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Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan Consumer Advisory Committee Meeting

2240 E. Gonzales Road, Suite 200, Oxnard, CA 93036
Wednesday, December 4, 2013
5:00 p.m.

AGENDA

SWEARING IN OF COMMITTEE MEMBERS

CALL TO ORDER / ROLL CALL

WELCOME AND INTRODUCTIONS

PUBLIC COMMENT A Speaker Card must be completed and submitted to the Secretary of the Committee by anyone wishing to comment:

- **Public Comment** – Comments regarding items not on the agenda but within the subject matter jurisdiction of the Committee.
- **Agenda Item Comment** – Comments on the subject matter jurisdiction of the Committee pertaining to a specific item on the agenda. The speaker is recognized and introduced by the Committee Chair during the Committee's consideration of the item.

APPROVE MINUTES

1. Regular Meeting of September 11, 2013

APPROVAL ITEMS

2. Recruiting of Beneficiary Member for CAC, Ruth Watson, COO

Meeting Agenda available at http://www.goldcoasthealthplan.org

ADMINISTRATIVE REPORTS RELATING TO THIS AGENDA AND MATERIALS RELATED TO AN AGENDA ITEM SUBMITTED TO THE COMMITTEE AFTER DISTRIBUTION OF THE AGENDA PACKET ARE AVAILABLE FOR PUBLIC REVIEW DURING NORMAL BUSINESS HOURS AT THE OFFICE OF THE SECRETARY OF THE COMMITTEE, 2220 E. GONZALES ROAD, SUITE 200, OXNARD, CA.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT, IF YOU NEED SPECIAL ASSISTANCE TO PARTICIPATE IN THIS MEETING, PLEASE CONTACT CONNIE AT 805/981-5285. REASONABLE ADVANCE NOTIFICATION OF THE NEED FOR ACCOMMODATION PRIOR TO THE MEETING (48 HOURS ADVANCE NOTICE IS PREFERABLE) WILL ENABLE US TO MAKE REASONABLE ARRANGEMENTS TO ENSURE ACCESSIBILITY TO THIS MEETING.

Ventura County Medi-Cal Managed Care Commission (VCMMCC) dba Gold Coast Health Plan
December 4, 2013 Consumer Advisory Committee Meeting Agenda *(continued)*
PLACE: 2240 E. Gonzalez, Room 200, Oxnard, CA
TIME: 5:00 p.m.

DISCUSSION ITEMS

3. CEO Report, Michael Engelhard, CEO
4. CFO Report – FY2012-2013 Audit Results, Michelle Raleigh, CFO
5. Medi-Cal Expansion / LIHP, Ruth Watson, COO
6. Behavioral Health, Dr. Nancy Wharfield, Medical Director
7. Covered California Update, Guillermo Gonzalez, Government Relations Director
8. Managed Care Basics, Sherri Bennett, Network Operations Director
9. Health Education - Outreach Update, Lupe Gonzalez, Health Education Manager

COMMENTS FROM COMMITTEE MEMBERS

ADJOURNMENT

Unless otherwise determined by the Committee, the next regular meeting of the Consumer Advisory Committee will be held in March 12, 2014 at 5:00 p.m. at 2240 E. Gonzales Road, Suite 200, Oxnard CA 93036.

Meeting Agenda available at http://www.goldcoasthealthplan.org

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Ventura County Medi-Cal Managed Care Commission
(VCMMCC) dba Gold Coast Health Plan (GCHP)
Consumer Advisory Committee Minutes
September 11, 2013
(Not official until approved)

CALL TO ORDER

Member Services Representative Harden, called the meeting to order at 5:03 p.m. in Suite 200 located at 2240 E. Gonzales Road, Oxnard, CA 93036.

ROLL CALL

COMMITTEE MEMBERS IN ATTENDANCE
Ruben Juarez, County Health Care Agency
Katharine Raley, County of Ventura Area Agency on Aging
Frisa Herrera, Casa Pacifica
Norma Gomez, Mixteco / Indigena Community Organizing Project (arrived at 3:10 p.m.)
Lilliana Coria, ARC of Ventura County
Rita Duarte-Weaver, Ventura County Public Health Dept.
Laurie Jean Jordan, Rainbow Connection / Tri-Counties Regional Center
Alicia Flores, La Hermandad
Pedro Mendoza, Tri-Counties Regional Center

EXCUSED / ABSENT COMMITTEE MEMBERS
Curtis Updike, County Human Services Agency (HSA)

COMMITTEE STAFF IN ATTENDANCE
Ruth Watson, COO
Michael Engelhard, CEO
Dr. Charles Cho, CMO
Luis Aguilar, Member Services Manager
Connie Harden, Member Services, Project Specialist
Dr. Nancy Wharfield, Medical Director Health Services
Lupe Gonzalez, Health Education Manager
Sherri Bennett, Director Network Operations
Guillermo Gonzalez, Government Relations Director
Rebekah Eccles, Executive Administrative Assistant

OTHER STAFF IN ATTENDANCE
Julie Booth, Quality Improvement Director
Sonji Lopez, Member Services, Grievance & Appeals
Elena Aguayo, Member Services
Blanca Robles, Member Services
Percy Mayfield, Claims Manager

Stacy Diaz, Human Resources Manager
Brandy Armenta, Compliance Officer / Manager
David Becerra, Compliance Specialist
Robert Franco, Compliance Project Manager – Delegation Oversight
Chris Martinez, Compliance Specialist

OTHERS IN ATTENDANCE
Norma Cahue, County Human Services Agency

The Pledge of Allegiance was recited.

Language Interpreting and Translating services provided by GCHP from Lourdes González Campbell and Associates.

