



MassHealth Health Related Social Needs Supplemental Services Screening Tool for Health Needs Based Criteria – Example

This tool is intended to be used by HRSN (Health Related Social Needs) Providers to help show if a MassHealth ACO enrollee interested in receiving MassHealth HRSN housing or nutrition services has an eligible Health Needs Based Criteria (HNBC). Find more information about these services, including specific eligibility criteria, in the HRSN Supplemental Housing and HRSN Supplemental Nutrition Service Manuals. This tool may be used to guide a conversation with an enrollee or may be filled out independently by an enrollee.

SECTION 1: Enrollee Information

Enrollee name:

MassHealth ID:

Date of Birth:

SECTION 2: Enrollee Attestation

The MassHealth enrollee attests that the below information is true and accurate to the best of their knowledge.

☐ Yes ☐ No

Date:

SECTION 3: Enrollee Health Information

1. Behavioral Health Need

A. Do you have a mental health condition or substance use disorder?

☐ Yes ☐ No

B. If yes, please check all that apply:

- ☐ Anxiety (e.g., Social Anxiety Disorder, Separation Anxiety Disorder, Panic Disorder, Medication-Induced Anxiety Disorder, General Anxiety Disorder)
- ☐ Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Depression (e.g., Major Depressive Disorder)
- ☐ Hoarding Disorder
- ☐ Serious Emotional Disturbance (e.g., Avoidant/restrictive food intake disorder [ARFID], eating disorders, Obsessive Compulsive Disorder [OCD], childhood schizophrenia)
- ☐ Serious Mental Illness (e.g., Schizophrenia, Bipolar Disorder)
- ☐ Substance Use Disorder (e.g., Opioid Use Disorder, Alcohol Use Disorder, Phencyclidine Use Disorder, Cannabis Use Disorder)
- ☐ Trauma/Stress Disorder (e.g., Post-Traumatic Stress Disorder)
- ☐ Other behavioral health condition – please list here:

C. If yes, does your mental health condition or substance use disorder require treatment or care to improve or maintain your current condition, or prevent it from getting worse?

☐ Yes ☐ No

2. Complex Physical Health Need

A. Do you have a medical condition that is serious, ongoing, or disabling?

☐ Yes ☐ No

B. If yes, please check all that apply:

- ☐ Autoimmune Conditions (e.g., rheumatoid arthritis, lupus)
- ☐ Cancer (e.g., breast cancer, lymphoma, leukemia, melanoma, kidney cancer, lung cancer, prostate cancer, colorectal cancer, bladder cancer)
- ☐ Cardiovascular disease/Cardiac Condition (e.g. hypertension, heart disease, history of heart attack, high cholesterol, heart failure)
- ☐ Developmental Disabilities (e.g., Autism, Cerebral Palsy)
- ☐ Diabetes (e.g., Prediabetes, insulin dependent diabetes, Type 2 Diabetes, Type 1 Diabetes)
- ☐ Disabilities (e.g., visual impairment, hearing impairment, locomotor disability)
- ☐ Gastrointestinal (GI) Conditions (e.g., Crohn's, Celiac Disease, Irritable Bowel Syndrome (IBS), Peptic Ulcer Disease)
- ☐ Hematologic Conditions/Blood-related conditions (e.g., anemia, Sickle Cell Disease)
- ☐ HIV/AIDS
- ☐ Kidney disease/Renal disease (e.g., End-Stage Renal Disease, Chronic Kidney Disease)
- ☐ Liver disease (e.g., hepatitis, cirrhosis)
- ☐ Lung disease / respiratory condition/ Pulmonary Disease (e.g., asthma, Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, pulmonary fibrosis)
- ☐ Metabolic Conditions – Other (e.g., malnutrition, obesity)
- ☐ Neurologic Conditions (e.g., stroke, Parkinson's disease, Alzheimer's disease, Amyotrophic Lateral Sclerosis (ALS), dementia, epilepsy, Multiple Sclerosis)
- ☐ Other complex physical health conditions (e.g., transplant recipient) – please list here:

C. Does your complex physical health condition require treatment or care to improve or maintain your current condition, or prevent it from getting worse?

☐ Yes ☐ No

3. Need for Assistance with Daily Living (ADL) or Instrumental Activities of Daily Living (IADL)

A. Do you need help performing any of the following activities (please check all that apply)?

- ☐ Bathing
- ☐ Dressing
- ☐ Eating
- ☐ Using the toilet
- ☐ Walking or moving yourself from a bed to a wheelchair (if applicable)
- ☐ I don't need assistance with any of the above activities

B. Do you need help performing any of the following activities (please check all that apply)?

☐ Meal preparation

☐ Household work such as doing dishes, dusting, making one's bed, tidying up, or laundry

☐ Managing personal finances

☐ Managing medications

☐ Phone use

☐ Shopping

☐ Transportation (e.g., do not drive independently, need assistance navigating public transportation, need assistance arranging rides)

☐ I don't need assistance with any of the above activities

4. Emergency Room Utilization

A. In the past 6 months have you been to the emergency room (ER) 2 or more times?

☐ Yes ☐ No

B. In the past 12 months have you been to the emergency room (ER) 4 or more times?

☐ Yes ☐ No

5. Pregnancy and High Risk Pregnancy

A. Are you currently pregnant or were you pregnant in the last 2 months?

☐ Yes ☐ No

B. If no, were you pregnant in the last 3 to 12 months?

☐ Yes ☐ No

C. If yes to either 5A or 5B questions above, are you currently or did you experience problems during your pregnancy or have been told or made aware that you have a "high risk" pregnancy? (e.g., medical condition that existed before the pregnancy, gestational diabetes or high blood pressure, premature labor, needing to see a specialist who is not your obstetrician, etc.)?

☐ Yes ☐ No