DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10180 (07/08)

STATE OF WISCONSIN

Effective 2/1/08

NEW ENROLLEE HEALTH NEEDS ASSESSMENT (NEHNA) SURVEY - ENROLLEE VERSION

Name (Last, First, MI)		Medicaid Number		Birth Date
Address	City	State	Zip Code	Telephone Number ( )

You may choose to not answer any or all of the questions. The information you give will only be used to help your health plan meet your health care needs. Your answers will be shared only with your health plan and health care providers.

Question	Yes	No	Not Sure	Additional Answer
1. Primary language used in your family?				☐ English ☐ Spanish ☐ Hmong ☐ Russian ☐ Other ______________ ☐ Read ☐ Speak
2. Are there other phone numbers that can be used to reach you? If, yes, please list (include area code).	☐	☐	☐	(____)______________(____)______________________ Best time to call _______ AM ______PM
3. Are there other people we can contact if we need to reach you? If yes, please list the name and phone number of these people.	☐	☐	☐	Name ______________________________ Phone (___)____________________________ Name ______________________________ Phone (____)
4. Will you be moving from your present address anytime in the next six months?	☐	☐	☐	New address, if known.______________________ ____________________________________
5. Have you or your child(ren) seen a doctor or other medical provider for any illness or injury in the past year?	☐	☐	☐	If yes, who? _____________ Why? ______________
6. Do you have a doctor or medical provider that you consider your regular or family doctor?	☐	☐	☐	If yes, doctor's name ______________________ Clinic's name _________________________
7. Do you have children under age 21 in your home? If no, skip to #8.	☐	☐	☐	If yes, what are their ages? ___________________
a. Do you have any concerns about their growth or health?	☐	☐	☐	If yes, who? ______________ What? ____________
b. Have all of these children seen a doctor in the past year?	☐	☐	☐	If no, who hasn't? __________________________
c Are any of these children in the Birth to 3 Program?	☐	☐	☐	If yes, who? ______________________________

Question	Yes	No	Not Sure	More information
8. Have you or your child(ren) been in the hospital or had surgery in the past year?	☐	☐	☐	If yes, who? ______________For what?_______________
a. Is any surgery planned?	☐	☐	☐	If yes, who? ______________For what?_______________
9. Are you or any member of your family pregnant?	☐	☐	☐	If yes, who? ______________________________________ Estimated due date? ______________________________
10. Do you or any member of your family need prescription medicine for any of the following medical conditions?				If yes:
Asthma (“attacks” of difficult breathing)	☐	☐	☐	Who?____
Diabetes (high or low blood sugar)	☐	☐	☐	Who?____
High blood pressure	☐	☐	☐	Who?____
Heart problems	☐	☐	☐	Who?____
Disabilities (blind, deaf, wheelchair bound, etc.)	☐	☐	☐	Who?____
Mental health treatment	☐	☐	☐	Who?____
Alcohol or other drug abuse	☐	☐	☐	Who?____
Pain	☐	☐	☐	Who?____
If YES: Do any of these conditions limit or prevent any routine daily activities?	☐	☐	☐	Other information? ____________________________ ____ ____
Have any of these conditions lasted, or are expected to last at least 12 months?	☐	☐	☐	____
11. Do you or a family member need regular medical care for any other health problem?	☐	☐	☐	If yes, who? ___________________ What? __________ ____
12. Will you need assistance with transportation to health care appointments?	☐	☐	☐	
13. Do you or a member of your family smoke cigarettes or use other tobacco products?	☐	☐		If yes, who? ___________________________________
a. If yes, does this person want help quitting?	☐	☐		If yes, who? ___________________________________

For questions, call: 800 291-2002. Send the completed form to: Wisconsin HMO Enrollment Specialist, P.O. Box 510408, Milwaukee WI 53203-9962.