Horizon Blue Cross Blue Shield of New Jersey

MEMBER COMPREHENSIVE NEEDS ASSESSMENT FORM

Revised December 2017

Horizon Blue Cross Blue Shield of New Jersey

MEMBER COMPREHENSIVE NEEDS ASSESSMENT FORM

Section 1: Member Information

Name:	Date:
Horizon NJ Health Member ID #:	Birth Date:
Phone Number:	Cell Phone Number:
Mailing Address:	
Are you willing to participate in Care Management? ❑ Yes ❑ No	
Email Address:	
Horizon NJ Health can contact you by Cell Phone: ❑ Yes ❑ No	Horizon NJ Health can contact you by Email: ❑ Yes ❑ No
Horizon NJ Health can contact you by Text: ❑ Yes ❑ No	Height: Weight: lbs

Do you have any religious or cultural beliefs that may affect your medical care decisions? ❑ Yes ❑ No

If yes, please explain: _____

_____

What is your primary language?

❑ English ❑ Spanish ❑ Vietnamese
❑ Arabic ❑ Portuguese ❑ Other

If English is not your primary language, can you speak English? ❑ Yes ❑ No ❑ Very Little

If English is not your primary language, can you understand English? ❑ Yes ❑ No ❑ Very Little

What is your ethnicity? ❑ Caucasian ❑ Latin/Hispanic ❑ African American ❑ Pacific Islander/Asian
❑ American Indian ❑ Bi-Racial Other_____

Do you have any allergies to food, medicine, or the environment? *Please check all that apply:*

❑ Iodine ❑ Nuts ❑ Penicillin ❑ Sulfa ❑ Latex ❑ Milk
❑ Shell Fish ❑ Tape ❑ Bees ❑ Seasonal Allergies

Medicine (*list*) _____

Other (*list*) _____

Do you have an Emergency Contact Person? ❑ Yes ❑ No

Can we contact this person on your behalf in an emergency situation? ❑ Yes ❑ No

Contact Person's Name: _____

Contact Person's Phone Number: _____

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Who is completing this assessment? ❑ Member ❑ Other

If other, name:_____ Relationship:_____

Do you have other Health Insurance? ❑ Yes ❑ No If Yes, please provide:

Company Name:_____

Subscriber Name:_____

Member ID #:_____ Group #: _____ Effective Date: _____

Section 2: Your Medications

Please list the drugs you are taking. How often? Dose? List:

_____

_____

_____

_____

Does your Primary Care Provider (PCP) know about all the medications you are taking? ❑ Yes ❑ No

Do you take your medications as ordered by your PCP or Specialist? ❑ Yes ❑ No

Do you have trouble taking or getting your medicine? ❑ Yes ❑ No If yes, why?

- ❑ Cannot get to a pharmacy
- ❑ Cost too much money
- ❑ Forget to take
- ❑ Health Plan benefit does not cover it
- ❑ I do not know why I need to take it
- ❑ I do not like how it makes me feel
- ❑ Other (list) _____

Do you take any over the counter medicines (such as vitamins, herbs, cold medicine, and aspirin)?
❑ Yes ❑ No If yes, please list.

_____

_____

_____

Please provide the name and phone number of the pharmacy you use:

Name: _____

Phone Number: _____

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Section 3: Health Information

Do you have or have you ever had one of the following health conditions? If so, when did it begin?

