MEDICALLY FRAIL QUESTIONNAIRE

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 1598 (12-2013)

Clear Fields

Date

Health Care Needs Questionnaire

The purpose of completing the Heath Care Needs Questionnaire is to help determine if you qualify for the status of "medically frail". Individuals who are "medically frail" include those with serious and complex medical conditions, and those with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

Each completed questionnaire will be evaluated by a medical professional. If it is determined that you likely qualify as "medically frail", you will receive a letter and will be asked to have the letter signed following a visit to a primary care provider. Your primary care provider will need to provide a list of medical conditions and a medication list. The primary care provider will need to send the signed letter, the list of medical conditions, and the medication list to the Department of Human Services. After the Department receives this information, you may be deemed "medically frail". If you are deemed "medically frail", you will receive notification by mail and your status as "medically frail" will be effective the first day of the following month. You will also be notified by mail if you are not deemed "medically frail. If you are not deemed "medically frail", your eligibility will not be impacted and your coverage will continue.

Instructions: Please complete the following questionnaire. You may complete it by filling out the questionnaire and return it by either:

1. MAIL: DHS Medical Services, 600 E Boulevard Ave, Dept 325, Bismarck ND 58505-0250
2. FAX: 701-328-1544
3. EMAIL to: medicallyfrail@nd.gov

Name	Home Telephone Number	Cell Phone Number	
Address	City	State	ZIP Code

General Health and Needs

1. In general, compared to other people your age, how would you rate your health (select only one box)?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. In general, compared to other people your age, how would you rate your mental health (select only one box)?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

3. Are you currently receiving help on a **daily basis** from family or friends for **any** of the following activities (answer yes or no to each question)?	YES	NO
Personal hygiene/grooming--such as brushing teeth, washing face, combing hair		
Assistance walking or if you use a wheelchair, help once seated in chair		
Help transferring from one place to another--such as moving from chair to bed, chair to toilet or bed to standing position		
Help eating -- Using a feeding tube or someone needing to feed you with a fork or spoon		
Managing medications--includes help with reminders to take medicines, opening bottles, taking the correct dosage, giving injections		

4. Are you currently receiving services on a **daily basis** from any agency or provider for **any** of the following activities (answer each question)?	YES	NO
Personal hygiene/grooming--such as brushing teeth, washing face, combing hair		
Assistance walking or if you use a wheelchair, help once seated in chair		
Help transferring from one place to another--such as moving from chair to bed, chair to toilet or bed to standing position		
Help eating -- Using a feeding tube or someone needing to feed you with a fork or spoon		
Managing medications--includes help with reminders to take medicines, opening bottles, taking the correct dosage, giving injections		

Use of Hospitals, Emergency Rooms, and Clinics

5. In the **last six months**, how many times did you stay one or more nights in a **hospital**?
   ☐ Not been hospitalized in the last six months ☐ One time ☐ Two times ☐ Three times

6. If hospitalized, were any of these hospital stays related to **mental health**?
   ☐ Not been hospitalized in the last six months ☐ None ☐ One time ☐ Two times ☐ Three or more times

7. In the **last six months**, how many times have you used an **emergency room**?
   ☐ Not used emergency room in the last six months ☐ One time ☐ Two times ☐ Three or more times

8. In the **last six months**, how many times have you been seen in a **clinic** by a doctor or nurse practitioner or physician assistant for a health concern?
   ☐ No visits in last month ☐ One time ☐ Two times ☐ Three times
   ☐ Four times ☐ Five to nine times ☐ Ten or more times

9. In the **last six months**, how many times have you been seen by a mental health professional in a **clinic** for a mental health concern?
   ☐ No visits in last month ☐ One time ☐ Two times ☐ Three times
   ☐ Four times ☐ Five to nine times ☐ Ten or more times

Conditions and Special Needs to Get you Better Care

10. Has a doctor, nurse, or other health professional EVER told you that you had any of the following? For each, select "Yes," "No," or you're "Not sure."

	YES	NO	Don't Know/ Not Sure		YES	NO	Don't Know/ Not Sure
Diabetes				HIV or AIDS			
Severe joint pain				Sickle Cell Disease			
Asthma				Obesity			
Cancer				High cholesterol			
Stroke				High blood pressure			
Heart disease				Kidney disease			
Emphysema				Depression/other mental health issues			

11. Do any of the following statements apply to you today (answer all that apply):	YES	NO
I have major financial problems due to unpaid medical bills		
I am not able to work, even part time, due to a health/mental health condition		
My family/close friends feel overwhelmed by my health/mental health problems		
I consider myself "medically frail"		