WELCOME AND INTRODUCTIONS

Member Services Manager Aguilar welcomed new Committee members and introduced COO Ruth Watson.

COO Ruth Watson asked Committee members to introduce themselves.

PUBLIC COMMENT / CORRESPONDENCE

None

1. APPROVAL OF MINUTES – MARCH 13, 2013

Committee Member Juarez moved to approve the Regular Meeting Minutes of March 13, 2013. Committee Member Raley seconded. The motion carried. **Approved 8-0.**

DISCUSSION ITEMS

2. CEO UPDATE

CEO Engelhard reviewed his report and highlighted several topics including: 1) The two openings on the Commission. There have been two resignations and the Commission will vote on October 1, 2014; 2) The Plan's financial standing; now completing its second year in operation, made approximately $6.6 million this year; and 3) GCHP has outgrown its current locations and is again working with the previous real estate broker to relocate much needed office and meeting space. The focus is geared toward the Oxnard / Camarillo area to continue to meet the needs of our members while maintaining our growth.

Committee Member Norma Gomez arrived.

Committee Member Raley applauded GCHP's efforts and growth. She reports she has not heard any complaints in six months.

COO Watson noted the two handout pages that were not included in the original package. First is a slide relating to the ACA which Government Relations Director Gonzalez will address later in his presentation. The second insert is the New Member Orientation handout. Correction is being made to the Spanish Orientation Meeting Flyer to correct the date to Thursday, October 24th. Committee Member Duarte-Weaver complimented GCHP on the Orientation meeting she attended and stated she found it very informative and helpful.

3. CMO REPORT

CMO Dr. Cho reviewed GCHP's Mission Statement and the ways GCHP has executed this. He noted how GCHP has overcome many obstacles to get to this point with great Providers and network in place to support the needs of our members. He also urged the Committee to provide feedback on how the Plan is doing.

4. CONSUMER ADVISORY COMMITTEE (CAC) CHARTER

COO Watson requested that the Committee members review the CAC Charter included in the Committee packet before the next meeting and contact Connie Harden with any recommended changes or additions.

5. CAC GOALS AND OBJECTIVES

COO Watson requested that the Committee members review the CAC Goals and Objectives included in the Committee packet before the next meeting and contact Connie Harden if they have any recommended changes or additions

6. RECRUITING OF BENEFICIARY MEMBER FOR CAC

COO Watson informed the Committee that the Commission requested that a Medi-Cal beneficiary be added to the CAC, clarifying that the seat will be filled by a member who is an actual Medi-Cal beneficiary and not someone who represents Medi-Cal beneficiaries. COO Watson asked for three CAC members to volunteer to establish an ad hoc committee to review applications and select a candidate for presentation and approval to the full CAC.

Committee members Duarte-Weaver, Flores and Raley volunteered as the three members to sit on the ad hoc committee. Member Pedro Mendoza volunteered to serve if any one of the three ad hoc committee members were unavailable.

COO Watson requested that Committee members provide the names of potential applicants to Connie Harden.

Committee Member Jordan noted that to aid in the selection process, GCHP offer stipends, childcare & transportation.

A break was provided at 5:59 p.m.

The meeting reconvened at 6:18 p.m.

7. GCHP HOSPITAL DISCHARGE PROGRAM

Medical Director Health Services Dr. Wharfield reviewed the Transition Care Program. Dr. Wharfield stated the goal of this program is to improve the transition from the hospital inpatient setting to other care settings; improve quality of care; reduce readmissions for high-risk members; and create cost savings.

A discussion was held regarding the current practices and reviews.

Dr. Wharfield concluded that in this program the Discharge Planner's interventions assist in arranging home infusion and follow up appointments; ensuring that prescriptions have been filled; arranging transportation and referring members to our Care Management program when appropriate.

8. COVERED CALIFORNIA AND MEDI-CAL

Government Relations Director Guillermo Gonzalez made a presentation on Health Care Reform, also known as the Affordable Care Act (ACA). He reviewed several topics including 1) Covered California (Health Benefit Exchange); 2) Medi-Cal Expansion; 3) Bridge Plan Proposal; 4) GCHP's readiness; and 5) Outreach to the eligible.

A discussion was held regarding coverage for undocumented residents under the ACA. Director Gonzales informed the Committee that the ACA does not include this population. The Committee asked about the adequacy of GCHP's network to serve the increased membership. Director of Network Operations, Sherri Bennett informed the Committee that GCHP regularly analyzed the network and that at this time the network met the adequacy standards set by the State.

9. FUTURE MEETINGS

COO Watson asked the Committee members if the existing meeting time and schedule was still preferable for all members. It was suggested that a few preferences for meeting times be submitted via email to find the best time.

ADJOURNMENT

Meeting was adjourned at 7:08 p.m.

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Consumer Advisory Committee

Beneficiary Member Recruitment

CAC Beneficiary Recruitment

- Steps we have taken:
  - ►Outreach to CAC Members
  - ►Outreach to Community Based Organizations
  - ►Outreach to Providers

CAC Beneficiary Recruitment

- Steps we have taken:
  - ►Requested and received approval from the Commission to expand the search to the parent / guardian of a Member Oct. 28, 2013
  - ►October 28, 2013 – GCHP member Michelle Gerardi agreed to become a member of the Consumer Advisory Committee

AGENDA ITEM 3

To: Gold Coast Health Plan Consumer Advisory Committee

From: Michael Engelhard, CEO

Date: December 4, 2013

Re: CEO Update

Compliance

Compliance submitted three corrective action plans (CAP) to The Department of Health Care Services (DHCS) between October 18, 2013 and October 30, 2013. The CAP submission consisted of: Medical, Financial and Facility Site Review.

