289 LaClair Street, Coos Bay, Oregon 97420 541-269-7400 * 1-800-264-0014 * TTY 711

CHILDRENS HEALTH RISK ASSESSMENT

INITIAL / ANNUAL / UPDATE

CHILD'S NAME PRONOUNS:	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: I choose not to answer this question	ETHNICITY: PLEASE CIRCLE ONE Hispanic or Latino Not Hispanic or Latino I choose not to answer this question PLAN TYPE: PLEASE CIRCLE ONE CCOA – Medical, Dental, Behavioral Health, Transportation CCOB – Medical, Dental, Transportation CCOE – Behavioral Health, Transportation CCOG – Behavioral Health, Dental, Transportation

Information Sharing and Gathering

Advanced Health protects your information. All information is used to identify your needs. This survey will be reviewed by the care team serving you. This will be shared with providers to reduce duplication of information gathering. You do not have to answer any questions that do not apply or if you do not want to receive care coordination.

Advanced Health offers Care Coordination to all Members. Care Coordination can help you understand your benefits. It can help you:

- access therapy and substance use disorder help.
- find providers and get appointments.
- with transitions of care.
- find resources like housing, food, safety, climate risk devices, work, school, and health related social needs
- create a care plan to meet your needs.

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

Is English your primary language? YES ☐ No ☐

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

What language are you most comfortable speaking? ☐ English ☐ Spanish ☐ Chinese

☐ Vietnamese ☐ Russian ☐ Hindi ☐ American Sign Language ☐ Other

Do you need an interpreter? YES ☐ No ☐

You can ask Advanced Health Customer Service for a language interpreter. This help is free.

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:
_____

What is your child's gender? (check all that apply) ☐ Girl, Woman ☐ Boy, Man ☐ non-binary ☐ Agender/No gender ☐ Questioning ☐ Not Listed: Please specify: _____ ☐ I don't know ☐ I don't know what this question is asking ☐ I don't want to answer

What is your child's sexual orientation or sexual identity? (check all that apply) ☐ Same-gender loving ☐ Same-sex loving ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Pansexual ☐ Straight (attracted mainly to or only other garner(s) or sex(s)) ☐ Asexual ☐ Questioning ☐ I don't know ☐ Not Listed: Please specify: _____ ☐ I don't know what this question is asking ☐ I don't want to answer

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 their 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.

PHYSICAL HEALTH NEEDS

Who is their doctor? _____

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

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

Are they having any pain? ☐ Yes ☐ No

In the past 7 days if you have pain, how much?

☐ Some ☐ A lot ☐ N/A no pain

If yes, where is the pain and for how long have they had this pain? _____

Have they had a recent injury? ☐ Yes ☐ No

If so, please explain: _____

Do they have any urgent or emergent healthcare needs? ☐ Yes ☐ No

What are the needs? _____

Do they have a serious or chronic illness like one listed below? ☐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_____

Do they take any medications daily? ☐YES ☐ NO

What Medications?_____

Are they enrolled in a medication assistance program? ☐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 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

*Has their doctor said they have any of the following? ☐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

Are they living with other disabilities? Such as Intellectual or a Developmental Disability or Physical Disability?
☐YES ☐ NO ☐ I choose not to answer

Do they need help with any of the following (please circle any that may apply)?

Washing/bathing Using toilet Swallowing/chewing Preparing meals Getting Dressed

Getting in/out bed or chair Using the phone Housekeeping/Laundry Shopping

Medication Management

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

What DME and how have the Durable Medical Equipment items been purchased previously? _____

_____

ORAL HEALTH NEEDS

Who is their Dentist? _____

When was their last visit?☐ 0-6 Months ☐ 6-12 months ☐ 1 year ☐ More than a year

Do you know if they have Dental benefits? ☐YES ☐ NO

Have they ever been afraid to access or unable to access dental care? ☐YES ☐ NO

Have they had dental pain that comes and goes in the past 6 months? ☐YES ☐ NO

Pain or aching from chewing, or sensitivity to hot or cold in the past 6 months? ☐YES ☐ NO

Have they had a tooth pulled out because of a cavity within the past 6 months? ☐YES ☐ NO

Have they had a broken tooth? ☐YES ☐ NO

Have they had any ongoing dental pain that keeps them from normal activities such as sleeping, work, school, etc.? ☐YES ☐ NO

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

SOCIAL HEALTH NEEDS

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

At any point in the past 2 years, has season or migrant farm work been your family's main source of income? ☐ Yes ☐ No ☐ I chose not to answer

During the past year, what was the total combined income for your child's family members they live with?

