Health Plan of Nevada
A UnitedHealthcare Company

Health Needs Survey Form

Welcome to Health Plan of Nevada Medicaid! 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 over 18 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 6 p.m. If we have any questions, we may reach out to you.

Your name: _____ Date of Birth: _____

Medicaid ID #:_____ Primary Care Provider: _____

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 at home: _____

The language(s) we usually read and write at home: _____

Do you have any other health care insurance coverage? If yes, please list:_____

1. 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 do not have housing
   ☐ I have temporary housing

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

Family members enrolled in Health Plan of Nevada 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

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-962-8074 (TTY: 711).

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 Medicaid*:* 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 #8.

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

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

5. Does your child have any medical conditions? This is something that could require many doctor's visits and regular medications. ☐ **No** ☐ **Yes**
   Name of child(ren): _____

6. Does your child have any kind of emotional, developmental, or behavioral condition for which they need or get treatment or counseling? ☐ **No** ☐ **Yes**
   Name of child(ren): _____

7. If you answered yes to the previous questions, would you like one of our Care Managers to contact you about our programs and services? ☐ **No** ☐ **Yes**

8. Have you been told you have a medical condition? This is something that could require many doctor's visits and regular medications. ☐ **No** ☐ **Yes**

9. Do you have any kind of emotional, developmental, or behavioral conditions for which you need or get treatment or counseling? ☐ **No** ☐ **Yes**

10. If you answered yes to the previous questions, would you like one of our Care Managers to contact you about our programs and services? ☐ **No** ☐ **Yes**

11. During the past year, did you or anyone in your family visit the emergency room or have an overnight stay in the hospital?
    ☐ **No** ☐ **Yes**

    Name of Person(s) Admitted: For what problem?

    1. _____ 1. _____

    2. _____ 2. _____

12. Are you or anyone in your household pregnant that is covered by HPN Medicaid? ☐ **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 are they on any prescription medications for pain, or other narcotics? ☐ **No** ☐ **Yes**

    Would you like one of our care managers to contact you about our programs and services? ☐ **No** ☐**Yes**

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

☐ Yearly check-up
☐ COVID-19 vaccine
☐ Cervical cancer screening/Pap smear
☐ None
☐ Colorectal screening
☐ Flu shot
☐ Mammogram
☐ Choose not to answer

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

15. 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

16. 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

17. Has alcohol or drug use made it hard for you to work, keep relationships, or meet goals?

☐ **No** ☐ **Yes**

18. Have you been unable to get daily necessities? These could be things like childcare, food, transportation, ID card, cell phone, rent or utilities. ☐ **No** ☐ **Yes**

Would you like help with getting these resources? ☐ **No** ☐ **Yes**

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

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

20. In the past year, did you age out of the foster system? ☐ **No** ☐ **Yes**

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

Please complete and return this form to Health Plan of Nevada Medicaid, by placing it in the provided postage paid envelope.

Or mail it directly to us at: Health Plan of Nevada Medicaid, PO Box 15645, Las Vegas, NV 89195-8026.