Age 0-21 years
HEALTH APPRAISAL

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

Please complete the following questions the best that you can. Your answers will not affect your child's Medicaid benefits. The information you provide may be reviewed by a care manager. It may be shared with the member's primary care provider and care team for care coordination.

IMPORTANT: Complete the questions and answers about the member (not about a parent or guardian). Some questions may not apply to members under a certain age.

The completed Health Appraisal Survey may be emailed to: HCHPediatricsCM@azblue.com.

Member Information - REQUIRED: Be sure to complete your Child's Name and Member ID. This information will help us know who your child is.

Member Name: _____ Date of Birth: _____

Medicaid ID Number: _____ Today's Date: ____/____/_____

Mailing Address: _____

Primary Care Provider (PCP): _____

Contact Information:

Name of person completing this form: _____

Relationship to member:

☐ Self ☐ Parent/legal guardian ☐ Other (please specify): _____

How would you prefer to be contacted?

☐ Phone call ☐ Text ☐ Email ☐ Mail

Phone number: _____ Email address: _____

Race or Ethnicity:

☐ Asian
☐ American Indian or Alaska Native
☐ Black or African American
☐ Hispanic or Latino
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Other: _____
☐ Decline to answer

What is your preferred language:

☐ English ☐ Chinese (incl. Cantonese, Mandarin) ☐ Vietnamese
☐ Spanish ☐ Navajo ☐ Decline to answer
☐ Arabic ☐ Tagalog ☐ Other: _____

We are interested in honoring your values and beliefs. Do you/your child have any religious or cultural preferences we should know about that may impact the member's healthcare?

☐ Yes ☐ No ☐ Decline to answer

Please describe: _____

Has the member been seen for a well visit within the past 12 months?

☐ Yes ☐ No ☐ Decline to answer

If No, what kept you from completing a well visit:

☐ Lack of transportation
☐ Unable to get off work
☐ Nothing
☐ Difficulty scheduling an appointment
☐ Other (please explain): _____
_____

Is the member up to date on your/their vaccines?

☐ Yes ☐ No ☐ Do not know ☐ Decline to answer

When did the member last receive immunizations/vaccines? Date: _____

Who is your/your child's Dentist/Dental Office?

_____

Member's last dental visit was:

☐ Within the last 6 months
☐ 6-12 months ago
☐ More than 12 months ago
☐ Never
☐ Decline to answer

Does the member receive Behavioral Health services?

☐ Yes ☐ No ☐ Decline to answer

If yes, Behavioral Health Provider's name: _____

Medications (both prescription and over-the-counter) that the member is currently taking:

☐ None ☐ Decline to answer

Medication Name	Dose (how much)	How you take it (for example: by mouth or shot)	How often you take it

You can add more medications to the back of this form if needed.

List any other medications that the member took in the past 5 years, what they were for, and the outcome:

_____

_____

_____

List the member's past hospital stays or major procedures, like surgeries:

☐ The member has not had any past hospital stays or procedures ☐ Decline to answer

Reason for hospital stay or procedure			Date

You can add more hospital stays and procedures to the back of this form if needed.

Has the member gone to an Emergency Department (ED) for care in the past 6 months?

☐ Yes ☐ No ☐ Decline to answer

If yes, please explain the reason for the ED visit(s), the location, and the date of the visit(s):

_____

_____

In general, would you say that the member's health is:

☐ Excellent ☐ Very good ☐ Good
☐ Fair ☐ Poor ☐ Decline to answer

Does the member currently have any of the following conditions or diagnoses?

