CARE NEEDS SCREENING FOR ADULTS 18 AND OLDER

revere health choice MASSACHUSETTS

We want to get to know you so we can support you.
One way we can do this is by using your answers to the questions below.

Please return this completed survey in the self-addressed, postage paid envelope, submit by fax to 781-493-7909 or email to contactcenter.mail@reveremedical.com.

To complete this survey by telephone, or if you have questions please call:
1-844-457-8945 Monday - Friday, 8:00am - 5:00pm EST.

Para completar esta encuesta en ESPAÑOL, por favor Harne al: 1-844-457-8945.

Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____
Month Day Year

Are you completing this survey on behalf of the Member?
☐ Yes, I am answering on the Member's behalf. ☐ No, I am the Member.

If Yes, what is your relation to the Member? ☐ Parent ☐ Spouse
☐ Legal Guardian ☐ Paid Caregiver ☐ Unpaid Caregiver ☐ Other

Name of the person completing this survey on behalf of the Member:
_____

Home Phone: _____

Cell Phone: _____

Email Address: _____

What is your Revere Health Choice Identification Number?
It is located on the Revere Health Choice Member ID card mailed to you.

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

These questions help us make sure every patient receives the best possible care, and by knowing more about you, we will be able to do things like make sure information is sent in the right languages for you, and that the right services are available, and it helps us better serve other patients too. It is your choice if you do not want to answer any of these questions you can go on to the next one. The responses to these questions will be kept private, just like all of your other health information.

How would you describe your race? ***Choose all that would apply***

☐ Asian ☐ Black or African American ☐ White-Caucasian ☐ American Indian or Alaska Native ☐ Native
☐ Hawaiian or Other Pacific Islander ☐ I am not sure/don't know ☐ I choose not to answer
☐ Other, please describe: _____

Are you Hispanic or Latino origin or descent? ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ I choose not to answer ☐ I am not sure/don't know.

Which best describes your ethnicity*?* *Choose all that apply.*

☐ African	☐ African American	☐ Asian Indian	☐ American	☐ Asian Indian
☐ Brazilian	☐ Cambodian	☐ Cape Verdean	☐ Caribbean Islander	☐ Central American
☐ Chinese	☐ Colombian	☐ Cuban	☐ Dominican	☐ Eastern European
☐ European	☐ Filipino	☐ Guatemalan	☐ Haitian	☐ Honduran
☐ Japanese	☐ Korean	☐ Laotia n/Lao	☐ Mexican	☐ Middle Eastern or North African
☐ Portuguese	☐ Puerto Rican	☐ Russian	☐ Other, please describe: _____	

What language do you prefer to speak in? ☐ English ☐ Spanish ☐ Portuguese ☐ Cantonese
☐ Mandarin ☐ Haitian Sign Language, such as ASL ☐ French ☐ Vietnamese ☐ Russian ☐ Arabic
☐ Other, I choose not to answer ☐ I am not sure/don't know *If Other, please describe:* _____

What was your sex assigned at Birth? ☐ Male ☐ Female ☐ Unknown ☐ I choose not to answer

How would you describe your gender identity? ☐ Male ☐ Female ☐ Female-to Male (FTM)/Transgender
☐ Male/Trans Man ☐ Male-to Female (MTF)/Transgender ☐ Female/Trans Woman
☐ Genderqueer, neither exclusively male nor female ☐ Additional gender category or other ☐ I choose not to answer

Additional gender category or other, please describe: _____

What are your preferred Pronouns? ☐ She/Her ☐ He/His ☐ They/Their ☐ Ze/Zir ☐ I choose not to answer
Something else, please describe: _____

What is your sexual orientation? ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual
☐ I choose not to answer ☐ I am not sure/don't know *Something else, please describe:* _____

Do you need help to read or write in English? ☐ Yes ☐ No

Do you have any religious/spiritual/cultural practices that you would like us to know about?
☐ Yes ☐ No *If yes, please describe:* _____

Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■

In general, how would you rate your overall health (physical and mental health)?

