxes):**

- ☐ Cancer (active)
- ☐ Diabetes
- ☐ HIV or AIDS
- ☐ Cystic Fibrosis or other lung condition
- ☐ Stroke, Brain Injury or Spinal Injury
- ☐ Congenital heart defects, heart attack, heart failure (weak heart)
- ☐ Kidney Failure or End Stage Renal Disease (ESRD)
- ☐ Sickle Cell Disease
- ☐ 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 child's ability to do everyday things **AND** require your child to receive assistance with any of the following **(please check all applicable boxes):**

- ☐ Bathing
- ☐ Dressing
- ☐ Eating
- ☐ Using the bathroom
- ☐ Walking

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

- ☐ Alcoholism
- ☐ Depression
- ☐ Panic Disorder
- ☐ Psychotic Disorder
- ☐ Bipolar Disorder or Mania
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Schizophrenia or Schizoaffective 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 your child from doing everyday things?

- ☐ Yes
- ☐ No

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Question 5: Does your child 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 his/her own
- ☐ Seeing things clearly
- ☐ Making decisions about his/her health or well-being
- ☐ Self-Care (bathing, grooming, eating)
- ☐ Travel/Transportation (driving, taking the bus)
- ☐ Paying attention

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 has your child 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 has your child been in the Emergency Room or a hospital in the last 90 days for any reason? (enter number from 0-99)

☐☐

Question 4: Has lack of transportation kept your child from medical appointments, meetings, work, or from getting things needed for daily living? **Check all that apply.**

- ◯ Yes, it has kept my child from medical appointment or from getting medications
- ◯ Yes, it has kept my child from non-medical meetings, appointments, work or from getting things that he or she needs
- ◯ No
- ◯ I choose not to answer this question

Question 5: 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 6: Is your child in school? If so, what grade?_____

Question 7: Do you work or does your child 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 8: In the past year have you or your child 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 9: Does your child have any other unmet needs that you would like to discuss with a care coordinator?

◯ Yes ◯ No

Question 10: How quickly do you need to be contacted by a care coordinator who can help your child with these needs?

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

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Additional MCC Screening Questions:

Question 1: How much does your child weigh?

Question 2: How tall is your child?

Question 3: For female child old enough, is your child 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 her due date? MM DD YYYY

b. Is she currently getting care from a doctor or other health professional for her pregnancy?

- ◯ Yes
- ◯ No
- ◯ I don't know

c. Do you or her doctor have any concerns with this pregnancy?

- ◯ Yes - - what are those concerns? _____
  _____
- ◯ No
- ◯ I don't know
- ◯ Declined

Question 5: Has your child had a medical checkup in the last 12 months?

- ◯ Yes
- ◯ No
- ◯ I don't know

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Question 6 : Does your child 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: Is your child seeing any specialists?

◯ Yes ◯ No

a. If yes, what type?

◯ Cardiology
◯ Pulmonology
◯ Neurology
◯ Endocrinology
◯ Oncology
◯ Nephrology
◯ GYN//OB
◯ Other Specialist's Name:_____

Question 8: Does your child have surgery planned for the future?

◯ Yes ◯ No

a. If yes, what type of surgery is that?_____ ◯ Declined
b. What date? M M D D Y Y Y Y

Question 9: Please answer each question below that best describes your child.

a. Does your child need or use medicine prescribed by a doctor (other than vitamins)?

◯ Yes
◯ No
◯ I don't know

b. Can you tell us what that medicine is and what it is used for? _____

_____

_____

c. Does your child need or use medical equipment (such as, wheelchair, leg braces, or nebulizer)?

◯ Yes
◯ No
◯ I don't know

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d. If yes, was that prescribed by a doctor?

- ◯ Yes
- ◯ No
- ◯ I don't know

Question 10: Does your child need or receive special therapy, like physical therapy (PT), occupational therapy (OT) or speech therapy (ST)?

◯ Yes ◯ No ◯ I don't know

Question 11: Does your child need or get treatment or counseling for an emotional, developmental or behavioral problem?

◯ Yes ◯ No ◯ I don't know

Question 12: Is your child currently receiving home care or home hospice care?

◯ Yes ◯ No

Question 13: Is your child receiving Part C services?

◯ Yes ◯ No ◯ I don't know

Question 14: For children ages 10 and above only, fill in all that apply below.
During the past 12 months, did your child:

- ◯ Smoke or use tobacco products
- ◯ Drink alcohol (more than a few sips)
- ◯ Smoke or use marijuana
- ◯ Use anything else to get high ("Anything else" includes illegal drugs, over-the-counter and prescription drugs and/or things that you sniff or huff)
- ◯ I don't know
- ◯ Does not apply

Question 15: Does your child need help in any of the following areas?

◯ Eating healthy ◯ Exercising or increasing physical activity ◯ Getting to or maintaining a healthy weight
◯ Managing stress ◯ Stop smoking or chewing tobacco ◯ Stop using drugs or alcohol
◯ None ◯ I don't know

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.

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