HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Health Needs Survey Form

Welcome to Health Plan of Nevada! Your health is important to us. That's why we need a little more information to help provide you and your family with quality care to meet your medical needs. **Please take a few minutes to fill out this form. Each adult in the home needs to complete their own form. Your answers are confidential and will only be used to assist you and your family with medical care.** If you need help filling out this form, call us toll-free at **1-800-962-8074**, TTY **711**, Monday through Friday, 8 a.m. to 5 p.m. If we have any questions, we may reach out to you.

Your name: _____ Date of Birth: _____

Medicaid ID #: _____ Primary Care Provider: _____

Family members enrolled in Health Plan of Nevada's Medicaid or Nevada Check Up Program are:

Name of Child(ren):	Date of Birth of Child(ren):	Medicaid ID #	Primary Care Provider:	Are they up-to-date with all their shots?
1._____	1._____	1._____	1._____	1. ☐ No ☐ Yes ☐ Not sure
2._____	2._____	2._____	2._____	2. ☐ No ☐ Yes ☐ Not sure
3._____	3._____	3._____	3._____	3. ☐ No ☐ Yes ☐ Not sure
4._____	4._____	4._____	4._____	4. ☐ No ☐ Yes ☐ Not sure

Address:	Phone Number(s)/Email Address: Home: Work: Mobile: Email Address: Do we have permission to contact you by email/text? ☐ Yes ☐ No
The language(s) we usually speak and read at home: ☐ English ☐ Spanish ☐ Other *(please write here):*	

Please answer the following questions to help us take better care of you and your family members who are enrolled in Health Plan of Nevada: Your answers are confidential as governed by Federal and State Law, and will only be used to assist you with your medical care.
If there are no children in your household, please skip to question #10.

1. Does your child need or use more medical care, mental health or educational services than is usual for most children of the same age? ☐ **No** ☐ **Yes:**

Name of child(ren): _____

2. Does your child currently need or take medication prescribed by a doctor (other than vitamins)?

☐ **No** ☐ **Yes:** Name of child(ren): _____

If yes, is this because of any medical, behavioral or health condition? _____

3. Is your child limited or prevented in any way in their ability to do the things most children of the same age can do?

☐ **No** ☐ **Yes:** Name of child(ren): _____

If yes, is this because of any medical, behavioral or health condition? _____

Please complete and return this form to Health Plan of Nevada, by placing it in the provided postage paid envelope.
Or mail it directly to us at: Health Plan of Nevada, PO Box 15645, Las Vegas, NV 89195-8026.

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4. Does your child have any kind of emotional, developmental, or behavioral problem for which they need or get treatment or counseling?

☐ **No** ☐ **Yes:** Name of child(ren): _____

5. Does your child have any of the following health concerns?

☐ ADD/ADHD ☐ Anxiety/Depression ☐ Autism
☐ Cerebral Palsy ☐ Cystic Fibrosis ☐ HIV/AIDS
☐ Cancer ☐ Asthma ☐ Diabetes
☐ Obesity ☐ Serious Emotional Disturbance (SED) ☐ SUD (Substance Use Disorder)
☐ Sickle Cell Disease ☐ Hemophilia
☐ None ☐ Other Condition (please write specific issue): _____

Name of child(ren): _____

6. Does your child have any of the following health conditions?

☐ Vision Loss ☐ Hearing Loss ☐ Physical Disability
☐ Mental Disability ☐ Learning Disability
☐ None ☐ Other Condition (please write specific issue): _____

Name of child(ren): _____

7. Has your child had a regular check-up with their doctor in the last year? ☐ **No** ☐ **Yes**

8. Has your child seen a dentist in the last year? ☐ **No** ☐ **Yes**

9. Does your child often feel overwhelmed with stress and anxiety? ☐ **No** ☐ **Yes**

10. During the past year, were you or anyone in your family admitted for an overnight stay in a hospital?

☐ **No** ☐ **Yes:**

Name of Person(s) Admitted:	For what problem?
1. _____	1. _____
2. _____	2. _____

11. During the past year, have you or anyone in your family received medical care in a hospital emergency room?

☐ **No** ☐ **Yes:**

Name of Person(s) Admitted:	For what problem?
1. _____	1. _____
2. _____	2. _____

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12. Have you ever been told you have one or more of the following medical conditions?

- ☐ Cancer
- ☐ Chronic Pain
- ☐ Obesity
- ☐ Heart Problems
- ☐ Asthma, COPD, or other breathing problems
- ☐ Sickle Cell Disease
- ☐ Hemophilia
- ☐ Depression or Major Depression
- ☐ Significant Memory Loss or Dementia
- ☐ Schizophrenia/Serious Mental Illness (SMI)
- ☐ Substance Use Disorder (SUD)
- ☐ None
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Opioid Use Disorder
- ☐ High Blood Pressure
- ☐ Kidney Problems or currently on dialysis
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Bi-Polar Disorder
- ☐ Anxiety Disorder
- ☐ Intellectual/Developmental Disability
- ☐ Other Condition (please write specific issue):

_____

13. How many different prescription and over-the-counter medications do you take each day?

☐ 0-3 ☐ 4-6 ☐ More than 7

14. Have you received any of the following services in the past year?

- ☐ Yearly Check-up
- ☐ COVID-19 Vaccine
- ☐ Vision Screening
- ☐ Cervical Cancer Screening/Pap Smear
- ☐ Choose not to answer
- ☐ Colorectal Screening
- ☐ Flu Shot
- ☐ Mammogram
- ☐ None

15. Are you or anyone in your household pregnant now? ☐ **No** ☐ **Yes:**

If "yes," please provide the following information. (Include yourself if it applies):

Name: _____ Date of birth: _____ Due date: _____

Name: _____ Date of birth: _____ Due date: _____

Have you or they seen a doctor for this pregnancy? ☐ **No** ☐ **Yes**

Have you or they been told this is a high-risk pregnancy? ☐ **No** ☐ **Yes**

Are you or they on any prescription medications for pain, or other narcotics? ☐ **No** ☐ **Yes**

16. Is it hard for you to concentrate, remember things, or make decisions? ☐ **No** ☐ **Yes**

17. Over the last two weeks, how often have you been bothered by little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ No Response

18. Over the last two weeks, how often have you been feeling down, depressed or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ No Response

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19. In the past year, have you been unable to get any of the following when you really needed it?

- ☐ Child Care
- ☐ Household Goods
- ☐ Educational Assistance
- ☐ Food
- ☐ Help Managing your Money
- ☐ Transportation
- ☐ Housing
- ☐ Choose not to answer
- ☐ Clothing
- ☐ ID Cards
- ☐ Employment
- ☐ Legal Assistance
- ☐ Phone
- ☐ Utilities
- ☐ None

20. Has alcohol or drug use made it hard for you to work, keep relationships, or meet goals? ☐ **No** ☐ **Yes**

21. What is your housing situation today?

- ☐ I have housing
- ☐ I have housing, and part of my rent is paid by a housing assistance program
- ☐ I have temporary housing
- ☐ I do not have housing

22. In the past year, have you spent more than two nights in a jail or prison? ☐ **No** ☐ **Yes**

23. Do you feel physically and emotionally safe where you live right now? ☐ **No** ☐ **Yes**

24. Do you use tobacco products or vape? ☐ **No** ☐ **Yes**

If yes, are you interested in quitting? ☐ **No** ☐ **Yes**

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