☐ Very Good ☐ Good ☐ Poor

Describe overall health (Physical and mental health): _____

_____

Please describe your current health conditions (physical and mental health)? *Please select all that apply:*

☐ Breathing problems	☐ Cancer	☐ Diabetes	☐ Heart problems
☐ Stroke	☐ Seizures	☐ Kidney problems	☐ Bowel problems
☐ Bone problems	☐ ADHD	☐ Anxiety	☐ Bipolar
☐ Depression	☐ OCD	☐ Schizophrenia	☐ Substance Use
☐ Thoughts of hurting yourself	☐ Trauma	☐ Vision problems	☐ Hearing problems
☐ Thoughts of hurting others	☐ Development issues	☐ High blood pressure	☐ Other

Please describe your past health history (physical and mental health): _____

_____

Please list the medications you are currently taking (include prescriptions, OTC, supplements, etc.) :

_____

_____

Do your take the medications as prescribed by your provider (i.e..Missing a dose or doubling up?)

☐ Yes ☐ No ☐ Sometimes ☐ Declines response

What are the reasons you do not take your medications as prescribed by your provider?

☐ Cannot afford all of my medications ☐ Cannot get to the pharmacy to get my medications

☐ Do not understand medications ☐ Forget to take my medications ☐ Too many pills to take

☐ Too many side effects ☐ Other ☐ Declines response

How do you manage your medications (pill box, someone else helps, pill dispenser)? _____

_____

Do you have any questions about your medications (i.e., Side effects, affordability)?

☐ Yes ☐ No ☐ Unknown

Are you currently receiving services from any of these state agencies? *Please select all that apply:*

☐ Department of Developmental Services (DDS)
☐ Executive office of Elder Affairs (EoEA)
☐ Department of Mental Health (DMH)
☐ Bureau of Substance Abuse Services (BSAS)
☐ Massachusetts Commission for the Blind (MCB)
☐ Massachusetts Commission for the Deaf and Hard of Hearing (BLIND)
☐ Department of Transitional Assistance (DTA)
☐ Massachusetts Rehabilitation Commission (MRC)
☐ Department of Children and Families (DCF)
☐ None of the above

Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■

Are you currently receiving any of these services? ***Please select all that apply***

- ☐ Adult Day Health Services
- ☐ Adult Foster Care Services
- ☐ Continuous Skilled Nursing Services/Private Duty or Independent Nurse Services (services more than 100 days)
- ☐ Day Habilitation Services
- ☐ Group Adult Foster Care Services
- ☐ Nursing Facility Services (services more than 100 days)
- ☐ Inpatient and outpatient Chronic Disease Rehabilitation
- ☐ Hospital Services (services more than 100 days)
- ☐ Home based lab Services
- ☐ Live-in Caregiver
- ☐ Medication Management
- ☐ Palliative Care
- ☐ Respite Care
- ☐ Telemonitoring
- ☐ Transportation Services
- ☐ None of these services
- ☐ Personal Care Attendant Services
- ☐ Home Health
- ☐ Meals
- ☐ Mental Health
- ☐ Personal Care Attendant
- ☐ Social Work
- ☐ Therapies (PT, ST, OT)
- ☐ Visiting MD/NP
- ☐ Homemaker
- ☐ Lifeline
- ☐ VNA
- ☐ Other, please specify:_____

In the past 6 months have you been admitted to the hospital 2 or more times or been to the Emergency Room 3 or more times?

☐ Yes ☐ No ☐ Unsure

Do you have a primary doctor/physician?

☐ Yes ☐ No ☐ Unsure

Which statement best describes your current level of activity?

- ☐ I do not do physical activity and do not want to.
- ☐ I do not do physical activity and would like to be more active.
- ☐ I do physical activity.

Do you need someone to help with one (1) or more of the following (ADLs): Bathing, Eating, Dressing, Walking or using the Bathroom?

