AmeriHealth Caritas
New Hampshire

Please complete all sections that apply to you and each member in your family. The answers to these questions will help us see how we can best help you and will not affect you or your child's Medicaid benefits in any way. All answers are kept private. If you need help filling out this form, please call **1-833-704-1177**. TDD/TTY users may call **1-855-534-6730**.

Date:
Mailing Address: _____ Apt # _____
(street)

_____ _____ _____
(city) (state) (zip)

Complete this survey for each family member on this health plan. Write "same" when answers for additional members match answers for Member 1.

	Member 1	**Member 2**	**Member 3**
Name of person filling out the form for each member	_____	_____	_____
Relationship to member	□Self □Mother □Father □Grandparent □Foster parent □Child □Other _____	□Self □Mother □Father □Grandparent □Foster parent □Child □Other _____	□Self □Mother □Father □Grandparent □Foster parent □Child □Other _____

	Member 1	**Member 2**	**Member 3**
Member Name			
Member ID #			
Spoken Language	□English □Spanish □Other _____	□English □Spanish □Other _____	□English □Spanish □Other _____
Written Language	□English □Spanish □Other _____	□English □Spanish □Other _____	□English □Spanish □Other _____
Race (List up to two)			
Ethnicity (List up to two)			
Best phone number			
What type of phone number is this?	□Home □Cell □Other _____	□Home □Cell □Other _____	□Home □Cell □Other _____
Best email address			
How would you like us to contact you?	□Phone □Mail □Email □Text □Other _____	□Phone □Mail □Email □Text □Other _____	□Phone □Mail □Email □Text □Other _____

	Member 1	Member 2	Member 3
Where do you live?	□Own/Rent □Shelter □Homeless □Staying with family/friend □Other ________________	□Own/Rent □Shelter □Homeless □Staying with family/friend □Other ________________	□Own/Rent □Shelter □Homeless □Staying with family/friend □Other ________________
How many places have you lived in the past year?	□One □Two □Three or more	□One □Two □Three or more	□One □Two □Three or more
Do you feel safe at home?	□Yes, always □Unsure □Yes, sometimes □No □Choose not to answer	□Yes, always □Unsure □Yes, sometimes □No □Choose not to answer	□Yes, always □Unsure □Yes, sometimes □No □Choose not to answer
Do you have reliable transportation to doctor visits?	□Always □Sometimes □Rarely or Never	□Always □Sometimes □Rarely or Never	□Always □Sometimes □Rarely or Never
	<u>**General Health Information**</u>		
Are you being treated for any of these conditions? Check all that apply.	□Acquired Brain Disorder □Asthma □Cancer □Diabetes □Heart Disease □Hepatitis □HIV/AIDs □Intellectual or Developmental Disability □Lung Disease □Serious Physical Condition *(such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures)* □Sickle Cell Disease (not trait) □Stroke □Transplant □Other (please explain) ______________________ <u>Child Only</u> □Juvenile Arthritis □Developmental Issues □Neonatal Abstinence Syndrome	□Acquired Brain Disorder □Asthma □Cancer □Diabetes □Heart Disease □Hepatitis □HIV/AIDs □Intellectual or Developmental Disability □Lung Disease □Serious Physical Condition *(such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures)* □Sickle Cell Disease (not trait) □Stroke □Transplant □Other (please explain) ______________________ <u>Child Only</u> □Juvenile Arthritis □Developmental Issues □Neonatal Abstinence Syndrome	□Acquired Brain Disorder □Asthma □Cancer □Diabetes □Heart Disease □Hepatitis □HIV/AIDs □Intellectual or Developmental Disability □Lung Disease □Serious Physical Condition *(such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures)* □Sickle Cell Disease (not trait) □Stroke □Transplant □Other (please explain) ______________________ <u>Child Only</u> □Juvenile Arthritis □Developmental Issues □Neonatal Abstinence Syndrome
Are you currently on IV antibiotics for more than 3 weeks?	□Yes □No	□Yes □No	□Yes □No
Do you have constant pain?	□Yes □No	□Yes □No	□Yes □No
If yes, how intense is the pain on a scale of 1			