_____

This information will help us determine if you are eligible for any benefits. ☐ I choose not to answer

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 physically and emotionally safe where you currently live (in your home)? ☐ Yes ☐ No
☐ I choose not to answer

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 electricity, 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 Assisted Living Live with friend/relative Foster Home Retirement Home Nursing Home *I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park I choose not to answer this question

How many family members, including yours, does your child currently live with? Please list: _____

☐ I choose not to answer _____

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

In the past year, has your child spent more than 2nights in a row in a jail, prison, detention center, or juvenile correctional facility? ☐YES ☐ NO ☐ I choose not to answer

Is your child a refugee? ☐YES ☐ NO ☐ I choose not to answer

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

*Is this child in foster care? ☐YES ☐ NO

FUNCTIONAL NEEDS

Is your child living with other disabilities like an Intellectual or a Developmental Disability or Physical Disability? ☐YES ☐ NO ☐ I choose not to answer

Do you need help with any of the following (please circle any that may apply)?

Washing/bathing Using toilet Swallowing/chewing Preparing meals Getting Dressed

Getting in/out bed or chair Using the phone Housekeeping/Laundry Shopping

Medication Management Walking Making Decisions

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

What DME and how have your Durable Medical Equipment items been purchased previously? _____

_____

Do you 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

BEHAVIORAL HEALTH NEEDS

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

Anxiety☐ Depression☐ Stress☐ Lack of emotional/social support☐ Physical or Emotional Abuse☐

☐ N/A

Are they suicidal or expressing they want to hurt themselves? ☐YES ☐ NO

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed is your child? ☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

☐ I choose not to answer

*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

How would you describe their support system? _____

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 Child Welfare or a case worker through another agency? ☐YES ☐ NO

If yes, which agency: _____

Have they had 2 or more placements? ☐YES ☐ NO

Do they have other insurance? ☐YES ☐ NO

If yes, which one?_____

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

Which is your child's main insurance? ☐ None/uninsured ☐ Medicaid ☐ CHIP Medicaid ☐ Medicare ☐ Other Public Insurance (not CHIP) ☐ Other Public Insurance (CHIP) ☐ Private Insurance

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

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

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

MEMBER SELF ASSESSMENT

Compared to 1 year ago, how would you rate their physical health in general? ☐ Excellent ☐ Good ☐ Better ☐ Poor ☐ Not at all ☐ I choose not to answer _____

Compared to 1 year ago, how would you rate their dental health in general? ☐ Excellent ☐ Good ☐ Better ☐ Poor ☐ Not at all ☐ I choose not to answer _____

Compared to 1 year ago, how would you rate their emotional health in general? ☐ Excellent ☐ Good ☐ Better ☐ Poor ☐ Not at all ☐ I choose not to answer _____

*Risk Indicator

If you need immediate care coordination help, please call Member Services at 541-269-7400 *or* 1-800-264-0014 *or* TTY 711.

English

You can get this handbook in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 541-269-7400 or TTY 711 or 800-735-1232. We accept relay calls.

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You can get help from a certified and qualified health care interpreter.

Spanish

Puede obtener este documento en otros idiomas, en letra grande, braille o en un formato que usted prefiera. También puede recibir los servicios de un intérprete. Esta ayuda es gratuita. Llame al servicio de atención al cliente 541-269-7400 o TTY 711 or 800-735-1232. Aceptamos todas las llamadas de retransmisión.

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Usted puede obtener ayudar de un intérprete certificado y calificado en atención de salud.

