

Health Risk Screening: Infant (Less than 6 Months)

Member Information

1. Preferred mailing address: _____
2. Preferred phone number: +__ (____) ____ - _____
3. Email address: _____

4. Race:

- | | |
|--|---|
| <input type="checkbox"/> American Indian / Alaska Native | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Black / African American | <input type="checkbox"/> Native Hawaiian / Other Pacific Islander |
| <input type="checkbox"/> White | <input type="checkbox"/> Other |
| <input type="checkbox"/> I prefer not to answer | <input type="checkbox"/> Unknown |

Please list other race: _____

Is your child Native American?

- ☐ Yes ☐ No ☐ I prefer not to answer ☐ Unknown

Is your child eligible to receive Indian Health Services?

- ☐ Yes ☐ No ☐ I prefer not to answer ☐ Unknown

5. Ethnicity:

- | | | |
|---|---|--------------------------------|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Other |
| <input type="checkbox"/> I prefer not to answer | <input type="checkbox"/> Unknown | |

Please list other ethnicity: _____

6. Preferred Language:

- ☐ English ☐ Spanish ☐ Other ☐ Unknown

Please list other preferred language: _____

7. Does your child have any problems with their hearing, vision, or speech requiring special services?

- ☐ Yes ☐ No ☐ I prefer not to answer ☐ Unknown

Please explain problems with hearing, vision, or speech: _____

8. Do you need interpretation services?

- ☐ Yes ☐ No ☐ I prefer not to answer ☐ Unknown

9. In what language do you prefer written materials?

- ☐ English ☐ Spanish ☐ I prefer not to answer ☐ Other

Please list other language for written materials: _____

10. How difficult is it for you to understand information that doctors, nurses, and other health professionals tell you? Would you say it is:

- ☐ Very Easy ☐ Somewhat Easy ☐ Somewhat difficult ☐ Very difficult

11. What gender was your child assigned at birth on their birth certificate?

- ☐ Male ☐ Female ☐ I prefer not to answer ☐ Unknown

12. How many family members, including yourself, do you currently live with?

Birth History

13. Was your child born by vaginal delivery or C-Section?

- ☐ Vaginal delivery ☐ C-section ☐ Unknown

14. Was your child born prior to 39 weeks gestation?

- ☐ Yes ☐ No ☐ Unknown

At what week of pregnancy was your child born?

- ☐ 38 weeks
☐ 37 weeks
☐ 36 weeks
☐ 35 weeks
☐ 34 weeks
☐ 33 weeks
☐ 32 weeks
☐ 31 weeks
☐ 30 weeks
☐ 29 weeks
☐ 28 weeks
☐ 27 weeks
☐ 26 weeks
☐ 25 weeks
☐ 24 weeks
☐ 23 weeks
☐ 22 weeks
☐ Unknown

15. In this pregnancy, were there any problems?

☐ Yes ☐ No ☐ Unknown

What problems occurred during this pregnancy? _____

16. In this pregnancy, did labor start on its own?

☐ Yes ☐ No ☐ Unknown

Why was the delivery induced early?

☐ Diabetes ☐ Inadequate growth of the baby ☐ Non-medical reason
☐ Other ☐ Placental abruption (separation) ☐ Preeclampsia/high blood pressure
☐ Premature rupture of membranes ☐ Scheduled C-section ☐ Unknown

What was the reason for the early delivery?

17. What was your child's birth weight? _____ lbs. _____ oz.

18. Did your child have to spend any extra time in the hospital after birth?

☐ Yes ☐ No ☐ Unknown

If yes, how much extra time did your child have to spend in the hospital after birth?

☐ Less than 1 week
☐ 2 weeks
☐ 3 weeks
☐ 4 weeks
☐ 5 weeks
☐ 6 weeks
☐ More than 6 weeks
☐ Unknown

19. What was your child fed in the hospital after birth?

☐ Breast milk only ☐ Breast milk plus formula ☐ Formula only ☐ Unknown

Global Health/Safety

20. In general, how would you rate your child's health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Unknown

If you chose Poor, please explain the reason for your child's poor health rating: _____

21. On a scale of 0–10, how ready are you to make changes to your child’s health?
- ☐ 0-3 Not Ready to Change ☐ 4-7 Unsure ☐ 8-10 Ready for Change
- ☐ No Changes Needed ☐ Unknown

If you wrote 8–10, what changes are you ready to make for your child? _____

22. Does your child have a doctor or health care provider?
- ☐ Yes ☐ No ☐ Unknown

If you answered yes, what is your child’s doctor or health care provider’s name? _____

23. It is important to identify a doctor or health care provider to help your child stay healthy and in case they get sick. **Would you like help finding a doctor or health care provider?**
- ☐ Yes ☐ No