	Member 1	Member 2	Member 3
- 10 (10 being highest)**.**	Pain Level: ________________	Pain Level: ________________	Pain Level: ________________
Have you ever experienced trauma or abuse? (e.g. being physically hurt by, humiliated, or emotionally abused by another person)	□Yes □No	□Yes □No	□Yes □No
If you ever experienced trauma or abuse, would you like support (e.g. to talk with a counselor)?	□Yes □No	□Yes □No	□Yes □No
How often in the past 3 months were you worried that your food would run out?	□Always □Sometimes □Rarely or Never	□Always □Sometimes □Rarely or Never	□Always □Sometimes □Rarely or Never
If completing for a child, does your child participate in any of the following?	□ Family Centered Early Supports and Services □Special Medical Services □Partners in Health □None	□ Family Centered Early Supports and Services □Special Medical Services □Partners in Health □None	□ Family Centered Early Supports and Services □Special Medical Services □Partners in Health □None
Are you pregnant?	□ Yes □No □N/A	□ Yes □No □N/A	□ Yes □No □N/A
If yes, are there pregnancy complications (ex. diabetes, high blood pressure or multiples)?	□ Yes □No □N/A	□ Yes □No □N/A	□ Yes □No □N/A
Have alcohol, prescription drugs or other substances been used during the pregnancy?	□ Yes □No □N/A	□ Yes □No □N/A	□ Yes □No □N/A
Are you being treated for any of these Mental Health or Substance Use conditions? Check all that apply.	□ADHD □Autism □Bipolar Disorder □Depression □Eating Disorder (anorexia, bulimia, other) □Schizophrenia □Serious Mental Illness □Substance Use Problems □Other ___________________ □None <u>Child Only</u> □ Serious Emotional	□ADHD □Autism □Bipolar Disorder □Depression □Eating Disorder (anorexia, bulimia, other) □Schizophrenia □Serious Mental Illness □Substance Use Problems □Other ___________________ □None <u>Child Only</u> □ Serious Emotional	□ADHD □Autism □Bipolar Disorder □Depression □Eating Disorder (anorexia, bulimia, other) □Schizophrenia □Serious Mental Illness □Substance Use Problems □Other ___________________ □None <u>Child Only</u> □ Serious Emotional

	Member 1	Member 2	Member 3
	Disturbance	Disturbance	Disturbance
Do you drink alcoholic beverages?	□ Yes □No □Choose not to answer	□ Yes □No □Choose not to answer	□ Yes □No □Choose not to answer
If yes, has anyone told you that your alcohol use is a problem?	□Yes □No □Choose not to answer	□Yes □No □Choose not to answer	□Yes □No □Choose not to answer
Do you feel that you need help with drug or alcohol use?	□Yes □No □Choose not to answer	□Yes □No □Choose not to answer	□Yes □No □Choose not to answer
Are you currently using street drugs (such as heroin, cocaine) or other drugs other than as prescribed?	□Yes □No □Choose not to answer	□Yes □No □Choose not to answer	□Yes □No □Choose not to answer
Have you had an overdose in the past 12 months?	□Yes □No	□Yes □No	□Yes □No
Do you smoke cigarettes, use smokeless tobacco, or vape?	□Yes □No □Choose not to answer	□Yes □No □Choose not to answer	□Yes □No □Choose not to answer
Would you like to speak to someone about quitting?	□Yes □No	□Yes □No	□Yes □No
Over the past 2 weeks, how often have you had little interest or pleasure in doing things?	□Not at all □Several Days □More than half of the days □Nearly every day	□Not at all □Several Days □More than half of the days □Nearly every day	□Not at all □Several Days □More than half of the days □Nearly every day
Over the past 2 weeks, how often have you felt down, depressed, or hopeless?	□Not at all □Several Days □More than half of the days □Nearly every day	□Not at all □Several Days □More than half of the days □Nearly every day	□Not at all □Several Days □More than half of the days □Nearly every day
Would you like to speak with someone about Mental Health/Substance use services?	□Yes □No	□Yes □No	□Yes □No
Do you have difficulty doing the following activities by yourself? Check all that apply.	□Bathing □Dressing □Walking □Eating □Using the toilet □Getting in and out of chairs □Preparing meals □Managing money □Taking medication as prescribed □Performing home chores	□Bathing □Dressing □Walking □Eating □Using the toilet □Getting in and out of chairs □Preparing meals □Managing money □Taking medication as prescribed □Performing home chores	□Bathing □Dressing □Walking □Eating □Using the toilet □Getting in and out of chairs □Preparing meals □Managing money □Taking medication as prescribed □Performing home chores

	Member 1	Member 2	Member 3
	□Grocery shopping □Not applicable due to member's age	□Grocery shopping □Not applicable due to member's age	□Grocery shopping □Not applicable due to member's age
Have you used the emergency room 3 times or more in the last 3 months?	□Yes □No	□Yes □No	□Yes □No
Have you been hospitalized for more than a 2-week period in the last 3 months?	□Yes □No	□Yes □No	□Yes □No
If yes, was it for a new baby in the NICU (neonatal intensive care unit)?	□Yes □No	□Yes □No	□Yes □No
Have you made a suicide attempt in the past 12 months?	□Yes □No	□Yes □No	□Yes □No
Have you been released from jail or prison in the last 6 months?	□Yes □No □Choose not to answer	□Yes □No □Choose not to answer	□Yes □No □Choose not to answer
Would you like a care manager to reach out to you to assist you with health concerns, community resources or other questions or issues?	□Yes □No	□Yes □No	□Yes □No

Thank you for taking the time to answer these questions. Is there anything else you think we should know about you, your child, or family?