Medical Loss Ratio Evaluation

The Plan received a notice from the State Department of Health Care Services (DHCS) that the State Department of Managed Health Care (DMHC) will be performing a medical loss ratio evaluation for the 2012-13 fiscal year (i.e., 07/01/12-06/30/13) on behalf of DHCS. DMHC previously performed a medical loss ratio evaluation on the Plan for the period 07/01/11-12/31/11. These evaluations typically involve testing the information supporting the Plan's financial statements. This audit is expected to occur in February and March of 2014.

Medical Management System (MMS) Implementation / Xerox Nurses Transition

The Plan is on-schedule to implement the new MedHOK Medical Management System (MMS) the week of December 9, 2013, ahead of the original late first quarter 2014 target. The MedHOK system will replace the current ICMS MMS provided by Xerox.

With roughly three weeks remaining in the implementation schedule, the core project team (consisting of GCHP, MedHOK and Xerox resources) are wrapping up final system and user acceptance testing, training of the Health Services staff, and system cutover planning in preparation for go-live. The MedHOK team has proven to be a valued and committed partner throughout the implementation process.

In conjunction with the MedHOK MMS implementation, the Plan is preparing to transition the Xerox nurses to GCHP employees effective January 1, 2014.

Government Affairs Update

ACA and State Health Care Program Changes:

1. Medi-Cal Expansion / Low-Income Health Plan Transition

2. New Mental Health Benefits for Medi-Cal
3. Covered California
4. ACA 1202 Physician Payment Increase

State Budget: The Governor is expected to release the FY2014-15 State of California budget in mid-January. The Government Relations department will monitor new proposals for impacts to Medi-Cal and related programs.

Board Members Update

New Board members were sworn in at the October 28, 2013 meeting. The two new board members are:

1. Dr. Michelle Laba, Ventura County Medical Center Executive Committee seat, and
2. Dr. Gagan Pawar, Clinicas del Camino Real, Inc. Physician Representative seat.

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FY 2012-13 Audit Results

December 4, 2013

Consumer Advisory Committee

Michelle Raleigh, CFO

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Contents

- Background
- Results
- Next Steps

Background

- Annual financial audit is a requirement of GCHP's contract with the State's Department of Health Care Services
- Primary purpose of audit is for stakeholders to gain assurance that Plan's financial statements are properly presented, are free of material misstatements, and have been prepared in conformity with accounting principles generally accepted in the U.S.
- Secondary purpose is to test and comment on internal processes and controls

Results

- Auditors issued an “unqualified” opinion – the highest level of opinion an auditor can make
- Certain adjustments were made to the reported 6/30/13 financial results, primarily based on information received from the State after GCHP initially finalized financial reporting
- Auditor made 3 observations concerning internal controls

Results

- FY2012-13 Net Income and Tangible Net Equity (TNE) increased approximately $4.2 million

	06/30/13 As Reported		Audit Adjustments*		06/30/13 Restated
Net Income	$ 6,568,145		$ 4,154,838		$ 10,722,983
TNE	$ 7,736,261		$ 4,154,838		$ 11,891,100
Required TNE (68% of full requirement as of 6/30/13 per phase-in schedule)	$ 10,974,140		$ -		$ 10,974,140
Excess/(Deficiency) of current TNE requirement at 6/30/13	$ (3,237,879)		$ 4,154,838		$ 916,960

*Audit Adjustments:	
1. Identified by Management - finalized State Rates (increase to revenue)	$ 4,087,976
2. Identified by Auditors - health care expense adjustment (decrease to health care expenses)	$ 66,862
3. Improvement to Net Income (1+2)	$ 4,154,838

Note: TNE includes $7.2 million in lines of credit with the County of Ventura

Next Steps

- GCHP staff will provide ongoing updates to Executive / Finance Committee regarding findings

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ACA Expansion Program Commission Update

Monday, November 18, 2013

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Objectives

Provide Current Program Status

- Low Income Health Plan (LIHP)
- Optional Expansion
- Mental Health Expansion
  - ► Managed Behavioral Health Organization (MBHO) Implementation

LIHP Status

- Transition PCP Assignment/Linkage
  - ►Current Membership Distribution:
    - o 75% VCMC and 25% Clinicas
    - o Anticipate 100% linkage
  - ►DHCS to share Member information the first part of December
  - ►BAA being executed with VCHCA
    - o To facilitate exchange of data for care coordination
  - ►Tested Methodology to be used to link members to their medical home

LIHP Status

- Member Outreach and Notification
  - ►DHCS Notifications
    - o 90 Day (10/4/13) – LIHP
    - o 60 Day (11/1/13) – DHCS
    - o 30 Day (12/1/13) – DHCS
  - ►Member outreach (postcards/flyers)
    - o Collaboration with VCHCA to distribute
  - ►GCHP LIHP Welcome Letter submitted to DHCS for approval

LIHP Status

- Partnership Efforts
  - ►Case Management “Task Force”
  - ►Joint Communications Workgroup
  - ►Project Management meetings

