Magellan COMPLETE CARE®

Reference#

CCC Plus Adult Member 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.

Member Last Name

Member First Name

Member Address

Member Medicaid ID #

Member ID # Plan

Member Contact/Phone

Member Primary Care Provider

Date Screening Completed

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

Welcome to Magellan Complete Care of Virginia (MCC of VA)! 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 of VA 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?

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)
- ◯ Diabetes
- ◯ HIV or AIDS
- ◯ Parkinson's Disease
- ◯ Stroke, Brain Injury or Spinal Injury
- ◯ Chronic Obstructive Pulmonary Disease (COPD) or Emphysema
- ◯ Heart Disease, 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 ability to do everyday things **AND** require you 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 you had/have 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 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):**

- ◯ 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 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 work more than 40 hours per week at two or more part-time jobs
- 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 does your health compare to other people your age?

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

Question 2: How often do you need to have someone help you read instructions, pamphlets, or other written material from your doctor or pharmacy?

◯ Never ◯ Often

◯ Rarely ◯ Always

◯ Sometimes ◯ I don't know

Question 3: How much do you weigh?

Question 4: How tall are you?

Question 5: Do you need or use medical equipment or other assistive devices?

◯ Yes ◯ No ◯ I don't know

If yes, please select the type of equipment:

◯ Wheelchair ◯ Hospital Bed

◯ Cane ◯ Feeding Aides

◯ Walker ◯ Oxygen

◯ Reacher ◯ Lifts

◯ Brace ◯ Vent

◯ Other ◯ Nebulizer

Question 6: Do you need or receive special therapy, like physical therapy (PT), occupational therapy (OT) or speech therapy (ST)?

◯ Yes ◯ No ◯ I don't know

Question 7: Do you need or receive treatment or counseling for an emotional, developmental or behavioral problem?

◯ Yes ◯ No ◯ I don't know

Question 8: 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

If yes, what are the medications used for:

Reference#

Additional MCC Screening Questions cont.

Question 9: In the last three months, how often have you taken medications differently than your doctor prescribed?

Daily Almost every day Sometimes Never I don't know

Question 10: 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

Question 11: How often has your health caused you to miss time away from school, work or other activities within the year?

Daily Almost every day Sometimes Never I don't know

Question 12: Have you had a routine checkup by your regular or primary care doctor in the past 3 years?

Yes No I don't know

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 I choose not to answer

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 I choose not to answer

c. Feeling nervous, anxious or on edge

Not at all Several days More than ½ the days Nearly every day
I don't know I choose not to answer

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 I choose not to answer

Question 14: What is the level of stress in your everyday life?

Very high High Medium Low Other
I don't know

Question 15: When is the last time you had a colonoscopy?

Never Within the last 10 years More than 10 years ago
I don't know

Additional MCC Screening Questions cont.

For women only, otherwise skip to question 21.

Question 16: Are you pregnant?

◯ Yes; if yes go to #17 ◯ No; if no skip to number 18 ◯ I don't know

Question 17: If yes, how long have you 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

Question 18: If not pregnant, are you planning to get pregnant in the next 12 months?

◯ Yes ◯ No ◯ I don't know

Question 19: When was the last time you had a mammogram?

◯ Never ◯ Within the last 3 years ◯ More than 3 years ago ◯ I have had a hysterectomy
◯ I don't know

Question 20: When was the last time you had a pap smear?

◯ Never ◯ Within the last 3 years ◯ More than 3 years ago ◯ I have had a hysterectomy
◯ I don't know

Question 21: Have you had the flu vaccine in the last year?

◯ Yes ◯ No ◯ I don't know

Question 22: How often do you walk, run, or do other exercises for 30 minutes a day that make you breathe heavier or make your heart beat faster?

◯ 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

Question 23: How often do you eat fast food, processed foods (such as chicken nuggets, hot dogs, bologna) or fried foods?

◯ Daily ◯ Almost every day ◯ Sometimes ◯ Never

Question 24: Do you currently use tobacco products (cigarettes, chewing tobacco, cigars, pipes)?

◯ Yes, I currently use tobacco products ◯ No, I have never used tobacco products
◯ No, I quit within the last 6 months ◯ No, I quit more than 6 months ago

(For tobacco users only) Do you want to quit using tobacco?

◯ Yes, within the next 30 days ◯ Yes, within the next 6 months ◯ No, not thinking of quitting
◯ I don't know

Question 25: In the past year, how often have you used the following?

Alcohol

Men 5 drinks a day

Women 4 drinks a day

◯ Daily ◯ Almost every day ◯ Sometimes ◯ Never ◯ I don't know

Drugs

Prescription drugs for non-medical reasons

◯ Daily ◯ Almost every day ◯ Sometimes ◯ Never ◯ I don't know

Illegal Drugs

◯ Daily ◯ Almost every day ◯ Sometimes ◯ Never ◯ I don't know

Question 26: Do you need help in any of the following areas?

◯ Eating healthy ◯ Exercising or increasing physical activity ◯ Getting to or maintaining a healthy weight

◯ Managing stress ◯ Stopping smoking or chewing tobacco ◯ Stopping drug or alcohol use

◯ Not at this time ◯ Other _____ ◯ 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 1-800-424-4524 (TTY 711) from 8 a.m. to 8 p.m. local time, Monday-Friday.