☐ Anxiety Disorder
☐ Asthma
☐ Attention-Deficit/Hyperactivity Disorder (ADHD)
☐ Autism Spectrum Disorder
☐ Autoimmune Disorder
☐ Birth Defect
☐ Cancer
If yes, please specify type and location:

_____

☐ Cystic Fibrosis
☐ Depression / Bipolar Disorder / Other Mood Disorder
☐ Diabetes
☐ Down Syndrome
☐ Eating Disorder
☐ Epilepsy / Seizure Disorder
☐ Genetic Disorder
☐ Heart Condition
☐ Kidney Disease
☐ Learning Disability
☐ Liver Disease
☐ Metabolic Condition
☐ Sickle Cell Anemia
☐ Skin Disorder
☐ Substance use disorder
☐ Thyroid Disorder
☐ Transplant
If yes, which organ:

_____

☐ Hearing Impairment
☐ Vision Impairment
☐ None
☐ Decline to answer
☐ Other (add anything not included above):

_____

Does the member have any past conditions or diagnoses?

☐ Yes ☐ No ☐ Unsure ☐ Decline to answer

If yes, list conditions or diagnoses:

_____

_____

_____

Are you/your child on a special diet?

☐ Yes ☐ No ☐ Decline to answer ☐ Other

Explain special diet:

_____

_____

_____

Activities of Daily Living

Please rate the member's level of independence with:

Bathing or showering

☐ Does it on their own ☐ Does it with help ☐ Does not do it ☐ Decline to answer ☐ Not applicable

Getting dressed

☐ Does it on their own ☐ Does it with help ☐ Does not do it ☐ Decline to answer ☐ Not applicable

Using the toilet

☐ Does it on their own ☐ Does it with help ☐ Does not do it ☐ Decline to answer ☐ Not applicable

Getting in and out of a bed, chair, or wheelchair

☐ Does it on their own ☐ Does it with help ☐ Does not do it ☐ Decline to answer ☐ Not applicable

Eating

☐ Does it on their own ☐ Does it with help ☐ Does not do it ☐ Decline to answer ☐ Not applicable

Controlling the bladder and bowels (avoiding accidents)

☐ Does it on their own ☐ Does it with help ☐ Does not do it ☐ Decline to answer ☐ Not applicable

Does the member use any of the following:

☐ None
☐ Apnea monitor
☐ Communication device
☐ Feeding tube
☐ Feeding pump
☐ Hearing aids
☐ Insulin pump
☐ Nebulizer
☐ Orthotic braces/splints
☐ Oxygen
☐ Pulse oximeter
☐ Suction machine
☐ Special bed
☐ Tracheostomy
☐ Ventilator
☐ Wheelchair
☐ Other: _____
☐ Decline to answer

Do you/your child wear glasses or contacts?

☐ Yes ☐ No ☐ Decline to answer

☐ Other (please describe):

_____

_____

Does the member receive any therapies or services?

☐ Behavioral Health Therapy/Counseling
☐ Dialysis (kidney disease services)
☐ Home Health Services, including nursing services
☐ Occupational Therapy
☐ Physical Therapy
☐ Respiratory Therapy
☐ Speech Therapy
☐ None
☐ Decline to answer
☐ Other: _____

Is the member receiving Women, Infants, and Children (WIC) services or assistance?

☐ Yes ☐ No ☐ Decline to answer

Has the member's doctor ever told them that they are overweight or underweight?

☐ Yes, overweight ☐ Yes, underweight ☐ No ☐ Decline to answer

How would you rate the member's overall nutrition?

☐ There are no concerns
☐ There are some concerns
☐ There are many concerns
☐ Decline to answer

If there are concerns, please describe:

_____

_____

Has the member ever been pregnant?

☐ Yes
☐ No
☐ Unsure
☐ Not applicable
☐ Decline to answer

If yes, please provide details such as the number of pregnancies, date(s) of delivery, and any complications:

_____

_____

Does the member have support from family, friends, caregivers, and school (if applicable) to meet their health needs?

☐ Yes ☐ No ☐ Unsure ☐ Decline to answer

If no, please provide more information:

_____

_____

_____

Exercise and Activity

On average, how many minutes of physical activity or active play does the member get each day?

☐ Less than 30 minutes
☐ 30-60 minutes
☐ 60-90 minutes
☐ More than 90 minutes
☐ Decline to answer

How is the member's level of activity compared to others their age?

