Initial Health Risk Screening (Pediatric)

Amerigroup RealSolutions in healthcare

Please complete this form. Email it to GF360@amerigroup.com

Section 1 - Demographics

Amerigroup ID#		Medicaid ID#	
Childs DFCS Personal ID			
Child's First Name		Child's Last Name	
Residential Address		City, State Zip	
Home phone number	(_____) _____ - _____	Cell Phone number	(_____) _____ - _____
Name of Legal Guardian/Foster Care/Adoptive Parent			
Person completing this health risk screening	☐ Child ☐ State or Other Representative ☐ Parent/Caregiver ☐ Foster Parent	Name of the person completing the assessment, if not the child	
DFCS/DJJ Case Worker Name		DFCS/DJJ Contact number	

Section 2 - Current Health Services

Primary Care Provider

PCP Name		Phone number	(_____) _____ - _____
PCP Address		City, State Zip	
Date of last visit to the PCP	____ / ____ / 20 ____		

Dentist

Dentist Name		Phone number	(_____) _____ - _____
Dentist Address		City, State Zip	
Date of last visit to the Dentist	____ / ____ / 20 ____	How often does your child see a dentist?	☐ Every 6 months ☐ Once a year ☐ More than a year between visits
If yes, what is the dental issue?			

Specialist

Specialist Name		Phone number	(_____) _____ - _____
Type of Specialist		Date of last visit to specialist	____ / ____ / 20 ____

Hospital, Emergency Room & Facility Admissions

Has the child been admitted to the hospital or inpatient behavioral health facility in the past 3 months?	☐ Yes ☐ No	Date of last admission	____ / ____ / 20 ____
If Yes, reason for admission?			
Has the child been recently seen in the ER?	☐ Yes ☐ No	Date of last ER visit	____ / ____ / 20 ____
If yes, reason for the ER visit			

Services

Is the child currently receiving any of the following services?

	Yes/No	How Often?	Service	Yes/No	How Often?
1-Speech Therapy	☐ Yes ☐ No		6-Physical Therapy	☐ Yes ☐ No	
2-Home Health Services	☐ Yes ☐ No		7-Dialysis	☐ Yes ☐ No	
3-Occupational Therapy	☐ Yes ☐ No		8-Chemotherapy or Radiation Therapy	☐ Yes ☐ No	
4-Rehab Services	☐ Yes ☐ No		9-Behavioral/ Mental Health Services	☐ Yes ☐ No	
5-Substance Abuse Services	☐ Yes ☐ No				

Medical Equipment & Supplies

Does the child have or use any of the following medical equipment or supplies?

	Yes/No	How Often?	Does the child/parent/caregiver know how to use the equipment or supplies?	Name of supplier (vendor)
1. Wound Supplies	☐ Yes ☐ No		☐ Yes ☐ No	
2. Wheelchair	☐ Yes ☐ No		☐ Yes ☐ No	
3. Oxygen	☐ Yes ☐ No		☐ Yes ☐ No	
4. Specialty Bed	☐ Yes ☐ No		☐ Yes ☐ No	

Initial Health Risk Screening (Pediatric)

Amerigroup RealSolutions in healthcare

5. Feeding Pump	☐ Yes ☐ No		☐ Yes ☐ No	
6. Insulin Pump	☐ Yes ☐ No		☐ Yes ☐ No	
7. Mechanical Lift (Hoyer Lift)	☐ Yes ☐ No		☐ Yes ☐ No	
8. Breathing Machine (CPAP, BiPAP, Ventilator, Nebulizer)	☐ Yes ☐ No		☐ Yes ☐ No	
9. Other: _____			☐ Yes ☐ No	
10. Other: _____			☐ Yes ☐ No	

Is the child currently waiting for any equipment or supplies?	☐ Yes ☐ No
Does the child need to use medical care, home health or other health services at least once every three months?	☐ Yes ☐ No
Does the child current need to get treatment or counseling for any kind of mental health, substance abuse/alcohol or emotional problem?	☐ Yes ☐ No

Section 3 - Current Health Status

Child's height		Child's weight	

Does the child have any of the following conditions?

