Fallon Health
Care Needs Screening Form

PLEASE DO NOT FOLD.

Please take a few minutes to complete this screening. Your Care Needs Screening will help Fallon Health provide better health services and coordinate the care you receive. We will keep the information you provide private. By submitting this form, you are giving us permission to share your information with the people involved in your care. **Your answers will NOT affect your MassHealth/Medicaid benefits.**

Please note that this screening tool does NOT take the place of a medical evaluation with your Primary Care Provider. If you have any urgent medical or behavioral health needs, please schedule an appointment with your Primary Care Provider, or go to your nearest emergency care center.

Survey instructions

1. Please fill out one screening form for each new member.

2. You will need to have on hand:
    a. Your plan member ID number
    b. The name, phone number and address of your doctor or nurse

3. Answer each of the questions by checking the appropriate box or filling in the space provided.

4. You are sometimes told to skip over some questions in this survey. When this happens, you will see a note that tells you what question to answer next.

5. This screening will take about 15 minutes to complete.

6. If you need help or have questions about completing this form, please call Customer Service at the number on the back of your member ID card, Monday through Friday from 8 a.m. to 6 p.m.

fallonhealth
Fallon 365 Care

General member information

Q1 NAME

Last Name:_____

First Name:_____ MI:_____

Q2 ID NUMBER

Fallon MassHealth ID number:_____

Q3 BIRTHDATE

(*example: 04/11/2002*):_____

Q4 ADDRESS

Apartment/house number and street name:_____

City/Town:_____ State:_____ ZIP code:_____

Q5 PHONE

Phone (*example: (999) 999-9999*):_____Cell:_____

Q6 EMAIL

Email:_____

Q7a SEX AT BIRTH

Please indicate your sex at birth:

Male	
Female	
Intersex	
Unspecified	
Not listed (*please specify below*)	

The following questions ask about the member's pronouns, gender identity, and sexual orientation.

Q7b PRONOUNS

Please indicate your pronouns:

He/Him/His	
She/Her/Hers	
They/Them/Their	
Other (*please specify below*)	

Q8a GENDER IDENTITY

Please indicate your gender identity (*check all that apply*):

Male	
Female	
Gender queer/gender nonconforming; neither exclusively male nor female	
Transgender male/Trans man	
Transgender female/Trans woman	
I do not know/I am not sure	
I choose not to answer	
My gender is not listed (*please specify below*)	

Q8b SEXUAL ORIENTATION

Please indicate your sexual orientation (*check all that apply*):

Bisexual	
Straight or heterosexual	
Lesbian or homosexual	
Queer, pansexual, and/or questioning	
I do not know/I am not sure	
I choose not to answer	
My sexual orientation is not listed (*please specify below*)	

Q8a RACE

How would you describe your race? *Please check all that apply.*

American Indian/Alaskan Native	
Asian	
Black/African American	
Native Hawaiian/Pacific Islander	
White	
I do not know/I am not sure	
I choose not to answer	
My race is not listed (*please specify below*)	

Q8b RACE

Are you of Hispanic or Latino origin or descent?

Hispanic or Latino	
Not Hispanic or Latino	
I do not know/I am not sure	
I choose not to answer	

Q8c ETHNICITY

How would you describe your ethnic background? You may choose up to 2 options. For example, "American" or "Mexican", or "Cuban" and Puerto Rican". *Please check all that apply.*

African	
African American	
American	
Asian	
Asian Indian	
Brazilian	
Cambodian	
Cape Verdean	
Caribbean Island	
Central American (*not otherwise specified*)	

Chicano	
Chinese	
Columbian	
Cuban	
Dominican	
Eastern European	
Filipino	
Guatemalan	
Honduran	
Japanese	
Korean	
Laotian	
Mexican	
Mexican American	
Middle Eastern	
Portuguese	
Puerto Rican	
Salvadoran	
South American (*not otherwise specified*)	
Vietnamese	
I do not know/I am not sure	
I choose not to answer	
My ethnicity is not listed (*please specify below*)	

Q9 RELATIONSHIP

Relationship (to member) of person completing this form?