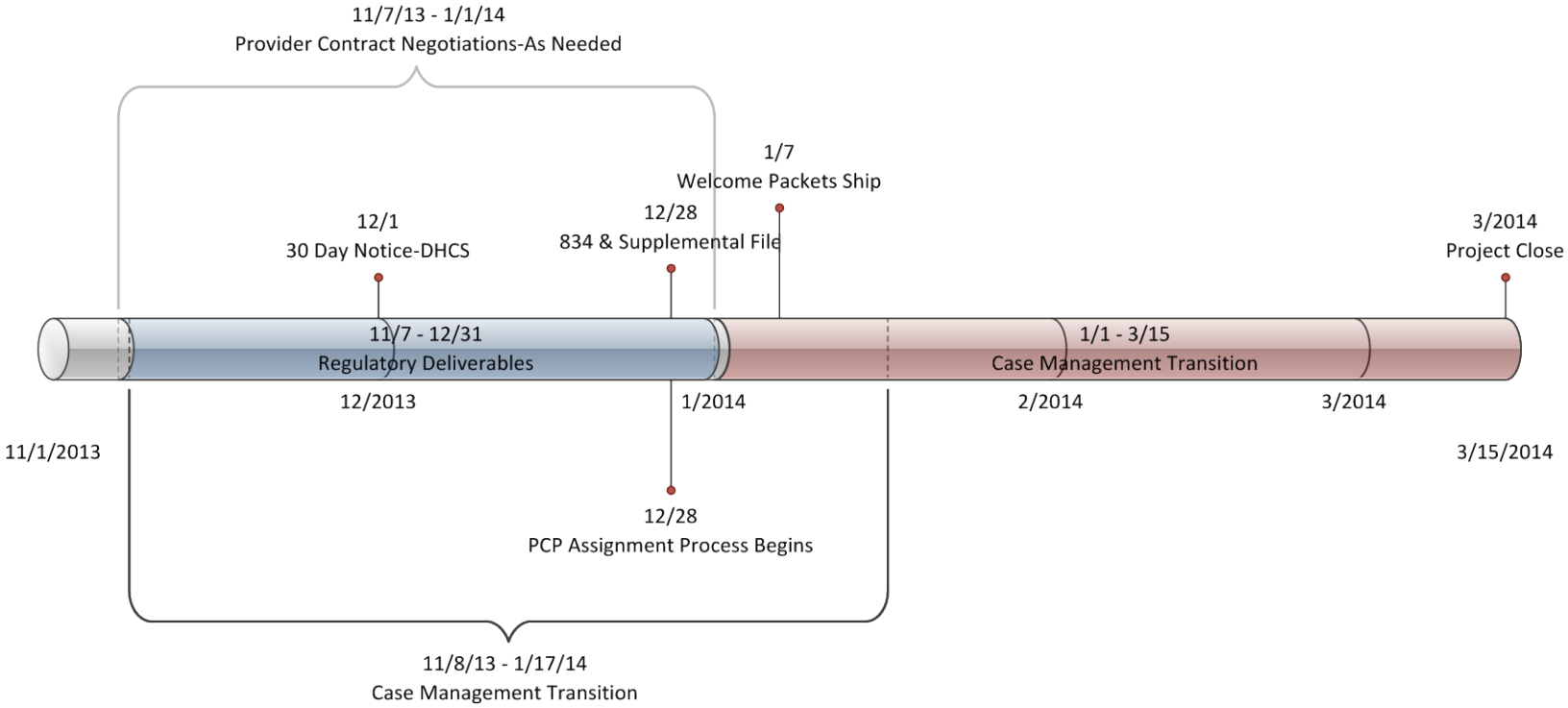
LIHP-Eligibility Comparison

Eligibility Requirements	LIHP	MediCal*
Citizenship or Residency Status (5 yr)	Y	Y
Residency-Ventura County	Y	Y
Income (MCE: 0-133% FPL)	Y	100-138%
Age (19-64)	Y	Y
Not Eligible for Medi-Cal or AIM	Y	N/A
Asset Test (going away 1/1/14)	N	?
* After January 1, 2014 Expansion		

LIHP-Benefit Comparison

- DHCS to provide Benefit Crosswalk for mandated benefits
- Additional services provided by the county for ACE members
- GCHP to identify variances and develop messaging for members and providers

LIHP Timeline



Anticipated Regulatory Deliverables (12/1-12/31):

- Contract Amendment-pending
- Continuity of care-Requirements & Reporting-Pending
- Policies & Procedures-pending
- Updated EOC-pending DHCS template language
- Rates & Rate Categories-pending

Technical Work Effort (12/1-12/31):

- Aid Code Mapping (to include new MAGI Codes
- Update/configure ika (codes, rates, etc)-Pending
- Data Mapping (834/supplemental)
- Provider linking/assignment
- Update / Test fulfillment process (Welcome Letter, EOC & ID Card)

Optional Expansion

- Newly Eligible Income Range
  - 100-133% + 5% bonus = 138% Federal Poverty Level (FPL)
- New Modified Adjusted Gross Income (MAGI) Aid Codes
- Benefits will mirror what is currently provided in Fee-For-Service Medi-Cal

Optional Expansion

- Challenges:
  - Unknown health status of the 133-138% FPL population
  - No Pre-Authorization or Claims history will be available

Expansion Outreach

- GCHP Communications Team plans to develop
  - ►Radio Ads
  - ►Flyers
  - ►Notifications
  - ►Joint Communications with VCHCA
  - ►Piggyback on County Outreach Grants
  - ►Community Events

Questions?

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ACA Expansion - Behavioral Health

Behavioral Health Benefits

- January 1, 2014 all health plans must provide behavioral benefits
- Behavioral Health benefit will be covered by Medi-Cal Managed Care - GCHP
- Provides expanded benefits for mild to moderate behavioral health conditions
- Expanded substance abuse treatment benefit

Managed Behavioral Health Organization

- The new behavioral health benefit provides coverage for "mild to moderate" behavioral health services. Benefit includes individual and group therapy, psychological testing, and outpatient medication management.*

- DHCS has already notified the enrollees of the benefit change and is still working to develop many of the details necessary for the plan to administer the benefit.

- GCHP has entered into an agreement with Beacon Health Strategies, a managed behavioral health organization (MBHO), to help us administer this new benefit.