Asthma
❑ Yes ❑ No Date: _____

Anxiety
❑ Yes ❑ No Date: _____

Arthritis
❑ Yes ❑ No Date: _____

Alzheimer's
❑ Yes ❑ No Date: _____

Bi-Polar Disease
❑ Yes ❑ No Date: _____

Cancer
❑ Yes ❑ No Date: _____

Chronic Kidney Disease (CKD)
❑ Yes ❑ No Date: _____

Congestive Heart Failure (CHF)
❑ Yes ❑ No Date: _____

Depression
❑ Yes ❑ No Date: _____

Diabetes
❑ Yes ❑ No Date: _____

End Stage Renal Disease
❑ Yes ❑ No Date: _____

Heart Disease
❑ Yes ❑ No Date: _____

Hemophilia
❑ Yes ❑ No Date: _____

Hepatitis
❑ Yes ❑ No Date: _____

High Blood Pressure
❑ Yes ❑ No Date: _____

HIV/AIDS
❑ Yes ❑ No Date: _____

Lead Poisoning
❑ Yes ❑ No Date: _____

Memory Problems
❑ Yes ❑ No Date: _____

Multiple Sclerosis
❑ Yes ❑ No Date: _____

Obesity
❑ Yes ❑ No Date: _____

Organ Transplant List
❑ Yes ❑ No Date: _____

Paralysis
❑ Yes ❑ No Date: _____

Parkinson's Disease
❑ Yes ❑ No Date: _____

Peripheral Vascular Disease
❑ Yes ❑ No Date: _____

Pulmonary Disease/COPD
❑ Yes ❑ No Date: _____

Respiratory Disease/TB
❑ Yes ❑ No Date: _____

Schizophrenia
❑ Yes ❑ No Date: _____

Seizures
❑ Yes ❑ No Date: _____

Sickle Cell Disease
❑ Yes ❑ No Date: _____

Spinal Cord Injury
❑ Yes ❑ No Date: _____

Substance Abuse
❑ Yes ❑ No Date: _____

Stroke
❑ Yes ❑ No Date: _____

Thyroid Disease
❑ Yes ❑ No Date: _____

Traumatic/Acquired Brain Injury
❑ Yes ❑ No Date: _____

Vent Dependent
❑ Yes ❑ No Date: _____

Other
❑ Yes ❑ No Date: _____

Have you missed work or school in the past 3 months because of any of the above conditions?
❑ Yes ❑ No If yes, how many times: _____

Do you have any of the following?

- ❑ Cataracts
- ❑ Glaucoma
- ❑ Blindness
- ❑ Problems with Vision
- ❑ Use Magnifier Glasses
- ❑ Wear Corrective Lenses
- ❑ Wear Contact Lenses
- ❑ Legally Blind
- ❑ Deafness
- ❑ Hearing Loss
- ❑ Impaired Hearing
- ❑ None

On a scale of 1 to 5, with 1 being "poor" and 5 being "excellent" how would you rate your overall health during the past three month, including medical, dental, and behavioral health :
❑ Poor ❑ Fair ❑ Good ❑ Very Good ❑ Excellent

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Have you had any of the following preventive services?			
Blood Sugar (HbgA1c) Test	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Bone Density Test	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Cholesterol/Lipid Profile	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Colon Cancer Screening	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Dental Exam	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Eye Exam	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Family Planning	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Flu Vaccine	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Hearing Test	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Lead Screening (Children)	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Polio	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
DtaP	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
MMR	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Varicella	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Hepatitis B	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Mammogram	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Pneumonia Vaccine	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Prostate Screening	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
PSAP/Cervical Screening	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Spirometry	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Tetanus Shot (past 10 years)	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested
Other	❑ Yes ❑ No	Date:_____	❑ Needed ❑ Not Interested

Call your child's doctor to keep your children's vaccines requirements up to date.

Dentist Name:_____

Phone Number:_____ Date of last appointment (routine or emergency):_____

Do you exercise 3 or more days per week? ❑ Yes ❑ No

What type of exercise activity do you do? ❑ No activity ❑ Gym ❑ Walking ❑ Bike Riding ❑ Swimming
❑ Gardening ❑ Pilates ❑ Yoga ❑ Zumba
❑ Other (*list*): _____

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Do you have trouble buying food/formula? ❑ Yes ❑ No If yes, why?

- ❑ No problem
- ❑ Cannot afford
- ❑ Supermarket too far away
- ❑ Need transportation
- ❑ Dependent on other to shop for me
- ❑ Other (*list*): _____

In the past 3 months, have you gained or lost weight without trying ? ❑ Yes ❑ No

What type of diet has your PCP recommended for you? *Please check all that apply:*

❑ None ❑ Diabetic ❑ Lactose Free ❑ Low Salt ❑ Low Protein ❑ Gluten Free

❑ Other (*list*): _____

Would you like to speak with a Registered Dietician? ❑ Yes ❑ No

Do you have any problems with foods or chewing/eating? ❑ Yes ❑ No *Please check all that apply:*

- ❑ No Problem with food or eating
- ❑ Difficulty Sucking
- ❑ Difficulty Swallowing
- ❑ Excessive Fussiness
- ❑ Loose or Missing Teeth
- ❑ Nausea/Vomiting
- ❑ Colic
- ❑ Preparing Meals
- ❑ Food Allergies
- ❑ GI Feeds
- ❑ Lactose Intolerance
- ❑ Special Formula
- ❑ Dry Mouth
- ❑ Eating Disorder
- ❑ Weight Loss Surgery
- ❑ Other _____

Do you use WIC, food banks, food stamps or other resources to get food?

- ❑ No
- ❑ Food Stamp/Families First Card
- ❑ Other _____
- ❑ Food Bank
- ❑ WIC

In the past 6 months, have you fallen? ❑ Yes ❑ No

If yes, how many times have you fallen? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 or more

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Do you have any of the following?

