MOLINA HEALTHCARE | Molina Complete Care

Reference#

CCC Plus 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 Address

Child's Medicaid ID #

Child's ID # Plan

Parent/Caregiver Contact/Phone

Child's Primary Care Provider

Date Screening Completed

Child's 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 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 /Guardian

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
- ☐ Congenital heart defects, heart attack, heart failure (weak heart)
- ☐ Kidney Failure or End Stage Renal Disease (ESRD)
- ☐ Stroke, Brain Injury or Spinal Injury
- ☐ Cystic Fibrosis or other lung condition
- ☐ HIV or AIDS
- ☐ Sickle Cell Desease
- ☐ Transplant or on a transplant wait list
- ☐ Other chronic (long term) disabling condition – IF YES, Member Complexity Attestation must be completed
  - ☐ Asthma
  - ☐ Blood disease (Hepatitis)
  - ☐ Low birth weight, failure to thrive or other birth problems
  - ☐ Sleep problems
  - ☐ Tuberculosis
  - ☐ Autism or Autism Spectrum Disorder
  - ☐ High blood pressure
  - ☐ Obesity or overweight
  - ☐ 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 your own
- Paying attention
- Making decisions about your health or well-being
- Self-Care (bathing, grooming, eating)
- Travel/Transportation (driving, taking the bus)
- 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**.

- 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

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

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
◯ Do not contact me
◯ 61-90 days
◯ 91-120 days

Additional MCC Screening Questions

Question 1: How does your child's health compare to other children?

◯ Excellent
◯ Very Good
◯ Good
◯ Poor
◯ I don't know

Question 2: Does your child have a regular or primary care doctor?

◯ Yes ◯ No ◯ I don't know

Question 3: Has your child had a medical checkup regular or primary care doctor in the last 12 months?

◯ Yes ◯ No ◯ I don't know

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Additional MCC Screening Questions cont:

Question 4: How much does your child weigh?

Question 5: How tall is your child?

Question 6: Does your child need or use medical equipment or other assistive devices?

- ◯ Yes
- ◯ No
- ◯ I don't know

If yes, please select the type of equipment:

- ◯ Wheelchair
- ◯ Cane
- ◯ Walker
- ◯ Feeding Aides
- ◯ Other
- ◯ Reacher
- ◯ Brace
- ◯ Hospital Bed
- ◯ Oxygen
- ◯ Lifts
- ◯ Vent
- ◯ Nebulizer

Question 7: 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 8: Does your child need or receive treatment or counseling for an emotional, developmental or behavioral problem?

- ◯ Yes
- ◯ No
- ◯ I don't know

Question 9: For female child old enough, has your child started her menstrual cycle or period?

- ◯ Does not apply
- ◯ Yes
- ◯ No
- ◯ I don't know

Is your daughter pregnant?

- ◯ Yes
- ◯ No

If yes, how long has she been pregnant?

- ◯ 1-3 months
- ◯ 4-6 months
- ◯ 7-9 months
- ◯ I don't know

When is your baby due? M M D D Y Y Y Y

Is she getting medical care?

- ◯ Yes
- ◯ No
- ◯ I don't know

Question 10: Has your child had the flu shot or flu mist in the last year?

- ◯ Yes
- ◯ No
- ◯ I don't know

Question 11: For children who are old enough, how often does your child get 60 minutes a day of physical activity a day (such as playing sports, walking fast or running)?

- ◯ Less than 1 time per week
- ◯ 1-2 times per week
- ◯ 3 times per week
- ◯ 4 times per week
- ◯ 5 or more times per week
- ◯ I don't know

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Additional MCC Screening Questions cont.

Question 12: How often does your child eat fast food, processed foods (such as chicken nuggets, hot dogs, bologna) or fried foods?

Daily Almost every day Sometimes Never I don't know

Question 13: For children ages 10 or older, 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 14: Does your child need help in any of the following areas?

Eating healthy
Exercising or increasing physical activity
Managing stress
Getting to or maintaining a healthy weight
Not at this time
Stopping smoking or chewing tobacco
I don't know
Stopping drug or alcohol use
Other

Question 15: Is your child seeing any specialists?

Yes No

If yes, what type?

Cardiology
Endocrinology
Pulmonology
Oncology
Neurology
Nephrology
Other Specialist's name

Question 16: Does your child have surgery planned for the future?

Yes No

If yes, what type of surgery is that? Declined

What date?

Question 17: Please answer each question below that best describes your child.
Does your child need or use medicine prescribed by a doctor (other than vitamins)?

Yes No I don't know

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

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

Yes No I don't know

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

Yes No I don't know

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Additional MCC Screening Questions cont.

Question 18: Is your child currently receiving home care or home hospice care?

◯ Yes ◯ No

Question 19: Is your child receiving Part C services?

◯ Yes ◯ No ◯ I don't know

Thank you for allowing us to learn more about your child. We will use this information to help your child live healthier. If assistance is needed, please call 1-800-424-4524 (TTY 711) from 8 a.m. to 8 p.m. local time, Monday-Friday.

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