Health Information Form

ONE FORM PER MEMBER - **AGES 17 AND UNDER**

Tell us about your child's health history. *This form will help us find out if there are any extra services or tools your child may need.*

Member First Name: _____ Member Last Name: _____

Medicaid ID#: _____ Date of Birth (mm/dd/year): _____

1. Do you feel your child's health is: ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor ☐ Prefer not to say
2. Has your child seen a Primary Care Provider (PCP) (e.g., a doctor, nurse or clinic that your child sees for check-ups and routine care) in the last 12 months: ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
3. Does your child have a specialist(s), for example an allergy doctor or a heart doctor, that they see on an ongoing basis? ☐ Yes ☐ No ☐ Prefer not to say
4. Over the past two weeks, how often has your child shown little interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Prefer not to say
5. Over the past two weeks, how often has your child appeared to be feeling down depressed or hopeless? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Prefer not to say
6. How many emergency room (ER) visits has your child had in the past six months? ☐ 0 visits ☐ 1-2 visits ☐ 3-4 visits ☐ 5 or more visits ☐ Prefer not to say
7. How many unplanned hospitalizations has your child had in the last 12 months? ☐ 0 visits ☐ 1-2 visits ☐ 3-4 visits ☐ 5 or more visits ☐ Prefer not to say
8. Has your child seen a dentist in the last 12 months? (Ages 12 months and older.) ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say ☐ N/A
9. Has your child had a flu shot in the last 12 months? (Ages 6 months and older.) ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say ☐ N/A
10. Is your child up-to-date on their immunizations? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
11. Has your child had an eye exam in the last 12 months? (Ages 3 and older.) ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say ☐ N/A
12. Does your child have any physical or behavioral health conditions where they are under the care of a doctor or told that they should be under the care of a doctor? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
13. Does your child have two or more chronic conditions such as heart conditions, diabetes, asthma, conduct disorder, attention deficit/hyperactivity disorder (ADHD), autism, auto immune disorders, or seizures? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
14. In the last seven days, has your child complained of pain? How would you rate their pain on a scale of 0 to 10, with 0 being no pain to 10 being excruciating pain? ☐ 0-3 pain rating ☐ 4-5 pain rating ☐ 6 pain rating ☐ 7-8 pain rating ☐ 9 pain rating ☐ 10 pain rating ☐ Prefer not to say
15. Does your child take four or more prescription medications on a regular basis? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
16. Does your child take their medications as prescribed and instructed by their doctor? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say ☐ N/A
17. Do you have any concerns about your child's medicines? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
18. Does your child use any medical equipment currently? (e.g., wheelchair, walker, crutches, nebulizer, diabetic supplies) ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
19. Does your child need more help with activities of daily living than other children their age? (e.g., bathing, medication, dressing, feeding) ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
20. What is your child's current weight? lbs.
21. What is your child's current height in inches?
22. Has a doctor or specialist recommended your child gain or lose weight? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say
23. In the past 12 months has your child ever threatened or talked about harming themselves or others? ☐ Yes ☐ No ☐ Prefer not to say
24. Is your child pregnant or do you suspect that they are pregnant? (Females ages 8 and older.) ☐ Yes ☐ No ☐ Prefer not to say ☐ N/A

(Continue on reverse side.)

25. Does your child currently use tobacco, electronic cigarettes, vaping or smokeless tobacco products?
☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

26. Does your child spend time with anyone who uses cigarettes or other tobacco products?
☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

27. How often does your child consume alcohol?
☐ Never ☐ Less than monthly ☐ Monthly
☐ Weekly ☐ Daily or almost daily ☐ Unsure
☐ Prefer not to say ☐ N/A

28. Does your child regularly wear a seatbelt or ride in a car seat? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

29. For children ages 6 and older who are capable of physical activity: In the past week, on how many days has your child done a total of 30 minutes or more of physical activity, that was enough to raise their heart rate and breathing rate? (This may include sports, exercise and brisk walking or cycling for recreation or to get to and from places). ☐ 5-7 ☐ 3-4 ☐ 1-2 ☐ 0
☐ Unsure ☐ Prefer not to say ☐ N/A

30. In the past 12 months has your child used recreational drugs? ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

31. Has your child had a well-child exam or KAN Be Healthy screening in the past 12 months?
☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

32. Because difficult relationships can cause health problems, we are asking all of our members the following question: Does a partner or anyone at home hurt, hit or threaten your child? ☐ Yes ☐ No
☐ Prefer not to say

33. Does your child have a regular, safe place to sleep and store their things? ☐ Yes ☐ No ☐ Prefer not to say

34. What is your child's employment status?
☐ Employed ☐ Too young to be employed
☐ Unemployed, actively seeking employment
☐ Unemployed, not seeking employment
☐ Unemployed, but may want to seek employment
☐ Prefer not to say

35. Does your child have a Social Security disability determination? ☐ Yes ☐ No ☐ Prefer not to say

36. Does your child have any current legal problems or on probation or parole? ☐ Yes ☐ No ☐ Unsure
☐ Prefer not to say ☐ N/A

37. How often do you, as the parent or guardian, need to have someone help you read instructions, pamphlets or other written material from your child's doctor or pharmacy? ☐ Never ☐ Sometimes ☐ Usually
☐ Always ☐ Prefer not to say

38. Is your family currently receiving supports for healthy eating? (Supplemental Nutrition Assistance Program (SNAP), Food Stamps, Special Supplemental Food Program for Women, Infants and Children (WIC), etc.)
☐ No ☐ Yes ☐ No, but would like to ☐ Don't know
☐ Prefer not to say

39. Does your family worry about paying bills? ☐ Yes
☐ No ☐ Unsure ☐ Prefer not to say ☐ N/A

40. What is your child's highest level of education?
☐ Has not yet entered school
☐ Is making satisfactory progress
☐ Has or is at risk of failing or dropping out
☐ Has earned a high school diploma or GED

41. At how many addresses has your child lived in the past 12 months?

42. If employed, do you feel that your child is employed adequately based on their skills and knowledge?
☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say ☐ N/A

43. Within the past 30 days, where has your child been living? (may select multiple options)?
☐ Owned or rented home ☐ Homeless
☐ Stayed at someone else's home ☐ Hotel
☐ Group home setting ☐ Other
☐ Transitional living facility or temporary emergency shelter
☐ Prefer not to say

If your child is having any problems (physical, social, behavioral) that you would like to talk to a Sunflower staff person about, please call us toll free at **1-877-644-4623 (TTY 711)**.

Sunflower will use the information on this form to help your child get healthcare services. Your child's information will be kept private and confidential as required by state and federal law. For more information, please see the Notice of Privacy Practice section of your member handbook or call us at **1-877-644-4623 or TTY 711**.

Please send this completed form back to Sunflower. You can:

- Use the prepaid envelope (if provided).
- Mail to Medical Management Notifications, PO Box 2010, Farmington MO 63640-9706.
- Fax (toll free) to 1-855-581-2246.
- Email to SunflowerPHCM@sunflowerhealthplan.com.