☐ Much less active
☐ Less active
☐ About the same
☐ More active
☐ Much more active
☐ Decline to answer

Sleep

On average, how many hours of sleep does the member get each night?	_____ hours
On average, how many hours per day does the member have screen time (TV, video games, phone, and other electronics)?	_____ hours

Are there any concerns about the member's health or development?

☐ Yes ☐ No ☐ Unsure ☐ Decline to answer

If yes, please describe:

_____

_____

Cognitive

Is the member able to communicate and understand instructions?

☐ Yes
☐ No
☐ Unsure
☐ Not applicable
☐ Decline to answer

Is the member able to learn and remember information about their health?

☐ Yes
☐ No
☐ Unsure
☐ Not applicable
☐ Decline to answer

SOCIAL NEEDS: The next few questions are about basic things people need that can affect health. Your answers help us know if the member needs extra help. If there are needs, someone from our care management team may reach out to you.

Finances: How often does this describe the member or their household? I/we don't have enough money to pay my/our bills.

☐ Never ☐ Sometimes ☐ Always
☐ Rarely ☐ Often ☐ Decline to answer

Housing: Are you worried or concerned that in the next 2 months you (or your child) may not have stable housing that you own, rent, or stay in as a part of a household?

☐ Yes ☐ No ☐ Decline to answer

Food: Within the past 12 months, did the member/their household worry that food would run out before there was money to buy more?

☐ Yes ☐ No ☐ Decline to answer

Transportation: In the last 6 months, has the member ever had to go without healthcare because they didn't have a way to get there?

☐ Yes ☐ No ☐ Decline to answer

Do you have childcare when you need it?

☐ Yes ☐ No ☐ Decline to answer

Substance Use: Please answer the following questions about the member, if the member is age 12 or older.

In the past year, how many times has the member used:

Tobacco
☐ Weekly or more ☐ Monthly ☐ Once or twice ☐ Never

Alcohol
☐ Weekly or more ☐ Monthly ☐ Once or twice ☐ Never

Marijuana
☐ Weekly or more ☐ Monthly ☐ Once or twice ☐ Never

Prescription drugs that were not prescribed for you (such as pain medication or Adderall)
☐ Weekly or more ☐ Monthly ☐ Once or twice ☐ Never

Illegal drugs (such as cocaine or ecstasy)
☐ Weekly or more ☐ Monthly ☐ Once or twice ☐ Never

Inhalants (such as nitrous oxide)
☐ Weekly or more ☐ Monthly ☐ Once or twice ☐ Never

Herbs or synthetic drugs (such as salvia, "K2", or bath salts)
☐ Weekly or more ☐ Monthly ☐ Once or twice ☐ Never

Has the member been exposed to any of these drugs?		
☐ Yes	☐ No	☐ Decline to answer
If yes, which one(s):		
_____		

Over the last 2 weeks, how often has the member been bothered by any of the following problems?		
Feeling down, depressed, irritable, or hopeless?		
☐ Not at all	☐ More than half the days	☐ Decline to answer
☐ Several days	☐ Nearly every day	
Little interest or pleasure in doing things?		
☐ Not at all	☐ More than half the days	☐ Decline to answer
☐ Several days	☐ Nearly every day	
Trouble falling asleep, staying asleep, or sleeping too much?		
☐ Not at all	☐ More than half the days	☐ Decline to answer
☐ Several days	☐ Nearly every day	
Poor appetite, weight loss, or overeating?		
☐ Not at all	☐ More than half the days	☐ Decline to answer
☐ Several days	☐ Nearly every day	
Feeling tired or having little energy?		
☐ Not at all	☐ More than half the days	☐ Decline to answer
☐ Several days	☐ Nearly every day	
Feeling bad about yourself – or feeling that you are a failure, or have let yourself or your family down?		
☐ Not at all	☐ More than half the days	☐ Decline to answer
☐ Several days	☐ Nearly every day	
Trouble concentrating on things, such as school work, reading, or watching TV?		
☐ Not at all	☐ More than half the days	☐ Decline to answer
☐ Several days	☐ Nearly every day	
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?		
☐ Not at all	☐ More than half the days	☐ Decline to answer
☐ Several days	☐ Nearly every day	
Thoughts that you would be better off dead, or of hurting yourself in some way?		
☐ Not at all	☐ More than half the days	☐ Decline to answer
☐ Several days	☐ Nearly every day	

