

Demographic Information

Medallion 4.0 Maternity 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

Date of Birth: _____

MM DD YYYY

Member Address: _____

Welcome to Molina Complete Car (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 want to make sure that you are getting all the care you need at this time, so that your baby gets the best start. As your body changes, you might need to make lifestyle changes.

All answers you provide will be kept private and only used to help us give you the best information and service possible.

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? _____

MCC Pregnancy Screening Questions

Question 1: Are you pregnant?

☐ Yes ☐ No

a. If no, have you recently experienced a pregnancy loss?

☐ Yes ☐ No

b. Are you planning to get pregnant in the next 12 months?

☐ Yes ☐ No ☐ I don't know ☐ Declined

If not pregnant , skip to medically complex questions and complete.

Question 2: When is your pregnancy due date? ☐ I don't know
M M D D Y Y Y Y

Question 3: Is this your first pregnancy?

☐ Yes ☐ No

Question 4: Are you pregnant with more than one baby?

☐ Yes ☐ No

Question 5: Are you having any complications during this pregnancy or a past pregnancy? Or does your doctor have any concerns with this pregnancy?

☐ Yes ☐ No

Question 6: If pregnant before, did you have a sudden increase in blood pressure after 20 weeks of pregnancy or seizures during or after pregnancy?

☐ Yes ☐ No

Question 7: Have you chosen a doctor for pregnancy and delivery care? If so, what is your obstetrician's name:

(* fields will be validated and errors returned to plan for correction)

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):**

- | | |
|---|---|
| <input type="radio"/> Cancer (active) | <input type="radio"/> Chronic Obstructive Pulmonary Disease (COPD) or Emphysema |
| <input type="radio"/> Diabetes | <input type="radio"/> Heart Disease, heart attack, heart failure (weak heart) |
| <input type="radio"/> HIV or AIDS | <input type="radio"/> Kidney Failure or End Stage Renal Disease (ESRD) |
| <input type="radio"/> Parkinson's Disease | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> Stroke, Brain Injury or Spinal Injury | <input type="radio"/> Transplant or on a transplant wait list |
| <input type="radio"/> Other chronic (long term) disabling condition – IF YES, Member Complexity Attestation must be completed | |
| <input type="radio"/> Asthma | |
| <input type="radio"/> High blood pressure | |
| <input type="radio"/> High cholesterol | |
| <input type="radio"/> Obesity or overweight | |
| <input type="radio"/> Tuberculosis | |
| <input type="radio"/> Hepatitis | |
| <input type="radio"/> Other <input type="text"/> | |

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):**

- | | | |
|--------------------------------|--|-------------------------------|
| <input type="radio"/> Bathing | <input type="radio"/> Eating | <input type="radio"/> Walking |
| <input type="radio"/> Dressing | <input type="radio"/> 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):**

- | | |
|---|---|
| <input type="radio"/> Alcoholism | <input type="radio"/> Bipolar Disorder or Mania |
| <input type="radio"/> Depression | <input type="radio"/> Post-Traumatic Stress Disorder (PTSD) |
| <input type="radio"/> Panic Disorder | <input type="radio"/> Schizophrenia or Schizoaffective Disorder |
| <input type="radio"/> Psychotic Disorder | <input type="radio"/> Substance Use Disorder or Addiction |
| <input type="radio"/> Other chronic (long term) mental health condition – IF YES, Member Complexity Attestation must be completed | |
| <input type="text"/> | |

Question 4: Do any of the conditions you selected above keep you from doing everyday things?

- ☐ Yes ☐ No

Question 5: Do you have an intellectual or developmental disability and require help with any of the following: **(please check all applicable boxes):**

- | | |
|---|--|
| <input type="radio"/> Learning or problem-solving | <input type="radio"/> Making decisions about your health or well-being |
| <input type="radio"/> Listening or speaking | <input type="radio"/> Self-Care (bathing, grooming, eating) |
| <input type="radio"/> Living on your own | <input type="radio"/> Travel/Transportation (driving, taking the bus) |
| <input type="radio"/> Seeing things clearly | |

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.**

- | | |
|----------------------------------|---|
| <input type="radio"/> Food | <input type="radio"/> Phone |
| <input type="radio"/> Utilities | <input type="radio"/> Prescription drugs or medicine |
| <input type="radio"/> Clothing | <input type="radio"/> Health care (doctor appointment, mental health services, addiction treatment) |
| <input type="radio"/> Child care | <input type="radio"/> 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 ☐ Associate's degree
- ☐ High school diploma or equivalency (GED) ☐ Bachelor's degree or higher
- ☐ Some college but no degree ☐ I choose not to answer this question
- ☐ Workforce Credential or industry certification after high school

Question 8: Do you have a job?

- ☐ I have a part-time or temporary job ☐ I do not have a job and am looking for one
- ☐ I have a full time job ☐ I do not have a job and I am not looking for one
- ☐ I choose not to answer this question

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

- ☐ Yes, I like my job
- ☐ I must work more than one job because I can't find a full time job
- ☐ I work more than 40 hours per week at two or more part-time jobs
- ☐ 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

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:** Could you tell us if you:

- ☐ Drink alcohol (more than a few sips)
☐ Smoke or use marijuana
☐ Use anything else to get high (like illegal drugs, over the counter or prescription drugs or things you sniff or huff)
☐ Does not apply

Question 4: 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

Question 5 : 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 6: Are you seeing any specialists?

- ☐ Yes
 ☐ No

a. If yes, what type?

- ☐ Cardiology
☐ Pulmonology
☐ Neurology
☐ Endocrinology
☐ Oncology
☐ Nephrology
☐ GYN/OB
☐ Other

Specialist's Name

Question 7: Do you 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 8: Are you currently receiving home care or home hospice care?

☐ Yes

☐ No

Question 9: Are you currently receiving any physical therapy (PT), occupational therapy (OT) or speech therapy (ST)?

☐ Yes

☐ No

Question 10: 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 11: 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

a. If yes, what are the medications used for: _____

Question 12: 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

Additional MCC Screening Questions cont.

Question 13: 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

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

- ☐ Yes ☐ No

Question 15: Do you have any special medical or behavioral health needs we need to discuss?

- ☐ Yes ☐ No

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.