- ☐ No, I do not need help
- ☐ Yes, I need help and I have all the help I need
- ☐ I need help with bathing
- ☐ I need help with eating
- ☐ I need help with dressing
- ☐ I need help with walking
- ☐ I need help with toileting

Do you need someone to help with one (1) or more of the following (IADLs): Shopping, Cooking, Housework, Laundry, Driving, Managing Finances?

- ☐ No, I do not need help
- ☐ Yes, I need help and I have all the help I need
- ☐ No need help with shopping
- ☐ Need help with cooking
- ☐ Need help with housework
- ☐ Need help with laundry
- ☐ Need help with managing finances
- ☐ Need help with transportation

Which statement best describes your medical equipment needs?

- ☐ Yes, I have all the equipment I need
- ☐ No, I do not have all the equipment I need
- ☐ Unsure

Describe equipment needs/status:_____

Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■

Are you currently experiencing pain?
☐ Yes ☐ No

Have you experienced pain in the past few months?
☐ Yes ☐ No

Describe the pain (frequency, intensity, type, duration, what causes and relieves pain, any limitation pain causes) _____

Do you follow a prescribed diet?
☐ Yes ☐ No ☐ Unsure

Have you experienced weight gain or loss in the past 6 months?
☐ Unintentional Weight Gain ☐ Unintentional Weight Loss
☐ Intentional Weight Gain ☐ Intentional Weight Loss ☐ No Change

Are you interested in assistance managing your weight/diet?
☐ Yes ☐ No ☐ Unsure

Details (i.e., following a prescribed diet, weight management: _____
_____

How would you describe your oral health including your mouth, teeth/false teeth, and dentures?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Describe your oral health: _____

For females only, are you currently pregnant or have you been pregnant in the last 12 months?
☐ Currently Pregnant ☐ Pregnant in the last 12 months
☐ No ☐ N/A
If pregnant, are you receiving prenatal care? ☐ Yes ☐ No

What is your current work status?
☐ Out of work and seeking work ☐ Out of work and no longer looking due to obstacles
☐ Part-time or temporary work (and seeking work) ☐ Part-time or temporary work (and satisfied)
☐ Full-time work ☐ Out of work by choice (student, retired, disabled, fulltime parent)

Have you ever experienced any of the following barriers to employment? Select all that apply.
☐ Criminal Record ☐ Lack of Training ☐ Lack of Childcare
☐ Medical/Physical Health Issues ☐ Mental Health Issues ☐ None of the Above

Tell us about your housing.
☐ Do not have housing (Staying with others. Staying in a hotel. Staying in a shelter. Living outside on the street. Living on a beach. Living in a car. Living in a vacant building. Living in a bus or train station. Living in a park.)
☐ Have housing today, but worried about losing it in the future.
☐ I Have housing.

Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■

If you do not have housing, what is your housing situation today? *Please Select all that apply*

☐ Staying with others ☐ Hotel ☐ Shelter ☐ Skilled Nursing Facility
☐ Living outside on the street ☐ Living on a beach ☐ Living in a park
☐ Living in an abandoned building ☐ Living in a bus or train station ☐ Other

Have you moved three (3) or more times within the past year? ☐ Yes ☐ No

Think about the place you live. Do you have problems with any of the following? *check all that apply*

☐ Infestation (bugs, mice, rats, etc.) ☐ Mold ☐ Lead paint or pipes
☐ Inadequate heat ☐ Oven or stove not working ☐ Water leaks
☐ Cigarette Smoke ☐ None of the above

Are you receiving housing assistance?

☐ Yes ☐ No ☐ No, but interested in applying
☐ Interested in assistance-Already applying/applied ☐ N/A

Do you have enough money to pay for housing? ☐ Yes ☐ No ☐ Not always ☐ Unsure

Are you up to date with your rent or mortgage? ☐ Yes ☐ No ☐ N/A

If no, are you being evicted or have you received a 14-day notice to quit? ☐ Yes ☐ No ☐ N/A

In the past 12 months, have you had difficulty accessing medical, behavioral health or social services? ☐ Yes ☐ No

If yes, please specify: _____

Has Transportation been a barrier for you in meeting their needs? (i.e., school, medical appts., grocery stores) ☐ Yes ☐ No

In the past 12 months, did not have a ride cause you to miss a health care visit(s)? ☐ Yes ☐ No ☐ Sometimes

If yes, please specify: _____

In the past 12 months, did not have a ride cause you to miss school, meeting or other things needed for daily living?

