

# HNE Be Healthy Health Needs Assessment (HNA)

Please take a few minutes to complete this survey.

This information is private. Your answers will NOT affect your health insurance benefits. When you have finished, please mail it back in the envelope provided. **Please complete one survey per person.** For additional copies go to hne.com, call HNE Member Services, or complete the checkbox at the bottom of this page. Thank you!

HNA completed by: \_\_\_\_\_ Relationship to member: \_\_\_\_\_

## PERSONAL INFORMATION

1. Last name: \_\_\_\_\_

First: \_\_\_\_\_

Middle: \_\_\_\_\_

2. Your current mailing address:

Number and Street: \_\_\_\_\_

Apartment #: \_\_\_\_\_

City/Town: \_\_\_\_\_

State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

2a. Please check the box if you are currently homeless:

3. Your date of birth: \_\_\_\_\_

4. Your gender:  Female  Male

5. What is your email address? \_\_\_\_\_

6. What is your HNE Be Healthy Member ID number? \_\_\_\_\_

7. What are your telephone numbers for HNE Be Healthy to contact you about your health needs?

Preferred number (area code first): \_\_\_\_\_

Secondary number (area code first): \_\_\_\_\_

8. Compared to others your age, how would you describe your health now?

Excellent

Good

Fair

Poor

9. Do you have trouble doing any of the following because of your health? Check as many as apply:

Walking several blocks without stopping

Bathing/showering

Sleeping

Eating

Preparing meals

Doing light household chores, such as vacuuming

Attending work or school

Exercising or playing

We did not include a Provider Directory or a Prescription Drug Formulary with your Welcome Kit. The Provider Directory, the Prescription Drug Formulary, and the HNA are available on our website. Go to hne.com and click HNE Be Healthy. You may use this form to request that we mail you copies. You also may use this form to request that we mail you additional HNA Surveys. Please check all that apply:

Please send me a Provider Directory.

Please send me a Prescription Drug Formulary.

Please send me \_\_\_\_\_ copies of the HNE Be Healthy Health Needs Assessment Survey.

You also can request this information by calling HNE Member Services at 413.788.0123 or 1.800.786.9999 (TTY users call 1.800.439.2730). We are available Monday through Friday from 8:00 a.m. to 5:00 p.m.

10. Do you have a regular doctor or nurse you usually go to for healthcare needs — sometimes referred to as a primary care provider (PCP)?

- Yes  No

10a. If YES, please provide the following information about your PCP:

Name:

Address:

Phone number:

10b. If YES, have you seen your PCP in the last 12 months?

- Yes  No

11. Are you pregnant?

- Yes  No

11a. If YES, when is your due date? \_\_\_\_\_

11b. Do you have an OB/GYN provider, a regular doctor, nurse, or midwife who is providing care during this pregnancy?

- Yes  No

11c. If YES, please provide the following information about your OB/GYN provider:

Name:

Address:

Phone Number:

12. Are you currently being treated, or have you ever been treated, for any of the following? Please check as many as apply:

- ADD/ADHD
- Alcohol use or drug use
- Anxiety
- Asthma
- Cancer
- Chronic pain
- Congestive heart failure

- Depression
- Developmental delays/learning disability
- Diabetes
- High blood pressure
- High cholesterol
- HIV/AIDS
- Kidney disease
- Migraines/persistent headaches
- Obesity/weight problems
- Other heart problems
- Stress
- Trouble breathing

13. Has anyone in your immediate family ever suffered from any of the following? (Your immediate family includes your mother, father, sister, brother, and your children — blood relatives only.) Please check as many as apply:

- ADD/ADHD
- Alcohol use or drug use
- Anxiety
- Asthma
- Cancer
- Chronic pain
- Congestive heart failure
- Depression
- Developmental delays/learning disability
- Diabetes
- High blood pressure
- High cholesterol
- HIV/AIDS
- Kidney disease
- Migraines/persistent headaches
- Obesity/weight problems
- Other heart problems
- Stress
- Trouble breathing

14. Do you currently take any prescription medications on a regular basis?

- Yes  No

15. In the last 12 months, how many times did you visit an emergency room?

- Never  
 1-3 times  
 4-6 times  
 More than 6 times

16. In the last 12 months, have you stayed overnight in a hospital?

- Yes  No

17. In the last 12 months, have you missed a doctor's appointment?

- Yes  No

18. Are you hearing-impaired?

- Yes  No

19. Do you currently use a wheelchair?

- Yes  No

20. Do you use tobacco products?

- Yes  No

20a. If YES, would you like to get information about quitting smoking or tobacco use?

- Yes  No

21. Would you like to get information about alcohol and substance use?

- Yes  No

22. How often do you buckle your seat belt?

- Always  Sometimes  Never

23. Do you have any children under age 8 in your household?

- Yes  No

23a. If yes, how often do you use a car seat or booster seat for your children when driving?

