**DEPARTMENT OF SOCIAL SERVICES**

**MO HEALTHNET MANAGED CARE HEALTH RISK ASSESSMENT**

**Please help us serve your family better by answering the following questions. Your answers are optional. Any answers you choose to give us will be sent to your health plan so they can help you get the services you need. One of these forms should be completed for each person in your family who is enrolling in a health plan.**

**Health plans cannot refuse to enroll you because of a medical condition or illness. A health plan cannot ask you to pick another health plan. If this happens, report it to Participant Services at 1-800-392-2161.**

**Name: Date of Birth:**

**Home Phone: Work Phone:**

**Emergency Phone/Beeper: Social Security Number:**

Please answer all questions. Circle Y for yes, and N for no.

1. Is English your main language? Y / N

If no, write your language

 If English is not your main language, call 1-800-348-6627 for help.

 Si el ingles no es su lenguaje principal, llame 1-800-348-6627 para la ayuda.

1. Do you need a Telecommunications Device for the Deaf (TDD)? Y / N
2. Are you pregnant? Y / N

If yes, when is your baby due?

1. Do you have any of the following: (answer yes or no to each):
2. Asthma? Y / N
3. Diabetes? Y / N
4. High Blood Pressure? Y / N
5. Do you need help getting vaccinations? Y / N
6. Have your children been screened for lead? Y / N
7. Do you need or use any of these (answer yes or no to each):
8. Medications prescribed by a Doctor? Y / N
9. Behavioral health treatment or counseling. Y / N
10. Substance abuse treatment or counseling. Y / N
11. Physical, speech, or occupational therapy. Y / N
12. Special equipment (for example: to help with moving, walking, talking,

hearing, breathing, feeding, personal care, etc.) Y / N

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