AdvancedHealth
Bridging the Future of Healthcare
289 LaClair Street, Coos Bay, Oregon 97420 541-269-7400 * 1-800-264-0014 * TTY 1-877-735-1232

CHILDRENS HEALTH RISK ASSESSMENT

INITIAL / ANNUAL / UPDATE

CHILD'S NAME:	**GUARDIANS NAME:**
ADDRESS:	**RELATIONSHIP:**
PHONE:	**EMAIL:**
DOB:	**SEX: M / F**
RACE: PLEASE CIRCLE ONE **American Indian / Alaska Native** **Asian** **Black / African American** **Hispanic / Latino** **Multiracial** **Native Hawaiian / Other Pacific Islander** **White** **Other:**	**ETHNICITY: PLEASE CIRCLE ONE** **Hispanic or Latino** **Not Hispanic or Latino** **PLAN TYPE: PLEASE CIRCLE ONE** **CCOA – Medical, Dental, Behavioral Health, Transportation** **CCOB – Medical, Dental, Transportation** **CCOE – Behavioral Health, Transportation** **CCOG – Behavioral Health, Dental, Transportation**

Is English your primary language? **YES ☐ No ☐**

How well is your understanding of English? **☐Good ☐ Some ☐ None**

What is your preferred language? **☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Russian**

☐ Hindi ☐ American Sign Language ☐ Other

Do you need an interpreter? **YES ☐ No ☐**

Name of person completing the form:_____ Relationship:_____

If not the parent(s) do, we have Guardianship papers on file? **YES ☐** No ☐

Does your child use any assistive devices to see or hear, such as glasses or hearing aids? **YES☐** No ☐

Do you have any cultural needs? (Such as health beliefs or customs) **YES** ☐ No ☐ Please explain: _____

(Optional) What gender does your child identify with? _____

Do you have someone you want us to talk to about their health information? (Example: your spouse, relative, friend, caregiver, or case manager) **YES** ☐ No ☐

Name: _____ Relationship: _____ Contact information: _____

Do we have permission to talk to this person about your health and healthcare needs today? ☐**YES** ☐ **NO**

Verbal Authorization is only good for one day. A Release of Information will need to be on file.

Who is their doctor? _____

When was their last visit? ☐ **0-6 Months** ☐ **6-12 months** ☐ **1 year**

Who is their Dentist?_____

When was their last visit?_☐ **0-6 Months** ☐ **6-12 months** ☐ **1 year**

Would you like additional information about their Dental benefit? ☐**YES** ☐ **NO**

In general, what would you say their health is? ☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent**

*(For girls only) Are they currently pregnant? ☐**YES** ☐ **NO**

Do you need assistance with transportation to appointments? ☐YES ☐ NO

Would you like additional information about their transportation benefits? ☐YES ☐ NO

*Have they been hospitalized over the last 6 months? ☐YES ☐ NO

If so, why and when?_____

*Have they visited the ED in the past year? ☐YES ☐ NO

If so, why and when? _____

Do they take any medications daily? ☐YES ☐ NO

Are you enrolled in a medication assistance program? ☐YES ☐ NO

Do they use any Durable Medical Equipment such as a wheelchair or brace or walker? ☐**YES** ☐ **NO**

(How have your Durable Medical Equipment items been purchased previously) _____

Do they have any allergies (Food/Medication/Environmental)? ☐YES ☐ NO

If yes, what allergies? _____

Do they usually eat a diet that includes fruit, vegetables, and whole grains? ☐**YES** ☐ **NO**

Height:_____Weight:_____Blood Pressure, if known:

Are their Immunizations up to date? ☐**YES** ☐ **NO** ☐**Unknown**

*Have you ever been informed that your child has an intellectual or developmental delay? ☐**YES** ☐ **NO**

*Diagnosed with Neonatal Abstinence Syndrome? ☐**YES** ☐ **NO**

In the past 7 days, how often did they exercise for at least 60 minutes in a day?

☐ **Every day** ☐ **3-6 days** ☐ **1 to 2 days** ☐ **-0- days**

Do you follow the recommended screen time guidelines? ☐ **0 (under 2 yrs.)** ☐ **1 hour daily (2-5 yrs.)** ☐ **2 hours per day (6-17 yrs.)**

Do they know basic safety rules such as?

