Driscoll Health Plan

Adult Health Plan Needs Assessment

Date: _____

Member Name: _____ **If Child: Parent(s)/Guardian:** _____

Member ID or SSN: _____ **Date of Birth:** _____ **Age:** _____

Member Address: _____

Member Phone Number: _____ **PCP Name:** _____

*** Complete for all Driscoll Health Plan Members. ***

1. How is the member's overall health? Excellent Good Poor Very Poor
   Please list POOR or VERY POOR conditions below:

_____

_____

2. Does the member need special equipment to walk, talk, hear, breathe, or feed? YES NO
   If YES, what equipment?

_____

3. Is your family involved in traveling for farm work? YES NO
   If YES, where does your family travel to?

_____

4. Does the member have a poor or very poor health condition? YES NO
   If POOR or VERY POOR, please list the conditions below:

_____

_____

5. Does the member have any of the following health problems?

____ Heart ____ Diabetes ____ Cystic Fibrosis ____ Depression

____ Cancer ____ Kidney ____ HIV/AIDS ____ Eating Disorders

____ Bleeding ____ COPD ____ Mental Health ____ Substance Misuse

If yes, list other problems:

_____

_____

6. Has the member had 3 Emergency Room visits or 1 admission for diabetes in the past 90 days? YES NO

Center for Disease Control and Prevention, (2011) A Framework for Patient-Centered Health Risk Assessments: Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries https://www.cdc.gov/policy/hst/hra/FrameworkForHRA.pdf

The Accountable Health Communities Health-Related Social Needs Screening Tool https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

7. Has the member had 3 Emergency Room visits or 1 admission for asthma in the past 90 days? YES NO

8. Is the member pregnant? YES NO If YES, continue.

Living Situation

1. What is your living situation today? Rent Own Live with a relative/friend

2. Where you live, do you have any problems such as pests, mold, leaks, etc.? YES NO
   If YES, please list problem(s):

_____

Food

1. In the past 12 months, did you worry that your food would run out before you got money to buy more?
   Often true Sometimes true Never true

2. In the past 12 months, did the food you bought not last and you did not have money to get more?
   Often true Sometimes true Never true

Transportation

1. In the past 12 months, has lack of reliable transportation kept you from a medical appointment, meetings, work, or from getting things needed for daily living? YES NO
   If YES, please list:

_____

Utilities

1. In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home? YES NO Already Shut Off

Safety

1. How often does anyone, including family and friends, physically hurt you?
   Never Rarely Sometimes Fairly Often Frequently

2. How often does anyone, including family and friends, insult or talk down to you?
   Never Rarely Sometimes Fairly Often Frequently

3. How often does anyone, including family and friends, threaten you with harm?
   Never Rarely Sometimes Fairly Often Frequently

4. How often does anyone, including family and friends, scream or curse at you?
   Never Rarely Sometimes Fairly Often Frequently

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The Accountable Health Communities Health-Related Social Needs Screening Tool https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf