Health Assessment Form

Dear Parent or Guardian:

Your child's health is important to us at UnitedHealthcare Community Plan. We want your child to stay as healthy as possible, and get the most from their health plan. That's why it's important that you fill out this survey and send it back to us right away. It will help us connect your child with benefits and services available to them. Your answers will not reduce their health care coverage in any way.

You can also do this by phone. Just call Member Services at <1-800-464-9484, TTY 711>.

We are glad to have your child as a member of UnitedHealthcare Community Plan and we look forward to serving their health care needs.

Please fill out a survey for each child in your family who has joined UnitedHealthcare Community Plan.

Name _____ Member ID Number _____

Address _____

City _____ State _____ ZIP _____

Date of Birth _____ Current Phone Number _____

Today's Date _____

1. How tall is your child? _____
2. How much does your child weigh? _____
3. How would you describe your child's weight?
   ☐ Average ☐ Underweight ☐ Overweight
4. Has your child had a medical checkup in the last 12 months?
   ☐ Yes ☐ No ☐ Not sure
5. Does your child have any of the following:
   ☐ Asthma
   ☐ Diabetes
   ☐ Sickle Cell Disease
   ☐ Hemophila
   ☐ ADD/ADHD
   ☐ Substance abuse
6. If female, is your child pregnant?
   ☐ Yes ☐ No If yes, how long has she been pregnant? _____
7. Does your child currently need or use medicine prescribed by a doctor? (other than vitamins)
   ☐ Yes ☐ No ☐ Not sure

   Is this for a condition that has lasted or is expected to last for at least 12 months?
   ☐ Yes ☐ No ☐ Not sure

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8. Does your child need or use more medical care, mental health or educational services than is usual for most children of the same age?
☐ Yes ☐ No ☐ Not sure

Is this for a condition that has lasted or is expected to last for at least 12 months?
☐ Yes ☐ No ☐ Not sure

9. Is your child unable to do things that most children of the same age can do?
☐ Yes ☐ No ☐ Not sure

Is this for a condition that has lasted or is expected to last for at least 12 months?
☐ Yes ☐ No ☐ Not sure

10. Does your child need or get special therapy, such as physical or occupational or speech therapy?
☐ Yes ☐ No ☐ Not sure

Is this for a condition that has lasted or is expected to last for at least 12 months?
☐ Yes ☐ No ☐ Not sure

11. Does your child get treatment or counseling for any kind of emotional, developmental or behavioral problem?
☐ Yes ☐ No ☐ Not sure

12. Does your child receive support services in the home?
☐ No
☐ Personal care attendant
☐ Nursing care
☐ Home health aide

13. Is your child enrolled in a foster care program?
☐ Yes ☐ No

14. Has your child experience or witnessed an event that caused or threatened to cause serious harm to him or herself, or to someone else?
☐ Yes ☐ No (Go to question 20) ☐ Not sure

15. What was the event?
☐ Car or other accident
☐ Fire
☐ Storm
☐ Physical illness or assault
☐ Other event
Please describe _____

16. How old was your child at the time of the event? _____

17. Your child seems to have more headaches and/or stomach aches when reminded of the event.
☐ Not true (as far as you know) ☐ Sometimes true ☐ Often true

18. Your child avoids doing thing that remind him/her of the event.
☐ Not true (as far as you know) ☐ Sometimes true ☐ Often true

19. Your child gets upset if reminded of the event.
☐ Not true (as far as you know) ☐ Sometimes true ☐ Often true

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20. How often do you worry that you don't have enough food for your family?
    ☐ Never ☐ Sometimes ☐ Always

21. How often do you worry that your home is unsafe, or that your family may become homeless?
    ☐ Never ☐ Sometimes ☐ Always

22. Do you know what community resources are available to you?
    ☐ Yes ☐ No ☐ Not sure

Thank you for completing the Health Assessment. Please return in the enclosed postage-paid envelope.

This assessment is not intended to provide you with a diagnosis. A diagnosis for any condition may be made only after being evaluated by a health care provider. Consider contacting your health care provider if your answers to the assessment indicate the possibility that you have any health problems.

Your answers on the health assessment give us information about you. By answering at least one of the questions you are agreeing that we can share this information with nurses or care managers. They may then contact you to help provide you with better access to health care programs.

Your data may also be combined with data from many other people who complete this assessment. This is so we can conduct research and other activities that will help us learn how best to serve you and many other people like you in the future.

We follow all Federal and State laws to protect your privacy data and information.

Your decision to complete the health assessment is completely voluntary. Completion of the assessment does not affect your enrollment in a health plan, treatment, and payment, eligibility for benefits or insurance coverage. It was created as a tool for you to use to take charge of your health and it is your decision on how and if you want to use it.

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