School and Social Well-being			
Does the member attend school?			
☐ Yes	☐ No	☐ Decline to answer	
If attending school, how often is the member absent or tardy?			
☐ Hardly ever ☐ Sometimes	☐ Quite often ☐ Not applicable	☐ Decline to answer	
Does the member have an Individualized Education Plan (IEP) or 504 Health Plan?			
☐ Yes	☐ No	☐ Decline to answer	☐ Not applicable
Does the member have friends?			
☐ Yes	☐ No	☐ Decline to answer	☐ Not applicable
Does the member get along well with others?			
☐ Yes	☐ No	☐ Decline to answer	☐ Not applicable
In the last year, has the member been bullied, or is there suspicion that the member is being bullied?			
☐ Yes	☐ No	☐ Decline to answer	☐ Not applicable
Is the member's access to the internet monitored?			
☐ Yes	☐ No	☐ Decline to answer	☐ Not applicable

Children, adolescents, and young adults can benefit from having an advance directive, such as a living will, healthcare proxy, durable power of attorney, Medical Orders for Life-Sustaining Treatment (MOLST), or Portable Orders for Life-Sustaining Treatment (POLST) in place. This is especially true for those with chronic or life-threatening health conditions. Does the member have such a document in place?			
☐ Yes	☐ No	☐ Unsure	☐ Decline to answer
If Yes, which type(s):			
☐ Living will		☐ Healthcare proxy	
☐ Behavioral Health power of attorney		☐ MOLST/POLST	
☐ Durable power of attorney		☐ Other (please specify): _____	

Would you like any information on any of the life planning options?			
☐ Yes	☐ No	☐ Unsure	☐ Decline to answer

OPTIONAL: The following questions are optional. We ask these questions to understand the member's needs. All information will remain confidential.

What is the member's sex assigned at birth/listed on birth document?

- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Decline to answer

What is the member's gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender male/trans man/female-to-male (FTM)
- ☐ Transgender female/trans woman/ male-to-female (MTF)
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional gender category or other: _____
- ☐ Two-Spirit
- ☐ Don't know
- ☐ Decline to answer

What are the member's pronouns?

When someone is talking with you/your child, what does you/your child prefer they say?

- ☐ He / Him
- ☐ She / Her
- ☐ They / Them
- ☐ Other: _____
- ☐ Don't know
- ☐ Decline to answer

What is the member's sexual orientation?

- ☐ Lesbian, gay, or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Don't know
- ☐ Decline to answer
- ☐ Something else, describe: _____

References:

1. Waisman Activities of Daily Living Scale (W-ADL). Maenner MJ, Smith LE, Hong J, Makuch R, Greenberg J, Mailick MR. An Evaluation of an Activities of Daily Living Scale for Adolescents and Adults with Developmental Disabilities. Disability and Health Journal. 2013 Jan;6(1):8-17.
2. Screening to Brief Intervention (S2BI). Levy, S., Weiss, R., Sherritt, L., Ziemnik, R., Spalding, A., Van Hook, S., & Shrier, L. A. (2014). An electronic screen for triaging adolescent substance use by risk levels. JAMA Pediatrics, 168(9), 822–828.
3. Patient Health Questionnaire 9 for Adolescents (PHQ-A). Johnson JG, Harris ES, Spitzer RL, Williams JBW: The Patient Health Questionnaire for Adolescents: Validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolescent Health 30:196–204, 2002.
4. Health Leads Screening Toolkit, American Academy of Family Physicians (AAFP) Social Needs Screening Tool.