Ankle Swelling	❑ Yes ❑ No	Fast Heart Rate	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	Feet Swelling	❑ Yes ❑ No
Constipation	❑ Yes ❑ No	Frequent Urination	❑ Yes ❑ No
Defibrillator	❑ Yes ❑ No	Loss of Appetite	❑ Yes ❑ No
Diarrhea	❑ Yes ❑ No	Loss of Bladder or Bowel Control	❑ Yes ❑ No
Difficulty Hearing	❑ Yes ❑ No	Memory Loss/forgetfulness	❑ Yes ❑ No
Difficulty Seeing	❑ Yes ❑ No	Nausea/Vomiting	❑ Yes ❑ No
Difficulty Swallowing	❑ Yes ❑ No	Open Wounds	❑ Yes ❑ No
Difficulty Walking	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No
Dizziness	❑ Yes ❑ No	Slow Heart Rate	❑ Yes ❑ No
Fainting	❑ Yes ❑ No	Sudden Weight Loss	❑ Yes ❑ No

❑ Other (*list*): _____

Do you have or experience Chronic Pain? ❑ Yes ❑ No

If yes, where is your pain? _____

If yes, how often do you have pain? ❑ Yes ❑ No *Please check all that apply:*

❑ All the time ❑ Sometimes ❑ Only at Night ❑ Only after exercising

Is your pain new in the past 3 months? ❑ Yes ❑ No

How do you manage your pain? _____

_____

Pain level (1-10) _____ Scale: 1 being very little pain, 10 being the worst pain you have felt

Have you lost interest in doing things? ❑ Yes ❑ No If yes, how often?

❑ Almost never ❑ Several days a week ❑ Nearly every day

Are you feeling down, depressed or hopeless ? ❑ Yes ❑ No If yes, how often?

❑ Almost never ❑ Several days a week ❑ Nearly every day

Do you feel like you're a burden to your family? ❑ Yes ❑ No ❑ N/A

Do you feel as if you can't ask others for help? ❑ Yes ❑ No ❑ N/A

Does worrying about your health interfere with your life? ❑ Yes ❑ No ❑ N/A

Which best describes your feelings about making healthy changes at this time?

❑ Willing to make changes in 30 days
❑ Willing to make changes in 6 months
❑ Made changes in the past 6 months
❑ Made changes and doing well for > 6 months
❑ Not willing to make changes

Have you been educated on your health benefits and care manager process? ❑ Yes ❑ No

Section 4: Your Living Arrangements

Where do you currently live?

- ❑ Apartment
- ❑ Assisted Living Facility
- ❑ Boarding Home
- ❑ Foster Home
- ❑ Group Home
- ❑ House
- ❑ Long Term Care Facility
- ❑ Rented Room
- ❑ Shelter
- ❑ Homeless
- ❑ Other (*list*): _____

Who do you live with?

- ❑ Alone
- ❑ Family Member
- ❑ Friend
- ❑ Resource Parent/Guardian
- ❑ Paid Help
- ❑ Parent/Guardian
- ❑ Spouse/Significant Other
- ❑ Other (*list*): _____

Do you feel safe at home? ❑ Yes ❑ No

Do you participate in any community/support programs? ❑ Yes ❑ No *If yes, list:*

_____

_____

Do you have a case/care manager through another agency or program (such as DDD, DCPP, Waiver program, ARC, etc.) ❑ Yes ❑ No List name of agency, name of case/care manager and phone number:

_____

_____

_____

Are you, or have you ever been, in a relationship in which you have been physically hurt or threatened?
❑ Yes ❑ No

Is there something else you need me to know?
❑ Yes ❑ No *If yes, explain:*

_____

_____

_____

_____

_____

_____

Do you provide care for someone else? ❑ Yes ❑ No If yes, how often?
❑ Occasionally ❑ Weekends ❑ Daily ❑ Weekly ❑ All the Time

Does someone provide care for you? ❑ Yes ❑ No If yes, how often?
❑ Occasionally ❑ Weekends ❑ Daily ❑ Weekly ❑ All the Time

If yes, who helps with your care?
❑ Family Member ❑ Paid Help ❑ Friend
❑ Parent/Guardian ❑ Foster Parent ❑ Spouse/Significant Other
❑ Other_____

Name the person or agency (Home Health Service or Personal Care Assistant) that cares for you?
Name: _____ Phone Number: _____

Which of the following activities do you have difficulty with?

Bath without help	❑ Yes ❑ No	Pay bills	❑ Yes ❑ No
Do routine household chores	❑ Yes ❑ No	Preparing meals	❑ Yes ❑ No
Dress yourself	❑ Yes ❑ No	Shop, groceries, run errands	❑ Yes ❑ No
Driving to appointments	❑ Yes ❑ No	Taking medications	❑ Yes ❑ No
Eat without help	❑ Yes ❑ No	Toileting	❑ Yes ❑ No
Getting in/out of bed or a chair	❑ Yes ❑ No	Using the telephone	❑ Yes ❑ No
Laundry	❑ Yes ❑ No	Walk	❑ Yes ❑ No
Oral health – brushing, flossing, chewing	❑ Yes ❑ No	Continence – control bowel/bladder	❑ Yes ❑ No