- GCHP/Beacon are coordinating discussions with providers to develop an implementation strategy.

- *Tri-Counties Regional Center (TCRC) covers autism for members meeting their severity criteria. Treatment for mild autism is NOT a covered benefit for GCHP Medi-Cal members.

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Health Care Reform
Medi-Cal
Covered California

Health Care Reform

- What is coming in 2014?
- Medi-Cal Expansion and Benefits
- Covered California (Health Benefit Exchange)
- Outreach to the Eligible

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Health Care Reform: What is Coming in 2014?

- Expansion of Medicaid-eligibility up to 138% FPL
- Individual Mandate
- Coverage and Subsidies Begin In Health Benefits Exchange
- Medi-Cal Coverage Enhancements
  - Mental Health and Substance Use Disorder Services
  - Adult Dental Services (May 1, 2014)-Denti-Cal

Medi-Cal Expansion

- About 7 million covered currently in California
- About 1 million are currently eligible but not enrolled
- Approximately 2.2 million will be newly eligible by 2019

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Source: UCLA Center for Health Policy

Medi-Cal Expansion Benefits*

Must include 10 essential health benefits:

1. Ambulatory outpatient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. **Mental health & substance use disorder services**
6. Prescription drugs
7. Rehabilitative and habilitative services
8. Laboratory services
9. Preventive care and chronic disease management
10. Pediatric services, including oral and vision care

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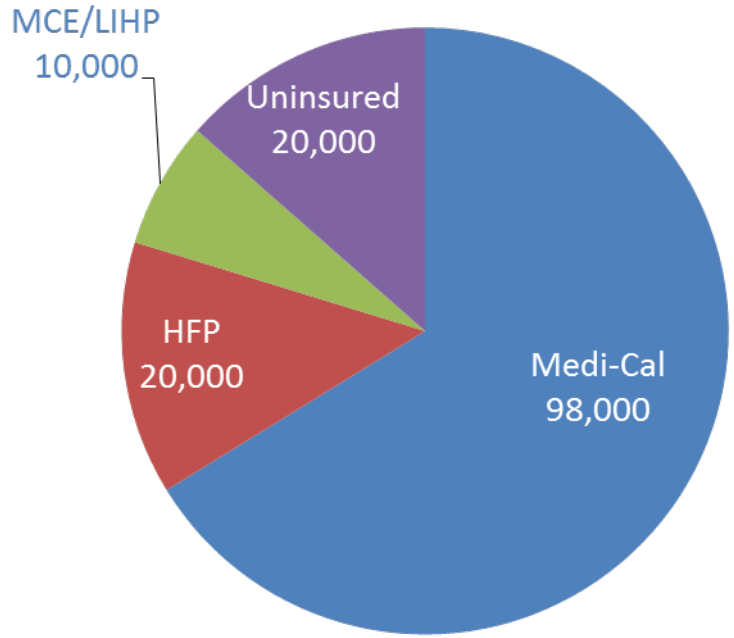
Medi-Cal / GCHP Enrollment Will Increase Approximately 45-50 Percent in 2013 and Beyond

Legacy Medi-Cal Population (as of 12/31/2012)	**98,000**
Expansion Population	
• **ACE MCE**	**10,000**
• **Uninsured***	**20,000**
• **Healthy Families ****	**20,000**



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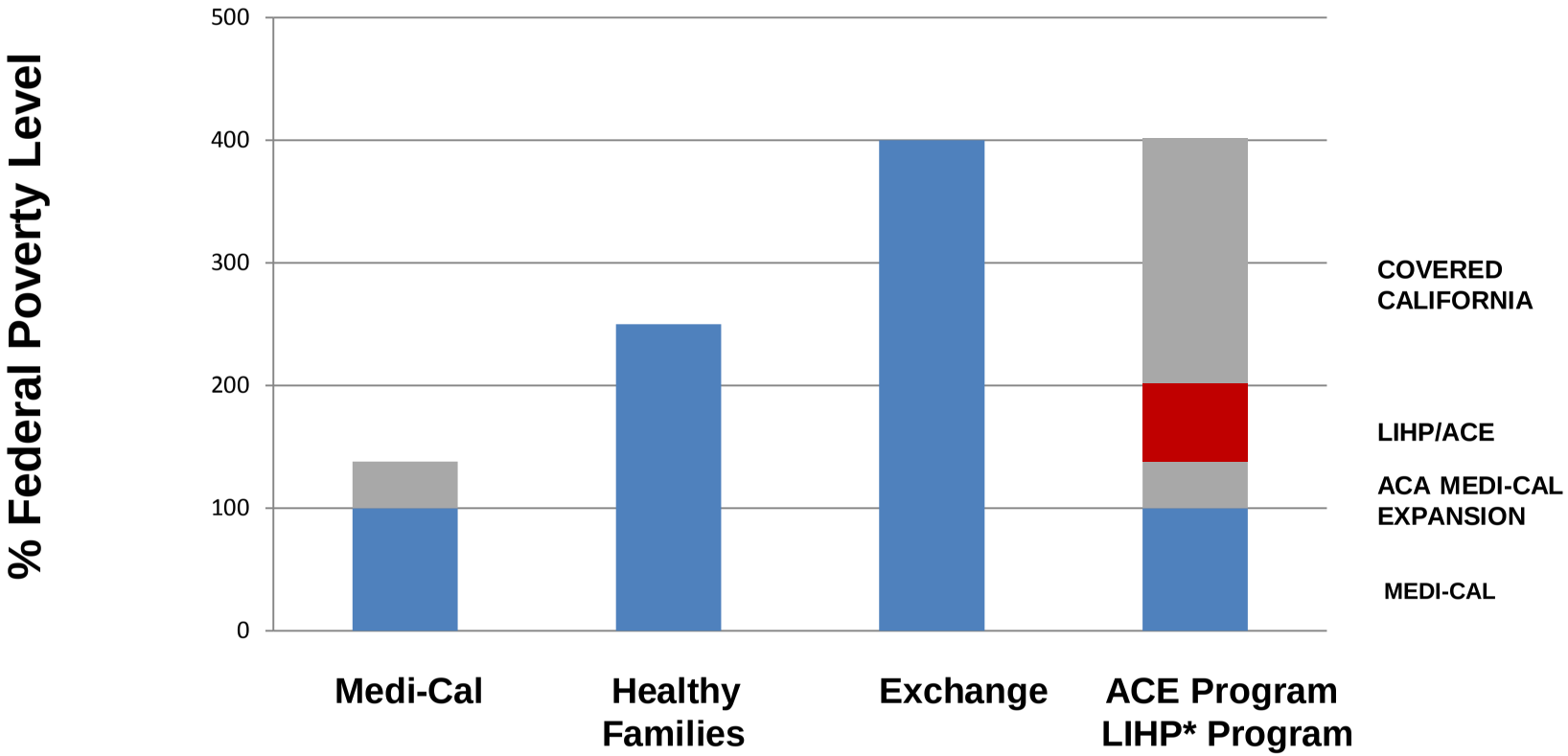
*Estimated enrollment over 12-24 months