24. Has your child seen their doctor or health care provider since birth?
- ☐ Yes ☐ No ☐ Unknown

25. Regular wellness exams can help make sure your child stays as healthy as they can. **Would you like help getting an appointment?**
- ☐ Yes ☐ No ☐ Unknown

26. Are your child’s immunizations up to date?
- ☐ Yes ☐ No ☐ Unknown
- Children get most of their vaccines during the first 2 years of life. That's because the diseases these vaccines prevent are very harmful to young children.*

27. How many times has your child been in the hospital in the last 3 months?
- ☐ None ☐ One time ☐ Two times ☐ Three or more times ☐ Unknown

28. How many times has your child been in the Emergency Department in the last 3 months?
- ☐ None ☐ One time ☐ Two times ☐ Three or more times ☐ Unknown

29. How many medicines is your child currently taking that were prescribed by their doctor or health care provider?

- ☐ 0 prescriptions
 ☐ 1-3 prescriptions
 ☐ 4-7 prescriptions
☐ Greater than or equal to 8 prescriptions
 ☐ Unknown

Does anything prevent your child from taking their medicine the way their doctor or health care provider wants them to?

- ☐ Yes
 ☐ No
 ☐ Unknown

What prevents your child from taking their medicines?

Do you ever forget to give your child their medicines?

- ☐ Yes
 ☐ No
 ☐ Sometimes
 ☐ Unknown

30. What is your child's weight? _____ lbs.

31. Have you or a health care provider been concerned about your child's weight?

- ☐ Yes - Overweight
 ☐ Yes - Underweight
 ☐ No
 ☐ Unknown

32. What are you feeding your baby now?

- ☐ Breast milk only
 ☐ Breast milk plus formula
 ☐ Formula
 ☐ Other

If other, what type of feeding is your baby receiving? _____

33. Does your child always use a seat belt or sit in a car seat when you drive or ride in a car?

- ☐ Yes
 ☐ No
 ☐ Unknown

Seat belt and car seat use is one of the most effective ways to save lives and reduce injuries in crashes.

34. Does your baby have a safe place to sleep? (Ideally in parents' room on a separate firm surface. The baby should be placed on their back and not have any soft bedding or toys in their sleeping area.)

- ☐ Yes
 ☐ No
 ☐ Unknown

35. Does your child live with anyone who is a regular smoker?

- ☐ Yes
 ☐ No
 ☐ Unknown

Secondhand smoke causes numerous health problems in infants and children, including more asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS).

36. How often do you feel unsafe in your neighborhood?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

37. In the past year, have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ Unsure ☐ I have not had a partner in the past year

Notes: _____

38. Which of the following types of equipment do you use that require electricity? (check all that apply)

☐ Wheelchair ☐ CPAP/BIPAP ☐ Refrigerated Medications ☐ Ventilator
☐ Oxygen ☐ None ☐ Other

Please list other equipment that requires electricity:

39. Are you on dialysis?

☐ Yes ☐ No ☐ Choose not to answer

40. Are you considered homebound? (Homebound means that leaving your home takes considerable and taxing effort)

☐ Yes ☐ No ☐ Choose not to answer

Social Concerns

41. Do you currently have concerns about having enough money to pay for your basic needs?

☐ Yes ☐ No ☐ Unknown

Please explain concerns about money to pay for basic needs: _____

42. Do you feel unsafe in your daily life?

☐ Yes ☐ No ☐ Unknown

Please explain any safety concerns you have: _____

43. Do you know of any really scary or upsetting things that have happened to you, your child, or anyone in your family?

☐ Yes ☐ No ☐ Unknown

If yes, please explain: _____

44. Do you have access to a safe, reliable telephone?

☐ Yes ☐ No ☐ Unknown

45. 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

46. Currently, are you or any family members you live with unable to get any of the following when it was really needed? (Check all that apply)

☐ Food ☐ Clothing ☐ Dental care ☐ Mental health care ☐ Utilities
☐ Child care ☐ Phone ☐ Medical care ☐ Transportation ☐ Eye care

47. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?

☐ Yes ☐ No ☐ Unknown

48. If you have trouble getting transportation when you need it, what is the MAIN reason you cannot get to where you want to go?