Do you have any friends or family that are willing to provide emotional support? ❑ Yes ❑ No

Social History

Do you use tobacco (smoke, chew, pipe, cigars)? ❑ Yes ❑ No
If yes, are you interested in quitting? ❑ Yes ❑ No

Have you ever used tobacco? ❑ Yes ❑ No
If yes, how long ago did you quit? _____

Do you drink alcoholic beverages? ❑ Yes ❑ No If yes, how often?
❑ Occasionally ❑ Weekends ❑ 1-2 times a week ❑ 3-4 times a week ❑ 5-7 times a week

Do you use recreational drugs? ❑ Yes ❑ No If yes, how often?
❑ Occasionally ❑ Weekends ❑ 1-2 times a week ❑ 3-4 times a week ❑ 5-7 times a week

Section 5: About Your Health Care

How often do you see your doctor or Primary Care Provider?

❑ I don't know my doctor ❑ Once a year ❑ Weekly
❑ I don't have a doctor ❑ Once a month ❑ As needed
❑ I've never seen my doctor ❑ Every 3 months

When did you last visit your doctor? _____

Do you need help with finding a doctor or changing your doctor? ❑ Yes ❑ No

Your doctor's name: _____ Phone number: _____

Do you have any problems making/keeping appointments? ❑ Yes ❑ No If yes, what is the issue?

❑ Transportation ❑ Need to be reminded ❑ Language barrier
❑ Difficulty getting an appointment ❑ Co-pay issues ❑ No doctor
❑ Do not like going ❑ Other _____

Do you see any specialists? ❑ Yes ❑ No If yes, Please provide the following information

Name: _____ Phone Number: _____
Date of last visit: _____

In the past 6 months, how many times have you visited the Emergency Room or Urgent Care Center?

❑ Never ❑ 1 visit ❑ 2 visits ❑ 3 visits ❑ more than 3 visits

Name: _____ Phone Number: _____
Date of last visit: _____
Name: _____ Phone Number: _____
Date of last visit: _____

Do you have any operations scheduled? ❑ Yes ❑ No If yes, what type?

_____
_____
_____

In the past 6 months, how many times have you been in the hospital overnight?

❑ Never ❑ 1 visit ❑ 2 visits ❑ 3 visits ❑ more than 3 visits

When you have a medical emergency, what do you do?

❑ Call my doctor ❑ Go to the ER ❑ Call a family member
❑ Nothing ❑ Use an Urgent Care Center ❑ Call 911

Do you have an emergency plan for any of the following?

If electric goes off ❑ Yes ❑ No
If there is a fire in your home ❑ Yes ❑ No
If you need medical help ❑ Yes ❑ No

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Do you use any Durable Medical Equipment (such as a wheel chair)? ❑ Yes ❑ No

❑ None ❑ Diabetic Supplies ❑ Diapers ❑ Hospital Bed ❑ Oxygen
❑ Tube Feeding Supplies ❑ Ventilator ❑ Wheelchair ❑ Wound Care Supplies
❑ Other _____

If yes, what company: _____

List your equipment: _____

_____

_____

_____

Do you have an Advance Directive or Living Will? ❑ Yes ❑ No

Would you like information about Advance Directives or Living Wills? ❑ Yes ❑ No

Do you understand the importance of having an Advance Directive or Living Will? ❑ Yes ❑ No

Do you have a Health Care Power of Attorney? ❑ Yes ❑ No

Would you like information about choosing a Health Care Power of Attorney? ❑ Yes ❑ No

Do you understand the importance of having a Health Care Power of Attorney? ❑ Yes ❑ No

How can we help you to achieve your health care goals?

_____

_____

_____

_____

_____

_____

_____

How would you describe your memory?

❑ Alert, no problems ❑ Easily distracted ❑ Forgetful ❑ Forgetful at times ❑ Non-verbal

Barriers/Risk Factors to Care

❑ None
❑ Behavioral Health
❑ Drug Use
❑ Homeless
❑ Obtaining Meals
❑ Obesity, Morbid
❑ Pregnant
❑ Substance
❑ Transportation
❑ Alcohol
❑ Dialysis
❑ Hard of Hearing (HOH)
❑ Need Assist with ADL's
❑ No PCP
❑ Physical Disability: describe_____
❑ Smokes
❑ Teen Pregnancy
❑ Vision
❑ Unsafe Home Environment: describe_____
❑ Other: _____

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If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-543-5656** (TTY/TDD **711**). This document is also available in other languages, as well as other formats, such as large print and Braille.

Spanish (Español): Para ayuda en español, llame al **1-800-543-5656** (TTY/TDD **711**).
Chinese (中文)：如需中文協助, 請致電 **1-800-543-5656** (TTY/TDD **711**)。

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