- Always  
 Sometimes  
 Never

24. Are you currently getting any services from any of the following state agencies? Your answers to this question will NOT affect your MassHealth/Medicaid benefits. Your answers can help us coordinate all the services you get and serve you better in the future. Please check all that apply:

- Massachusetts Commission for the Blind  
 Massachusetts Commission for the Deaf and Hard of Hearing  
 Massachusetts Rehabilitation Commission  
 Department of Mental Health  
 Department of Developmental Services  
 Department of Children and Families  
 Special Education  
 Early Intervention Program  
 Other (Please specify: \_\_\_\_\_)

25. How would you describe your race?

- You may choose up to two options here. For example "White" or "Black," or "Asian" and "Hispanic."*
- American Indian/Alaska native  
 Asian  
 Black/African American  
 Hispanic  
 Native Hawaiian or other Pacific Islander  
 White  
 Other race  
 Unknown/not specified

26. How would you describe your ethnic background?  
*You may chose up to two options here. For example "American" or "Mexican," or "Cuban" and "Puerto Rican."*

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> African                                    | <input type="checkbox"/> Colombian        | <input type="checkbox"/> Middle Eastern                           |
| <input type="checkbox"/> African American                           | <input type="checkbox"/> Cuban            | <input type="checkbox"/> Portuguese                               |
| <input type="checkbox"/> American                                   | <input type="checkbox"/> Dominican        | <input type="checkbox"/> Puerto Rican                             |
| <input type="checkbox"/> Asian                                      | <input type="checkbox"/> Eastern European | <input type="checkbox"/> Russian                                  |
| <input type="checkbox"/> Asian Indian                               | <input type="checkbox"/> European         | <input type="checkbox"/> Salvadoran                               |
| <input type="checkbox"/> Brazilian                                  | <input type="checkbox"/> Filipino         | <input type="checkbox"/> South American (not otherwise specified) |
| <input type="checkbox"/> Cambodian                                  | <input type="checkbox"/> Guatemalan       | <input type="checkbox"/> Vietnamese                               |
| <input type="checkbox"/> Cape Verdean                               | <input type="checkbox"/> Haitian          | <input type="checkbox"/> Other ethnicity                          |
| <input type="checkbox"/> Caribbean Islander                         | <input type="checkbox"/> Honduran         | <input type="checkbox"/> Unknown/ not specified                   |
| <input type="checkbox"/> Central American (not otherwise specified) | <input type="checkbox"/> Japanese         |   |
| <input type="checkbox"/> Chinese                                    | <input type="checkbox"/> Korean           |   |
|   | <input type="checkbox"/> Laotian          |   |
|   | <input type="checkbox"/> Mexican, Chicano |   |

27. Are you able to access private or public transportation for your medical appointments?:

- Yes  No



28. What language would you prefer we use for communicating with you? Please choose one:

Spoken	Written	Language
<input type="checkbox"/>	<input type="checkbox"/>	African (please specify):
<input type="checkbox"/>	<input type="checkbox"/>	Arabic (please specify):
<input type="checkbox"/>	<input type="checkbox"/>	Cape Verdean Creole
<input type="checkbox"/>	<input type="checkbox"/>	Chinese (please specify):
<input type="checkbox"/>	<input type="checkbox"/>	English
<input type="checkbox"/>	<input type="checkbox"/>	French
<input type="checkbox"/>	<input type="checkbox"/>	German
<input type="checkbox"/>	<input type="checkbox"/>	Greek
<input type="checkbox"/>	<input type="checkbox"/>	Haitian Creole
<input type="checkbox"/>	<input type="checkbox"/>	Hebrew
<input type="checkbox"/>	<input type="checkbox"/>	Hindi
<input type="checkbox"/>	<input type="checkbox"/>	Italian
<input type="checkbox"/>	<input type="checkbox"/>	Japanese
<input type="checkbox"/>	<input type="checkbox"/>	Korean
<input type="checkbox"/>	<input type="checkbox"/>	Persian
<input type="checkbox"/>	<input type="checkbox"/>	Polish
<input type="checkbox"/>	<input type="checkbox"/>	Portuguese
<input type="checkbox"/>	<input type="checkbox"/>	Russian
<input type="checkbox"/>	<input type="checkbox"/>	Spanish
<input type="checkbox"/>	<input type="checkbox"/>	Tagalog
<input type="checkbox"/>	<input type="checkbox"/>	Urdu
<input type="checkbox"/>	<input type="checkbox"/>	Vietnamese
<input type="checkbox"/>	<input type="checkbox"/>	Other Language (please specify):
<input type="checkbox"/>	<input type="checkbox"/>	Declined