☐ I do not have trouble getting transportation ☐ Car broke down
☐ Person who usually takes me is unavailable ☐ Costs too much
☐ I do not have a personal vehicle ☐ Transit system not available

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

☐ Yes ☐ No ☐ Unknown

50. What is your housing situation today?

☐ I have housing today and I am NOT worried about losing housing in the next 6 months

☐ I have housing today but I AM worried about losing housing in the next 6 months

☐ I do not have housing today, BUT I am:

☐ Staying with others

☐ Staying in a hotel

☐ Staying in a shelter

☐ Living outside on the street, on a beach, in a car, or in a park

51. What is your housing situation today?

☐ I have housing

☐ I do not have housing (staying with others, hotel, shelter, living outside, car, or park)

☐ I choose not to answer this question

52. What is your current work situation?

☐ Unemployed

☐ Part-time or temporary work

☐ Full-time work

☐ Otherwise unemployed but not seeking work (ex. student, retired, disabled, unpaid primary caregiver)

53. Are you unemployed or without regular income?

☐ Yes

☐ No

☐ Unknown

54. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

☐ Not at all

☐ Somewhat

☐ A little bit

☐ Quite a bit

☐ Very much

55. During the past 12 months, have you had a dental problem which you would have liked to see a dentist about but you did NOT see a dentist?

☐ Yes ☐ No

If no, what is the main reason you have not visited the dentist in the last 12 months?

- ☐ Fear, apprehension, nervousness, pain, dislike going
☐ Cost
☐ Do not have/know a dentist
☐ Did not have time
☐ Cannot get to the office (no appointments available)
☐ Have not thought about it
☐ Cannot get to the office/clinic (too far away, no transportation)
☐ Other priorities

56. In the past 12 months, have you gone to a hospital emergency room for a dental problem?

☐ Yes ☐ No

57. In the past 12 months, have you gone to a hospital emergency room for:

☐ Dental pain/infection ☐ Dental trauma/accident ☐ Other

Other: _____

58. On a scale of 0-10, how strongly do you agree with the following statement: "I can manage and control my health problems?"

- ☐ 10 – Very high
☐ 9
☐ 8
☐ 7
☐ 6
☐ 5
☐ 4
☐ 3
☐ 2
☐ 1
☐ 0 – Very Low
☐ N/A – You have no health problems or risks to your health

Physical Health

59. Have you ever been told by a doctor or health care provider that your child has any of these conditions? (Check all that apply.)

- | | | |
|--|--|--|
| <input type="checkbox"/> Bone/Growth disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cystic fibrosis |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Eczema | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Premature birth | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sickle cell disease (not trait) | <input type="checkbox"/> Transplant | |

Does your child have any other conditions not listed above? _____

Behavioral Health

60. Do you have any concerns about your child's learning, behavior, or development?

- ☐ Yes ☐ No ☐ Unknown

What are your concerns with your child? _____

61. How often do you feel that you lack companionship?

- ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

General Information:

62. Assessment Completed Date: _____/_____/_____

63. Assessment Completed By (Name): _____

64. Relationship to member: _____

- | | | |
|---------------------------------|--|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Member representative with permission | <input type="checkbox"/> Parent/Guardian |
| <input type="checkbox"/> Envolv | <input type="checkbox"/> Health Plan | <input type="checkbox"/> Vendor |
| | | <input type="checkbox"/> Other |

If other relationship to member, please explain: _____

65. Assessment Interval:

- ☐ Initial ☐ Yearly ☐ Change of condition ☐ Unknown

66. Name of agency completing assessment?

67. Credentials of staff completing assessment?

- ☐ RN ☐ LCPC ☐ LCSW ☐ Advanced practitioner ☐ LVN/LPN ☐ MD/DO
☐ Pharmacist ☐ Other Credentials ☐ None

68. If other, please provide credentials:

69. By what method was the HRS information obtained?

- ☐ Phone ☐ In-person/home visit ☐ Form faxed/mailed in ☐ Information not obtained

70. Was assistive (TDD/TYY) equipment used to complete this assessment?

- ☐ Yes ☐ No ☐ Unknown

71. Was a translator used to complete this assessment?

- ☐ Yes ☐ No ☐ Unknown

Translator information: _____

72. Was information obtained from a non-parent/non-guardian?

- ☐ Yes ☐ No ☐ Unknown

73. ATTESTATION: I have reviewed the Documentation Module. The member's POA and/or Authorized Representative information is updated in the Document Summary section.

- ☐ Yes ☐ No ☐ N/A

74. ATTESTATION: I have reviewed the Member Demographics module. The member's General Information section and Contact Information section have been transcribed and updated with the information obtained in this assessment.

- ☐ Yes ☐ No ☐ N/A

75. ATTESTATION: I have reviewed and updated the Member Contact Summary with caregiver/POA information if applicable.

- ☐ Yes ☐ No ☐ N/A

76. ATTESTATION: I have reviewed the Provider Contacts Summary module and the information is up to date and accurate.

- ☐ Yes ☐ No ☐ N/A

77. ATTESTATION: I have reviewed the Member's Diagnosis module and the member's information is up to date and accurate.

- ☐ Yes ☐ No ☐ N/A

78. ATTESTATION: I have reviewed all of the Member's Care Alerts.

- ☐ Yes ☐ No ☐ N/A