Wearing bike helmet ☐**YES** ☐ **NO** Crossing Street ☐**YES** ☐ **NO**

Wearing a seatbelt ☐**YES** ☐ **NO** Calling 911 ☐**YES** ☐ **NO**

Does your family have a fire safety and emergency plan? ☐**YES** ☐ **NO**

In the past 7 days how often did your child get at least 8 hours of sleep? ☐ **Every day** ☐ **3-6 days** ☐ **1-2 days** ☐ **-0- days**

Do you have access to a smart phone/computer? ☐**YES** ☐ **NO**

Do you run out of food before you are able to afford to buy more? ☐ **Yes** ☐ **No**

Are you currently receiving SNAP (Food Assistance) benefits? ☐ **Yes** ☐ **No**

Would you like information about applying for SNAP benefits? ☐ **Yes** ☐ **No**

Would you like a list of local food banks? ☐ **Yes** ☐ **No**

Do you have any clothing needs? ☐ **Yes** ☐ **No**

Do you feel safe in your neighborhood? ☐ **Yes** ☐ **No**

Do you feel safe in your home? ☐ **Yes** ☐ **No**

Have you missed any rent or mortgage payments in the last 6 months? ☐ **Yes** ☐ **No**

Have you received an eviction notice? ☐ **Yes** ☐ **No**

Have your utilities, such as water or electric, been shut off in the last 6 months? ☐**YES** ☐ **NO**

*Have you recently experienced homelessness or are at risk of becoming homeless? ☐**YES** ☐ **NO**

What is your living arrangement now? (Circle)

Own or Rent Home/Apt Live with friend/relative Foster Home Other:

Do you want help changing your living situation? ☐**YES** ☐ **NO**

Do they attend School? ☐**YES** ☐ **NO**

*Have they been asked to not return to school or Daycare? ☐**YES** ☐ **NO**

Do they have an Individual Education Plan (IEP)? ☐YES ☐ NO

*Has there been Department of Human Services (DHS) involvement or a history of abuse or neglect?

☐YES ☐ NO

*Has their doctor said they have a serious or chronic illness? ☐**YES** ☐ **NO**

If yes circle illness: Autism Asthma Cancer Diabetes Type I Diabetes Type II HIV/AIDS N/A Other:

Would you like additional educational materials about your child's health? ☐**YES** ☐ **NO**

Krames online at https://schuyler.kramesonline.com/ is a free patient education resource with simple basic educational health sheets.

Do they have a family history of any of the following? ☐**YES** ☐ **NO** If yes circle illness:

Heart High Blood Pressure Diabetes Cancer Lung or Breathing Problems Chronic Pain Stroke Hearing Problems Vision Problems Bladder or Kidney Problems Liver Problems Tuberculosis HIV/AIDS Allergies Asthma ☐ N/A Other

*Are they experiencing any of the following (If yes circle any that apply)?

Anxiety☐ Depression☐ Stress☐ Lack of emotional/social support☐ Abuse☐ ☐ N/A

*Have they been diagnosed with a behavioral or emotional illness? ☐**YES** ☐ **NO**

If yes, please list: _____

Would you like assistance in getting them connected to Behavioral Health services? ☐**YES** ☐ **NO**

If yes, please find the following: **Coos Crisis line (541) 266-6800** **Curry Crisis line (877) 519-9322**

Would you like additional information about their Behavioral Health Benefit? ☐**YES** ☐ **NO**

Do they use tobacco (smoke, vape or chew)? ☐**YES** ☐ **NO** ☐ **N/A**

*Do they use alcohol? ☐**YES** ☐ **NO** If yes, how often:_____

*Do they Use any illegal substances? ☐**YES** ☐ **NO** **N/A**

*Are you currently working with APD or a case worker through another agency? ☐**YES** ☐ **NO**

If yes, which agency: _____

Do they have other insurance? ☐**YES** ☐ **NO**

If yes, which one?_____

What is their ID#? _____This will help us coordinate your benefits.

Have they recently been part of a different Coordinated Care Organization? ☐**YES** ☐ **NO**

If yes, which one?_____ This will help us coordinate your benefits.

They may also qualify for extra help through our Intensive Care Coordination Program.

*Are you interested in participating in care coordination? ☐**YES** ☐ **NO**

If you are unsure if you fit in to any of the above groups, or think you need care coordination help, please call Member Services at 541-269-7400 *or* 1-800-264-0014 *or* TTY 1-877-769-7400.

You can get this letter in another language, large print, or another way that is best for you free of charge. You can also have a language interpreter free of charge.

Call Advanced Health Member Services at:

541-269-7400 or 800-264-0014 (TTY: 711)