Russian

Вы можете получить это документ на другом языке, напечатанное крупным шрифтом, шрифтом Брайля или в предпочитаемом вами формате. Вы также можете запросить услуги переводчика. Эта помощь предоставляется бесплатно. Звоните по тел. 541-269-7400

или TTY 711 or 800-735-1232. Мы принимаем звонки по линии трансляционной связи.

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Вы можете получить помощь от аккредитованного и квалифицированного медицинского переводчика.

Vietnamese

Quý vị có thể nhận tài liệu này bằng một ngôn ngữ khác, theo định dạng chữ in lớn, chữ nổi Braille hoặc một định dạng khác theo ý muốn. Quý vị cũng có thể yêu cầu được thông dịch viên hỗ trợ. Sự trợ giúp này là miễn phí. Gọi 541-269-7400 hoặc TTY (Đường dây Dành cho Người Khiếm thính hoặc Khuyết tật về Phát âm) 711 or 800-735-1232. Chúng tôi chấp nhận các cuộc gọi chuyển tiếp.

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Quý vị có thể nhận được sự giúp đỡ từ một thông dịch viên có chứng nhật và đủ tiêu chuẩn chuyên về chăm sóc sức khỏe.

Arabic

طريقة على مطبوعة أو ،كبير بخط مطبوعة أو ،أخرى بلغات وثيقة هذا على الحصول يمكنكم المساعدة هذه إن .شفهي مترجم طلب يمكنكم كما .لديكم المفضّلة الصيغة حسب أو برايل نستقبل .711 or 800-735-1232 الكاتبة المبرقة أو 541-269-7400 على اتصلو .مجانية المحولة المكالمات.

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الصحية الرعاية مجال في ومؤهل معتمد مترجم من المساعدة على الحصول يمكنكم.

Somali

Waxaad heli kartaa warqadan oo ku qoran luqaddo kale, far waaweyn, farta dadka indhaha aan qabin wax ku akhriyaan ee Braille ama qaabka aad doorbidayso. Waxaad sidoo kale codsan kartaa turjubaan. Taageeradani waa lacag la'aan. Wac 541-269-7400 ama TTY 711 or 800-735-1232. Waa aqbalnaa wicitaanada gudbinta.

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Waxaad caawimaad ka heli kartaa turjubaanka daryeelka caafimaadka oo xirfad leh isla markaana la aqoonsan yahay.

Simplified Chinese

您可获取本文件的其他语言版、大字版、盲文版或您偏好的格式版本。您还可要求提供口译员服务。本帮助免费。致电541-269-7400 **或** TTY 711 or 800-735-1232。**我**们会接听所有的转接来电。

-

您可以从经过认证且合格的医疗口语翻译人员那里获得帮助。

Traditional Chinese

您可獲得本信息函的其他語言版本、大字版、盲文版或您偏好的格式。您也可申請口譯員。以上協助均為免費。請致電541-269-7400 **或聽障專線** 711 or 800-735-1232。**我們接受所有傳譯電話。**

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您可透過經認證的合格醫療保健口譯員取得協助。

Advanced Health, CCO 289 LaClair Street, Coos Bay, OR 97423
541-269-7400 * 800-264-0014 * TTY 800-735-1232 or 711
Version 1 1.01.2025

Korean

이문서은 다른 언어, 큰 활자, 점자 또는 선호하는 형식으로 받아보실 수 있습니다. 통역사를 요청하실 수도 있습니다. 무료 지원해 드립니다. 541-269-7400 또는 TTY 711 or 800-735-1232에 전화하십시오. 저희는 중계 전화를 받습니다.

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공인 및 자격을 갖춘 의료서비스 전문 통역사의 도움을 받으실 수 있습니다.

Chuukese

En mi tongeni angei ei taropwe non pwan ew fosun fenu, mese watte mak, Braille ika pwan ew format ke mwochen. En mi tongeni pwan tingor emon chon chiaku Ei aninis ese fokkun pwan kamo. Kokori 541-269-7400 ika TTY 711 or 800-735-1232. Kich mi etiwa ekkewe keken relay.

