

## 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: \_\_\_\_\_ Gender  Male  Female  
MM DD YYYY

**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  Hispanic/Latino

White  American Indian/Alaskan Native

Black/African American  Native Hawaiian/Other Pacific Islander

I don't know  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
- 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
- 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

**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
- Depression
- Panic Disorder
- Psychotic Disorder
- Other chronic (long term) mental health condition – IF YES, Member Complexity Attestation must be completed
- Bipolar Disorder or Mania
- Post-Traumatic Stress Disorder (PTSD)
- Schizophrenia or Schizoaffective Disorder
- Substance Use Disorder or Addiction

**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  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 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

### 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: \_\_\_\_\_



c. Feeling nervous, anxious or on edge

Reference #:

- |  |  |
|--|--|
| <input type="radio"/> Not at all           | <input type="radio"/> Several days     |
| <input type="radio"/> More than ½ the days | <input type="radio"/> Nearly every day |
| <input type="radio"/> I don't know         | <input type="radio"/> Declined         |

d. Not being able to stop or control worrying

- |  |  |
|--|--|
| <input type="radio"/> Not at all           | <input type="radio"/> Several days     |
| <input type="radio"/> More than ½ the days | <input type="radio"/> Nearly every day |
| <input type="radio"/> I don't know         | <input type="radio"/> 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)?

- |  |  |
|--|--|
| <input type="radio"/> Yes                          | <input type="radio"/> No, I quit within the last 6 months    |
| <input type="radio"/> No, I quit over 6 months ago | <input type="radio"/> No, I have never used tobacco products |
| <input type="radio"/> I don't know                 | <input type="radio"/> 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.