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 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 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?
**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?

- MM
- DD
- YYYY
- I don’t know

**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):

- 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
- 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
- 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
- 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
- Making decisions about your health or well-being
- Listening or speaking
- Self-Care (bathing, grooming, eating)
- Living on your own
- 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
- Phone
- Utilities
- Prescription drugs or medicine
- Clothing
- Health care (doctor appointment, mental health services, addiction treatment)
- Child care
- 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 do not have a job and am 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 have never used tobacco products
- [ ] 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

References:

Magellan Complete Care of Virginia  3829 Gaskins Road, Richmond VA 23233  Toll-Free 1-800-424-4518 (TTY 711)  Online www.MCCofVA.com
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? ____________ ____________ ____________ ____________

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.