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En mi tongeni kopwe angei aninis seni emon mi certified ika qualified ren chon chiaku ren health care.

Ukrainian

В и можете отримати цей довідник іншими мовами, крупним шрифтом, шрифтом Брайля або у форматі, якому ви надаєте перевагу. Ви також можете попросити надати послуги перекладача. Ця допомога є безкоштовною. Дзвоніть по номеру телефону 541-269-7400 або телетайп у 711 or 800-735-1232. Ми приймаємо всі дзвінки, які на нас переводять.

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В и можете отримати допомогу від сертифікованого та кваліфікованого медичного перекладача.

Farsi

.می‌توانید این نامه را به زبان‌های دیگر، درشت‌خط، بریل یا قالب ترجیحی دیگری دریافت کنید
می‌توانید مترجم شفاهی نیز درخواست کنید .این کمک رایگان است .با
تماس بگیرید .تماس‌های رله را TTY 711 or 800-735-1232 یا #CustomerService#
.می‌پذیریم

-

می‌توانید از یک مترجم شفاهی دارای گواهی و باکفایت در زمینه بهداشت و

Swahili

Unaweza kupata herufi hii kwa lugha zingine, kwa herufi kubwa, kwa lugha ya maandishi kwa vipofu au namna yeyote unayopendelea. Unaweza pia kuomba mkalimani. Msaada huu ni wa bure. Piga #CustomerService# au TTY 711 or 800-735-1232. Tunakubali simu za kupitisha ujumbe.

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Unaweza pata usaidizi kutoka kwa mkalimani wa huduma ya afya aliyeidhinishwa na aliyehitimu.

Burmese

ဤစာကို အျခားဘာသာစကားမ်ား၊ ပုံႏွိပ္စာလုံးၾကီး၊ မ်က္မျမင္မ်ားအတြက္ ေရးလ္ သို႔မဟုတ္ သင္ပိုမိုႏွစ္သက္သည့္ ပုံစံျဖင့္ ရယူနိုင္ပါသည္။ သင္သည္ စကားျပန္တစ္ဦးလည္း ေတာင္းဆိုနိုင္ပါသည္။ ဤအကူအညီသည္ အခမဲ့ျဖစ္ပါသည္။ #CustomerService# သို႔မဟုတ္ 711 or 800-735-1232 ကို ဖုန္းဆက္ပါ။ ထပ္ဆင့္ေခၚဆိုမႈမ်ားကို ကၽြႏု္ပ္တို႔ လက္ခံပါသည္။

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သင္သည္ သင္တန္းဆင္းလက္မွတ္ရႏွင့့္ အရည္အခ်င္းပိုသည့့္ က်န္းမာေရး ေစာင့္ေပါက္မႈ စကားျပန္ဆိုမွလည္း အကူအညီရယူနိုင္ပါသည္။

Amharic

ይህንን ደብዳቤ በሌሎች ቋንቋዎች፣ በትልቅ ህትመት፣ በብሬይል ወይም እርሶ በሚመርጡት መልኩ ማግኘት ይችላሉ። በተጨማሪም አስተርጓሚ መጠየቅም ይችላሉ። ይህ ድጋፍ የሚሰጠው በነጻ ነው። ወደ #CustomerService# ወይም TTY 711 or 800-735-1232 ይደውሉ። የሪሌይ ጥሪዎችን እንቀበላለን።

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ፍቃድ ካለው እና ብቃት ካለው የጤና እንክብካቤ አስተርጓሚ ድጋፍ ማግኘት ይችላሉ።

Romanian

Puteți obține această scrisoare în alte limbi, cu scris cu litere majuscule, în Braille sau într-un format preferat. De asemenea, puteți solicita un interpret. Aceste servicii de asistență sunt gratuite. Sunați la #CustomerService# sau TTY 711 or 800-735-1232. Acceptăm apeluri adaptate persoanelor surdomute.

-

Puteți obține ajutor din partea unui interpret de îngrijire medicală certificat și calificat.