**Approx. 6,000 of these enrollees have been enrolled into GCHP since January 2013

Income Eligibility Levels- 2014

Current

Due to Federal Health Care Reform



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* LIHP – Low Income Health Plan

CA Health Benefit Exchange aka Covered California

- California - No extension of non-ACA compliant policies
- Consumer Options Hotline open from 8:00 a.m. to 8:00 p.m. at 855-857-0445

- Open enrollment period
  - October 1, 2013 to March 31, 2014
  - Individuals must sign up by December 15, 2013 for coverage to be effective January 1, 2014
  - Call Center 800-300-1506

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- Four “metal” plan levels pay from 60%-90% coverage

Covered California Update

- ✓ As of 11/19/13: 360,000 people completed applications - 39% are possibly Medi-Cal eligible
- ✓ Of the 79,891 who selected a plan, the top three plans selected are:
  - Anthem Blue Cross - 28.1%
  - Kaiser - 26.8%
  - Blue Shield - 25.6%

Covered CA Outreach Activities

- 2,218 certified educators
- 1,564 certified enrollment counselors
- 6,875 certified insurance agents
- 611 Call Center staff- support offered in 13 languages
- An Additional 280 Call Center staff to be hired in coming months

- Deadline driven radio messaging to emphasize 12/15 deadline

- “Welcome to Answers” and “That Covered Feeling” campaign to launch in January 2014. Will feature newly covered enrollees

- Streamlined training for enrollment counselors to launch in early January 2014

GCHP Outreach Activities

- Coordination with County, Healthcare Partners, Community Stakeholders
- Radio - Media Campaign and Internet Messaging
- New Member Orientations
- Telephone Outreach Campaign
- Health Fairs and Workshops
- Schools and Youth Day Camps
- Public Events and Community Festivals

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Questions ?

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Managed Care Basics

Consumer Advisory Committee Meeting
December 4, 2013

Sherri Tarpchinoff Bennett, Director of Network Operations

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Medi-Cal Managed Care Definition

Health Maintenance Organization (HMO)

AKA

Managed Care Plan, Health Plan, Plan

- Medi-Cal contracts with plans to provide defined set of covered benefits for a set per-member per-month amount.
- The plans then contract with medical groups, hospitals, and other providers to provide a full range of health services for their enrollees.

Gold Coast Health Plan

- An Independent Public Entity
- County Organized Health System (COHS) model
- Oversight by Ventura County Medi-Cal Managed Care Commission
- Ventura County
- Core Population is Medi-Cal

COHS Model

- Model was first established 30 years ago.
- Proven high quality, innovative, culturally competent, locally responsive and cost effective model.
- Provides care to California's most vulnerable residents
- **Six plans – only in California** (Gold Coast Health Plan, CalOPtima, CenCal Health, Central California Alliance for Health, Health Plan of San Mateo, and Partnership Health Plan of California)

Medi-Cal Eligibility Categories

- Families with Children
- Seniors & Persons of Disabilities (SPDs) – Medi-Cal only
- Dual Eligible (Medi-Cal & Medicare)
- Medi-Cal Share of Cost

FFS Medi-Cal-vs-GCHP Managed Care

FFS Medi-Cal

- Payment is FFS for each service delivered to a beneficiary
- Beneficiaries obtain services from any provider who has agreed to accept Medi-Cal payments
- Does not provide for the coordination of care
- Claim submission requirements are often not consistent with industry standards

GCHP – Managed Care

- Capitated Payments to PCP/ FFS to Specialists
- Members choose a contracted Primary Care Provider (PCP) who coordinates care (Medical Home)
- Plan provides assistance to members by coordinating care, care management, and customer call centers
- Streamline claims systems using industry standards

Capitation Definition

Capitation
or
“Per-Member Per-Month”
(PM PM)

The fixed amount of money paid on a monthly basis to the PCP or medical group for a defined set of medical services.