1. ADHD	☐ Yes ☐ No	12. Depression	☐ Yes ☐ No	23. Kidney failure	☐ Yes ☐ No
2. Anxiety	☐ Yes ☐ No	13. Developmental Delays	☐ Yes ☐ No	24. Mental Retardation	☐ Yes ☐ No
3. Asthma	☐ Yes ☐ No	14. Diabetes	☐ Yes ☐ No	25. MS/Multiple Sclerosis	☐ Yes ☐ No
4. Autism Spectrum	☐ Yes ☐ No	15. Digestive Problems	☐ Yes ☐ No	26. Oppositional Disorders	☐ Yes ☐ No
5. Behavioral/Mental Health Needs	☐ Yes ☐ No	16. Eating disorders	☐ Yes ☐ No	27. Psychotic Disorders	☐ Yes ☐ No
6. Bipolar Disorder	☐ Yes ☐ No	17. Epilepsy/Seizures	☐ Yes ☐ No	28. PTSD	☐ Yes ☐ No
7. Breathing Problems	☐ Yes ☐ No	18. Heart Disease	☐ Yes ☐ No	29. Quadriplegia	☐ Yes ☐ No
8. Cancer	☐ Yes ☐ No	19. Hepatitis B	☐ Yes ☐ No	30. Schizophrenia / Psychosis	☐ Yes ☐ No
9. Conduct Disorder	☐ Yes ☐ No	20. Hepatitis C	☐ Yes ☐ No	31. Stroke	☐ Yes ☐ No
10. Congestive Heart Failure	☐ Yes ☐ No	21. High Blood Pressure	☐ Yes ☐ No	32. Substance Abuse	☐ Yes ☐ No
11. COPD	☐ Yes ☐ No	22. HIV/Aids	☐ Yes ☐ No	33. Other Condition not listed	
Is the child currently pregnant?	☐ Yes ☐ No	If Pregnant, what is the child's due date?		____ / ____ / 20 ____	

Medications

Does your child take medications for any chronic conditions? If Yes , please list	☐ Yes ☐ No

Condition	Medication	How Often?

Does your child use **one (1)** or more prescription medications?	☐ Yes ☐ No
Is your child able to take his or her medications as prescribed and instructed by his or her doctor?	☐ Yes ☐ No
Does your child have any allergies to any medications, or anything else? If Yes , please list	☐ Yes ☐ No
Allergies	

Immunizations, Exams & Screenings

Is your child up to date on his or her immunizations?			☐ Yes ☐ No	
Has your child:	Had a flu shot in the last 12 months?	☐ Yes ☐ No	Received the Human Papillomavirus (HPV) Vaccine?	☐ Yes ☐ No
	Had an eye exam in the last 12 months?	☐ Yes ☐ No	Had a hearing exam in the last 12 months?	☐ Yes ☐ No

Initial Health Risk Screening (Pediatric)

Amerigroup RealSolutions in healthcare

Section 4 - Mental Health Status

Has this child been a danger to him/herself or to others in the last 90 days? *Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.*	☐ Yes ☐ No
Has this child experienced severe physical or sexual abuse or has she/he been exposed to extreme violent behavior in his/her home in the last 90 days? *Subjected to or witnessed extreme physical abuse, domestic violence or sexual abuse, e.g., severe bruising in unusual areas, forced to watch torture or sexual assault, witness to murder, etc.*	☐ Yes ☐ No
Does this child have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy? *Persistent chaotic, impulsive or disruptive behaviors; daily verbal outbursts; excessive noncompliance; constantly challenges the authority of caregiver; requires constant direction and supervision in all activities; requires total attention of caregiver; overly jealous of caregiver's other relationships; disruptive levels of activity; wanders the house at night; excessive truancy; fails to respond to limit setting or other discipline, etc.*	☐ Yes ☐ No
Has the child exhibited bizarre or unusual behaviors in the last 90 days? *History or pattern of fire-setting; cruelty to animals; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including alcohol or drug induced); repetitive body motions (e.g., head banging) or vocalizations (e.g., echolalia); smears feces; etc.*	☐ Yes ☐ No
Does the child have an immediate need for psychotropic medication consultation and/or prescription refill? *Either needs immediate evaluation of medication or needs a new prescription.*	☐ Yes ☐ No
Over the past 2 weeks, how often has your child been bothered by: little interest or pleasure in doing things?	☐ Yes ☐ No
Over the past 2 weeks, how often has your child been bothered by: feeling down, depressed or hopeless?	☐ Yes ☐ No

Section 5 - Knowledge/Readiness

If you have questions or would like to change your child's PCP or speak to a Care Coordinator, call us toll free at 1-855-661-2021. This number can also be found on your AMERIGROUP ID card and in your child Handbook. You can also visit our web site at www.myamerigroup.com for benefit information.

Submit