



FROM

western sky
community care.

Well-Being Survey

Tell us more about you. Your answers to the questions below can help us make sure you get the care that best fits you. Everything you provide will be kept confidential in accordance with HIPAA and will not change the care you now receive. If you would like to answer these questions by phone, please call Ambetter from Western Sky Community Care at 1-833-945-2029 (TTY 711). Please have your insurance card with you as we will need your Member ID number from the front of the card.

*Indicates a required question

Member Information

*Member Name (Last, First) *Member ID *Date of Birth (MMDDYYYY) *Preferred Phone Number () - *Email Address *In general, how would you rate your health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ UnsureDo you have a doctor or health care provider? ☐ Yes ☐ No ☐ Unsure

How many times have you been in the hospital in the last 3 months?

☐ None ☐ One time ☐ Two times ☐ Three or more times ☐ Unsure

How many times have you been in the Emergency Department in the last 3 months?

☐ None ☐ One time ☐ Two times ☐ Three or more times ☐ Unsure

*Have you ever been told by a doctor or health care provider that you have any of these conditions?

☐ Yes ☐ No ☐ Unsure (If yes, check all that apply)☐ Arthritis ☐ Asthma ☐ Cancer ☐ Chronic Kidney Disease ☐ COPD/Emphysema☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Pre-Diabetes ☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure☐ High Cholesterol ☐ HIV ☐ Learning Disability ☐ Sickle Cell Disease (not trait) ☐ Stroke ☐ Transplant

How many medicines are you currently taking that were prescribed by your doctor or health care provider?

☐ 0 Prescriptions ☐ 1-3 Prescriptions ☐ 4-7 Prescriptions ☐ Greater than or equal to 8 Prescriptions ☐ Unsure* **In the past two months have you been living in stable housing that you own, rent, or stay in as part of a household? ☐ Yes ☐ No ☐ Unsure

* During the past month, have you often been bothered by feeling down, depressed, or hopeless?

☐ Yes ☐ No ☐ Unsure

Are you actively receiving treatment for a mental health condition?

☐ Yes ☐ No ☐ Unsure

General Information

*Assessment Completion Date (MMDDYYYY) *Assessment Completed By (Name) *Relationship to member ☐ Self ☐ Member Representative with permission ☐ Parent/Guardian ☐ Other

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