Primary Care Provider – Medical Home

- **Primary Care Provider (PCP).** A clinic, physician(s) or mid-level licensed professional practicing under physician supervision who:
  - Provides primary care services - basic level of healthcare usually rendered in ambulatory settings with focus on general health needs
  - Supervises, coordinates, and provides primary care services
  - Initiates referrals to specialists
  - Maintains the continuity of care

Primary Care Services

- Office Visits
- Preventative Medicine Services
- CHDP Services
- Vaccines
- Basic Laboratory Testing
- Minor Surgeries and Other Misc. Procedures

Care Management

- The Gold Coast Health Plan Care Management Program is a collaborative process that includes the member, health care provider, family, and care manager.
  - **Medical Director of Health Services** who provides guidance for and is responsible for all clinical aspects of the Care Management program.
  - **Care Manager** GCHP Care Managers are licensed registered nurse professionals and licensed clinical social workers with specialty certifications specific to their role.

Types Care Management

- **Non-complex Care Management** is for members who require short term coordination of services and support. .
  - Discharge planning
  - New diagnosis/es that effect physical, emotional and mental health adjustment
  - Significant health change that requires support.
  - Coordination of primary and specialty care to improve adherence and/or access to necessary services
  - Cultural or language barriers that prevent understanding and access to needed services

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Issue 1 • Winter 2014

New options for insurance

January 1, 2014, will be more than the start of the new year. It also marks the date when many aspects of the Affordable Care Act (ACA) take effect.

Hello, my name is Michael Engelhard, and I am CEO at Gold Coast Health Plan (GCHP). I wanted to take a minute and speak to you about some of the key aspects of this new law. These features are intended to make it easier for you to obtain health insurance. They'll also provide new protections if you already have health care coverage.

Access to Medi-Cal increases. If you earn less than 138 percent of the poverty level, you'll be eligible to enroll in Medi-Cal. In other words, an individual making less than $15,856 or a family of four making less than $32,499 are eligible. Please contact the Ventura County Human Services Agency for more information at **888-472-4463**.

Health exchanges are one key aspect of the ACA. The exchanges are online marketplaces where you can shop for health insurance. California will run its own exchange called Covered California. Coverage won't begin until January; however, online sign-up started October 1, 2013. This open enrollment period ends on March 31, 2014, so make certain to act by then. Go to **www.coveredca.com** for more information.

Tax credits will help many people buy insurance. These credits will be available to people with incomes between 138 and 400 percent of the poverty guidelines who can't afford coverage elsewhere. You qualify for a tax credit that will lower the amount of your monthly premium if you are an individual making $28,726 to $45,960. If you are a family of four making $32,500 to $58,874, your children qualify for Medi-Cal and parents may receive a subsidy and/or a tax credit that lowers the amount of monthly premiums.

Coverage can't be denied because of pre-existing conditions. This protection applies if you're seeking new coverage or renewing an existing policy.

Annual benefit caps will be banned. This means insurance companies can no longer put limits on the benefits you receive in any given year.

If better health is one of your New Year's resolutions, the ACA may help make it possible. So, on behalf of everyone at GCHP, here's wishing you season's greetings and a healthy new year!

Michael Engelhard
CEO, Gold Coast Health Plan

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DIABETES

First steps to good care

When your Provider says you have diabetes, these aren't easy words to hear. Anger. Fear. Disbelief. These are some of the strong feelings you might have.

It may seem like a lot to deal with right now, but you are not alone. Your health care team members can help. They can teach you many ways to take charge of your diabetes. You can learn to manage it. Doing so can help you avoid the major health problems it can cause.

Steps to know. Your health care team will help you learn how to check your blood sugar (glucose) levels. This is a key part of managing diabetes. You can use the results to adjust your care. This could mean changing your eating or exercise habits, for instance. You may use a glucose meter many times a day to check your levels.

You should also have a lab test called an A1C two times a year. The test will help show you and your Provider how well your diabetes is being controlled.

Your health care team can also help you learn how to:

Use a meal plan. Smart food choices can help you control your blood sugar and protect your heart. Your meal plan will include healthy foods, such as: ■ Fruits. ■ Veggies. ■ Grains. ■ Beans. ■ Skinless chicken. ■ Low-fat milk.

You can still have many of the foods you like best too. Ask how to fit them in to your meal plan.

Be active. Regular exercise can help control blood sugar. Moving more can help improve your health in other ways as well. It's as simple as taking a walk or going for a bike ride. Ask your Provider how to get started. At first, you may need just a few minutes a day.

Take medicines as directed. This can include medicines for diabetes, blood pressure or cholesterol.

Be sure to see your Provider on a regular basis. Checkups can help you stay on top of diabetes.

Sources: American Diabetes Association; National Diabetes Education Program

» TAKE ACTION **Call Member Services at 888-301-1228 to find out what we cover for diabetes care and management.**

» AGENCIES WITH FOOD DISTRIBUTION LOCATIONS IN VENTURA COUNTY

There are many locations throughout Ventura County to get food if you need help. Contact Food Share at 805-983-7100 or go to *www.foodshare.com/gethelp.aspx* to find a food pantry near you.

Notice of Privacy Practices from Gold Coast Health Plan: New federal law changes have been made to your privacy rights. Gold Coast Health Plan must notify you on the changes and how they will impact you. You will receive a notice in the mail. You may obtain a copy by calling our Member Services department at **888-301-1228** or by visiting our website at *www.goldcoasthealthplan.org*.

winning health®

WINNING HEALTH is published as a community service for the friends and patrons of GOLD COAST HEALTH PLAN, 2220 E. Gonzales Road, Oxnard, CA 93036, telephone 888-301-1228.

Information in WINNING HEALTH comes from a wide range of medical experts. If you have any concerns or questions about specific content that may affect your health, please contact your health care Provider.

Models may be used in photos and illustrations.