☐ Yes ☐ No ☐ Sometimes

In the past 12 months, how often have you eaten smaller meals or skipped meals because you did not have enough food?

☐ Never ☐ Sometimes ☐ Often ☐ Very Often

Within the past 12 months, how often have you worried your food would run out before you could buy more?

☐ Never ☐ Sometimes ☐ Often ☐ Very Often

Do you receive food assistance? ☐ Yes ☐ No ☐ No, but interested in applying ☐ N/A

Do you have trouble affording any of the following in general? *Please select all that apply*

☐ Clothing ☐ Utilities ☐ Medical Supplies ☐ Child Care ☐ Child Supplies
☐ Other ☐ None of the above ☐ Decline to answer

In the past 12 months, have any utility firms/companies said they would shut off services in your home? This could be electric, gas, oil, or water.

☐ Yes ☐ No ☐ Already shut off ☐ N/A

Please mark your survey responses, using a blue or black pen, with an X, keeping the X inside the box as much as possible. EXAMPLE: Correct ☒ Not Correct ■

In the past 12 months, did you receive fuel assistance?

☐ Yes ☐ No ☐ No, but interested in applying ☐ N/A

What is your source of income?

☐ Employment ☐ Unemployment ☐ No income
☐ Social Security ☐ Retirement/pension ☐ SSI
☐ SSDI ☐ TAFDC (or cash assistance) ☐ EAEDC (or cash assistance)
☐ Child support ☐ Other

If other, please specify (other assistance): _____

Are you interested in applying for financial assistance? ☐ Yes ☐ No

Other Social Determinants of Health Comments (including who contact for any SDOH concerns mentioned above): _____

Do you have any history or current involvement with the legal system and/or legal concerns?

☐ Yes ☐ No ☐ Unsure ☐ Declined to answer

Legal Comments (legal involvement, ever been incarcerated, custody agreement, etc)

_____

Do you see a behavioral health provider? (psychologist, therapist, psychiatrist, counselor)

☐ Yes ☐ No ☐ Unsure

In the past two (2) weeks, how often have you…	Not at All	Several days	More than half (1/2) the days	Nearly every day
Felt nervous, anxious, or on the edge	☐	☐	☐	☐
Not been able to stop worrying or control your worrying	☐	☐	☐	☐
Felt down, depressed, or hopeless	☐	☐	☐	☐
Felt little interest or pleasure in doing things?	☐	☐	☐	☐

Have you ever taken any of the following? Select all that apply.

☐ Alcohol ☐ Amphetamines ☐ Cocaine/Crack ☐ Heroin
☐ Marijuana/Hash ☐ Meth/Crystal Meth ☐ Opiates/Painkillers ☐ Not used any of these substances
☐ Tobacco ☐ LSD/Acid ☐ Other, Please Specify: _____

In the last 7 days have you taken any of the following? Select all that apply.

☐ Alcohol ☐ Amphetamines ☐ Cocaine/Crack ☐ Heroin
☐ Marijuana/Hash ☐ Meth/Crystal Meth ☐ Opiates/Painkillers ☐ Not used any of these substances
☐ Tobacco ☐ LSD/Acid ☐ Other, Please Specify: _____

Would you like help to decrease or stop taking anything listed above?

☐ Yes ☐ No ☐ Unsure ☐ N/A ☐ Decline to answer

Is there something or someone in your home or community that make(s) you feel unsafe?

☐ Yes ☐ No ☐ Unsure

Thank you for taking the time to complete this survey!
Your answers will help us make a better health plan so you can access things like wellness programs, support and services that you may need.