Assessment Date: ________________________

Child's Name: ____

HID: ___________________________________	Medicaid ID: ______________________________

Child's Date of Birth: __________________________ (mm/dd/yyyy)

Gender at birth: ☐ Male ☐ Female ☐ I prefer not to say

Which of the following most accurately describes you now?

☐ Male ☐ Female ☐ Non-binary ☐ Transgender

☐ Intersex ☐ Other ☐ I prefer not to say

Race/Ethnicity:

☐ American Indian and Alaska Native, non-Hispanic

☐ Asian, non-Hispanic

☐ Black or African American, non-Hispanic

☐ Hispanic

☐ Native Hawaiian and Other Pacific Islander, non-Hispanic

☐ White, non-Hispanic

☐ Multiracial non-Hispanic

☐ Other race, non-Hispanic

Address: ____

Home Phone Number: ____________________	Cell Phone Number: _____________________

Email: ____

My preferred method of contact is: ____

Name of legal guardian(s): ____

How is the child related to you? I am the:

☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Legal Guardian

☐ Other, explain: ____

What language does the child speak at home?

☐ English ☐ Spanish ☐ Other: ____

Child's primary care doctor:	Last seen:
Child's dentist:	Last seen:
Child's eye doctor:	Last seen:

06.03.2022

Do you feel like you have problems getting care for your child? ☐ Yes ☐ No

Explain: ____________________

Is the child up to date on immunizations? ☐ Yes ☐ No ☐ I don't know

How would you rate the child's general physical health?

☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

How would you rate the child's general mental health?

☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

Has a doctor told you the child has any of these problems?

☐ Asthma/Allergies	☐ Cystic Fibrosis	☐ High Blood Pressure
☐ Large Heart/Heart Issue	☐ Liver Problems	☐ Kidney Problems
☐ Birth Defect (problem present at birth)	☐ History of Extreme Prematurity (delivered before 28 weeks of gestation)	☐ Cancer (in active treatment)
☐ Diabetes	☐ Blood Disorder (anemia/ sickle cell/ hemophilia)	☐ Seizures/Epilepsy
☐ Paralysis	☐ HIV/AIDS	☐ Pain (requiring pain management)
☐ Hearing Problem	☐ Vision Problem	☐ Growth Delay
☐ Developmental Delay	☐ ADHD/ADD	☐ Autism Spectrum
☐ Eating Disorder	☐ Depression Bipolar Disorder	☐ Schizophrenia
☐ Stress	☐ Substance Use/ Substance Overdose	☐ My child does not have any of these problems

If you identified that your child has a problem or problems (above) would you like a nurse to contact you to help you understand this condition, manage symptoms of this condition, or access more care for this condition?

☐ Yes ☐ No ☐ Not applicable

Is the child pregnant? ☐ Yes, due date: ____________ ☐ No ☐ Not applicable

Has the child been hospitalized (medical or mental hospital) in the last 6 months?

☐ Yes ☐ No If yes, explain: ____________________

How many times has the child been taken to the emergency department in the last 6 months?

☐ None ☐ Once or Twice ☐ Three Times or More

Does the child take medicine? ☐ Yes ☐ No

Do you understand the child's medicine(s)? ☐ Yes ☐ No

Does the child need an urgent refill for a medical or mental health medication? ☐ Yes ☐ No

Does the child receive any of these services?		
☐ Speech Therapy	☐ Physical Therapy	☐ Occupational Therapy
☐ Respiratory Therapy	☐ Nursing Services	☐ Home Health Aide
☐ Socially Necessary Services	☐Waiver Services	☐ Individual Educational Plan/IEP
☐ Autism Services/ABA		

Does the child use medical equipment?	
☐ Wheelchair	☐ Oxygen
☐ Ventilator/CPAP/BiPAP	☐ Feeding pump/tube feeling supplies
☐ Special bed	☐ Insulin pump
☐ Hearing aid/cochlear implant	☐ Prosthetics/orthotics (artificial limbs/braces)

Question			
Does lack of money ever make it hard for you to pay home related bills like water or heating?	☐ Yes	☐ No	
Does lack of money ever make it hard to pay for medical, behavioral or dental expenses?	☐ Yes	☐ No	
Does the child have difficulty getting to doctor or dentist appointments due to a lack of reliable transportation?	☐ Yes	☐ No	
Does the child ever go hungry because there is not enough food in the home?	☐ Yes	☐ No	
Does the child have stable housing/a safe home? Explain: ______________________	☐ Yes	☐ No	
Has the child had physical or sexual abuse or has she/he been exposed to extreme violent behavior in her/his home?	☐ Yes	☐ No	
Does the child need counseling? Explain: ______________________	☐ Yes	☐ No	
Is the child potty trained?	☐ Yes	☐ No	☐ Not applicable due to age
Does the child go to school?	☐ Yes	☐ No	☐ Not applicable due to age
Has the doctor ever told you that the child needs to lose weight?	☐ Yes	☐ No	
Height: __________ feet __________ inches Weight: __________ pounds	☐ Unsure		
Is the child on a special diet?	☐ Yes	☐ No	
Does the child smoke?	☐ Yes	☐ No	
Does the family smoke in the home?	☐ Yes	☐ No	
Does the child use street drugs or alcohol?	☐ Yes	☐ No	
I would like for a nurse from The Health Plan to contact me for help with something not identified on this screening.	☐ Yes	☐ No	