Self	
Parent	
Spouse/Partner	
Family/Relative	
Professional caregiver	

Authorized representative	

Q10 LANGUAGE

Preferred language spoken:

English	
Spanish	
Portuguese	
Chinese	
Haitian	
American Sign Language (ASL)	
French	
Vietnamese	
Russian	
Arabic	
I choose not to answer	
I am not sure/I do not know	
My language is not listed (*please specify below*)	

Q11 HEARING

Do you have hearing needs?

Yes		No	

Q12 HEARING

What is your preferred method of communication?

American Sign Language (ASL) interpreter	
Listening device	
Communication Access Real-Time Translations	
Text Telephone (TTY)	
Other (*please specify below*)	

Q13a VISION

Are you visually impaired?

Yes		No	

Do you require materials to be available in large print?

Yes		No	

Do you require materials to be available in Braille?

Yes		No	

Do you require materials to be available on audio CD?

Yes		No	

Q13b READING

What language do you feel most comfortable when reading medical or health care instructions?

English	
Spanish	
Vietnamese	
Portuguese	
Khmer	
Chinese	
Haitian/Creole	
Albanian	
Other (*please specify below*)	

Q14 STATE AGENCIES

Do you currently receive any services from state agencies?

Yes		No		Not sure	

Q15 STATE AGENCIES

If you answered yes above, please check all that apply:

Massachusetts Commission for the Blind	
Massachusetts Commission for the Deaf and Hard of Hearing	
Massachusetts Rehabilitation Commission	
Department of Mental Health	
Department of Developmental Services	
Division of Children and Families	
Special Education	
Department of Public Health	
Executive Office of Elder Affairs	
Bureau of Addiction Services	
CARES for Kids	
Justice Involvement	
Other (please specify below)	

Q16a LTSS AGENCY

Do you currently get services from a Long-Term Service and Support (LTSS) agency?

Yes		No		Not sure	

Q16b LTSS PROGRAM

If yes, what is the name of the agency?

What services do you currently receive, and how many hours per week for each service?

Service	Hours/ week

Are these services in your home or outside of the home?

In home	
Outside the home	
Both: In home and outside the home	

Are you receiving another service?

Yes		No	

Q17 YOUR HEALTH

How would you describe your health now?

Excellent	
Good	
Fair	
Poor	
I choose not to answer	

Q18 COMPLETING TASKS

Do you have any trouble completing any of the following tasks because of your health?
Please check all that apply.

Walking	
Eating	
Bathing/showering/grooming	
Bowel/bladder control	
Shopping	
Getting and/or taking medications prescribed	
Preparing meals	

Q19 PREGNANCY

Are you currently pregnant?

Yes		No		Not sure	

What is your due date?

_____/_____/_____

Q20 PREGNANCY CARE

Do you have an OB/GYN doctor, nurse, or midwife who is providing care during this pregnancy?

Yes		No		Not sure	

What is the name, address, and phone number of the provider?

Name:
Address:
Phone:

Q21 PREGNANCY CONCERNS

Do you have any concerns about your pregnancy?

Yes		No		Not sure	

Q22 PRENATAL CARE

Would you like to speak to a prenatal care manager?

Yes		No		Not sure	

Q22a DELIVERY

Have you delivered a child during the past 12 months?

Yes		No		I choose not to answer	

Would you like to speak with a case manager for assistance?

Yes		No		Not sure	

Q23a ER CARE

In the last 12 months, did you get care in an emergency room?

Yes		No		Not sure	

Q23b ER CARE

If you answered yes to question 23a, how many times?

1-3 times	
4-6 times	
More than 6 times	

Q24a HOSPITAL STAYS

In the last 12 months, have you stayed overnight in a hospital?

Yes		No		Not sure	

Q24b HOSPITAL STAYS

If you answered yes to question 24a, how many times?

1-2 times	
3-4 times	
More than 5 times	

Your health needs

Please select your age group

0-18 years		19-64 years	

Q25a CHRONIC ILLNESSES

Do you have any of the following chronic illnesses?

Heart disease	
COPD	
Asthma	
Diabetes	

Are you getting treatment for heart disease?

Yes		No	

Are you getting treatment for COPD?

Yes		No	

Are you getting treatment for asthma?

Yes		No	

Are you getting treatment for diabetes?

Yes		No	

Q26a PROVIDERS

Do you have a PCP or nurse practitioner (provider) who you go to for your health care needs?

Yes		No		Not sure	

What is the name, address, and phone number of the provider?

Name:
Address:
Phone:

Do you have a specialist who you usually go to for health care needs?

Yes		No		Not sure	

What is the name, address, and phone number of the provider?

Name:
Address:
Phone:

Do you have a mental health provider who you usually go to for health care needs?

Yes		No		Not sure	

What is the name, address, and phone number of the provider?

Name:
Address:
Phone:

Q27a BEHAVIORAL HEALTH CONCERNS

Do you have any concerns about your emotional or behavioral health that you would like to speak to someone about?

Yes		No		I choose not to answer	

Q28 SUBSTANCE CONCERNS

Do you have any concerns about your alcohol or drug use that you would like to speak to someone about?

Yes		No		I choose not to answer	

Q29 FEELING ISOLATED

How often do you feel lonely and isolated from those around you?

Never	
Rarely	
Sometimes	
Always	
I choose not to answer	

Q30a MEDICAL EQUIPMENT

Do you currently have any medical equipment for your day-to-day needs?

Yes		No		I choose not to answer	

Q30b MEDICAL EQUIPMENT

Do you need any help with your medical equipment that you use for your daily needs?

Yes		No		I choose not to answer	

Q30c MEDICAL EQUIPMENT

If you answered yes, please check all the equipment you need help with:

Wheelchair	
Walker	
CPAP	
Nebulizer	
Other (*please specify below*):	

Q31a TRANSPORTATION

In the past 12 months, has the lack of transportation kept you from getting to medical appointments and/or medication pick up?

Yes		No		I choose not to answer	

Q31b TRANSPORTATION

In the past 12 months, has the lack of transportation kept you from meetings, work, or from getting things needed for daily living?

Yes		No		I choose not to answer	

Q32 FEELING SAFE

Do you feel physically and emotionally safe where you currently live?

Yes, I do feel safe	
No, I do not feel safe	
I choose not to answer this question	

Q33 WORK SITUATION

What is your current work situation?

Unemployed	
Part-time or temporary work	
Full-time work	
Unemployed, but not seeking work (*e.g., student, retired, disabled, unpaid primary caregiver*)	
I choose not to answer	

For questions 34a and 34b, please indicate whether the statements that people have made about their food situation are often true, sometimes true, or never true for you or your household in the last 12 months.

Q34a FOOD SECURITY

In the last 12 months, the food that you bought just didn't last, and you didn't have money to get more. Was that often, sometimes, or never true for you or your household?

Often true	
Sometimes true	
Never true	
Unsure or refused	

Q34b FOOD SECURITY

In the last 12 months, you couldn't afford to eat balanced meals. Was that often true, sometimes true, or never true for you or your household?

Often true	
Sometimes true	
Never true	
Unsure or refused	

Q34c FOOD SECURITY

In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?

Yes		No		Not sure	

Q34d FOOD SECURITY

How often did this happen—almost every month, some months, but not every month, or in only 1 or 2 months?

Almost every month	
Some months, but not every month	
Only 1 or 2 months	
Not sure	

Q34e FOOD SECURITY

In the last 12 months, did you ever eat less than you should because there wasn't enough money for food?

Yes		No		Not sure	

Q34f FOOD SECURITY

In the last 12 months, were you ever hungry, but didn't eat because there wasn't enough money for food?

Yes		No		Not sure	

Q35a HOUSING

What is your current housing situation?

I have housing	
I do not have housing (*staying with others, a hotel, shelter, on the street, beach, car or park*)	
I choose not to answer	

Q35b HOUSING

Are you worried about losing your housing?

Yes		No		I choose not to answer	

Q36 HOUSING

Do you have any of the following problems? *Please check all that apply.*

Pests, such as bugs, ants, or mice	
Mold	
Lack of heat	
Oven or stove not working	

Smoke detectors missing or not working	
I choose not to answer	

Q37 AREAS OF CONCERN

In the past 12 months, have you been worried about any of the following issues?
Please check all that apply.

Finances (money)	
Heating and electricity	
Clothing	
Internet	
I choose not to answer	
Other (*please specify below*)	

Q38a TOBACCO

Do you use tobacco products?

Yes	
No	
Not sure	
I choose not to answer	

Q38b TOBACCO

Are you interested in quitting tobacco use in the next month?

Yes	
No	
Not sure	
I choose not to answer	

Q38c TOBACCO

Would you like information about quitting smoking or using tobacco products, and would you like to learn more about our Quit to Win program?

Yes		No	

Q39 PERSONAL GOALS

Do you have any personal goals?

Yes	
No	
Not sure	
I choose not to answer	

Q40 HEALTH GOALS

Do you have any health goals?

Yes	
No	
Not sure	
I choose not to answer	

Q41 YOUR CHILD'S BEHAVIORAL HEALTH

Is your child being treated for any of the following behavioral health conditions?

Adjustment disorder	
Anxiety disorder	
Attention deficit disorder	
Autism spectrum	
Conduct disorder	
Depression	
Learning disorder	
Substance abuse disorder	
I choose not to answer	
Other (*please specify below*):	

Q42 YOUR CHILD'S MEDICAL CONDITIONS

Does your child have any of the following medical conditions?

Asthma	
Obesity	
Diabetes	
Seizure disorders	

Is your child getting treatment for asthma?

Yes		No	

Is your child getting treatment for obesity?

Yes		No	

Is your child getting treatment for diabetes?

Yes		No	

Is your child getting treatment for seizure disorders?

Yes		No	

Q43 YOUR CHILD'S IMMUNIZATIONS

Are your child's immunizations up to date?

Yes		No		I choose not to answer	

Q44 YOUR CHILD'S RESIDENCE

Who does your child live with in their primary residence? *Please list everyone in the household.*

Q45 YOUR CHILD'S HEALTH

Does your child have any learning, developmental, or speech conditions that you would like to speak with someone about?

Yes	
No	
Not sure	
I choose not to answer	

Q45b SUPPORT FOR YOUR CHILD

Would you like information about school-related resources, or additional community support?

Yes	
No	
Not sure	
I choose not to answer	

Is your child on a current 504 or IEP plan, or receiving specialized services with their school?

Yes	
No	
Not sure	
I choose not to answer	

Do you need help coordinating services with the school, or other community supports?

Yes	
No	
Not sure	
I choose not to answer	

Q46 YOUR CHILD'S BEHAVIORAL HEALTH

Do you need assistance with getting help for your child with their emotional, behavioral, or substance-related issues?

Yes	
No	
Not sure	
I choose not to answer	

Q47 YOUR CHILD'S SUBSTANCE USE

Do you need assistance with getting help for your child with their alcohol or drug use issues?

Yes	
No	
Not sure	
I choose not to answer	

Thank you!

Thank you for taking the time to fill out the Care Needs Screening Form.

Fallon 365 Care will review your responses to determine if there are care management programs, educational materials, or other resources that you may find helpful.

If you have any questions about this screening, please call Customer Service at the number on the back of your member ID card, Monday through Friday from 8 a.m. to 6 p.m.

You can get this document for free in other formats, such as large prints, braille, or audio. Call 1-855-508-3390 (TRS 711), Monday–Friday, 8 a.m.–6 p.m. The call is free.

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