Member Services	Luis Aguilar
Health Education	Lupe Gonzalez, PhD, MPH
Editor	Steven Lalich
Medical Director	Charles Cho, MD

Tips for a healthy pregnancy

You want to give your baby the best start in life.

You can do this by taking good care of your body. It can help your baby be healthy. And it may help you get pregnant sooner.

Some key steps:

Get enough folic acid. You need 400 micrograms every day. It can help prevent certain birth defects.

These foods are good sources of folic acid:

- Leafy, dark-green vegetables, like spinach.
- Citrus fruits, like oranges.
- Beans.
- Breads and cereals with added folic acid.

You may need to take a supplement to make sure you get enough folic acid. Your Provider can tell you how much you need.

Stay at a healthy weight. Talk with your Provider. You may need to gain or lose weight before you get pregnant.

Take care of health problems. If you have an ongoing health problem, your Provider can help you get it under control. This includes:

- Asthma.
- Diabetes.
- High blood pressure.

Get immunized. Make sure you have had all your shots. They can help protect you and your baby from serious illness.

Your Provider can help you have a fit pregnancy.

Choose the best foods. Eat lots of fruits, vegetables, whole grains and low-fat dairy products.

Exercise every day. Try to get at least 30 minutes of moderate activity on most days of the week. Walking is a good choice. Exercise can help you feel more comfortable during pregnancy.

Don't smoke or drink alcohol. They can make it harder to get pregnant. And they could hurt your baby.

See your Provider before you get pregnant. He or she can help you get off to a good start.

Source: American College of Obstetricians and Gynecologists

SAFE TRAVELS FOR BABY

Car seat basics

Many babies enjoy car rides. Just be sure it's a safe ride every time.

1. Choose the right seat.

All infants should ride in a rear-facing seat until they are at least 2 years old. Or use a rear-facing seat until your child outgrows the seat's height and weight limits.

Rear-facing seats have harnesses. These should be fastened snugly at your baby's midchest. The harness should go through the slots that are at or below your baby's shoulders.

2. Install it the right way.

- Read all of the instructions for your infant's seat. They will describe how to secure the seat in the car. Some car's seat belts need special clips.
- Make sure the seat is installed tightly. The seat should not move more than 1 inch from side to side or front to back.
- Put the seat in the back seat. Infants in rear-facing seats should never ride in a front seat with an air bag. Even in a minor crash, the bag can inflate, causing serious injury.

Source: American Academy of Pediatrics

» PREGNANCY AND NEW PARENT E-NEWSLETTER **It's easy to sign up for *Pregnancy* and *New Parent* e-newsletters. Go to the "Health Services" page on the Gold Coast Health Plan's website and enter your email address. You'll start receiving your e-newsletter almost immediately. Do it today! Visit *www.goldcoasthealthplan.org*.**

Planning for a smooth recovery

A good recovery requires good planning, which is why we start looking ahead to the time you can leave the hospital as soon as we can.

You might be headed home or to another place. Either way, we want you to keep getting better after you leave the hospital. That means giving you the information you need to help heal.

Before you leave, you and your family will know:

- What your diagnosis is.
- How you're doing now.
- The types of medicines you need to take.
- The kind of care and services you may need.
- Where you can get help.
- Any doctor's visits or tests that have been scheduled.
- What symptoms to watch for.
- Whom to call if you have questions.

Will someone take care of you at home? Let your Provider know so they can include that person in plans for your discharge.

We want you to leave with your questions answered. If they aren't, let us know. We're here to help.

When you have a complaint

We want you to be happy with our service.

But if you're not, please let us know.

You can let your voice be heard in several different ways.

If the complaint is about your Provider's office, you may want to go there first.

Let someone on staff know what happened. Ask him or her for help fixing the problem.

The same goes for a complaint about hospital care. Ask to speak with a nurse or social worker.

For questions about charges, you may want to try calling the billing department.

If you prefer, though, you can just call Member Services.

You can bring your complaint to us at any time. Call Member Services at **888-301-1228**. You can also write us at P.O. Box 9176, Oxnard, CA, 93031.

Let us know as much about the problem as you can.

We want to hear from you.

Have you received a bill from a Provider?

Medi-Cal Members should not be billed for covered services.

If you receive a bill from a Medi-Cal Provider for a covered service, call us as soon as possible at **888-301-1228** (TTY **888-310-7347**).

When you call, have a copy of the bill with the following information: the date of the medical service, the name of the doctor or hospital, the amount of the bill, and your Gold Coast Health Plan (GCHP) ID number.

Always carry your GCHP Member ID card with you. Show your card at every doctor's visit to make sure services are covered and to avoid getting billed by mistake.

salud para triunfar

Gold Coast Health Plan℠
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Edición 1 • Invierno 2014

Nuevas opciones de seguro

El 1° de enero de 2014 será algo más que el inicio de un nuevo año. También marca la fecha en que entrarán en vigor muchos aspectos de la Ley de Cuidado de Salud Asequible (Affordable Care Act o ACA).

Hola, me llamo Michael Engelhard y soy el Presidente de Gold Coast Health Plan (GCHP). Quisiera tomar un minuto de su tiempo para hablarle de algunos de los aspectos clave de esta nueva ley. Estas características buscan que sea más fácil para usted obtener seguro de salud. También brindan nuevas protecciones si ya tiene cobertura de seguro médico.

Aumenta el acceso a Medi-Cal. Si usted gana menos del 138 por ciento del nivel de pobreza, será elegible para inscribirse en Medi-Cal. En otras palabras, una persona que gane menos de $15,856 o una familia de cuatro personas con ingresos inferiores a $32,499 son elegibles. Para obtener más información, comuníquese con la Agencia de Servicios Humanos del Condado de Ventura al **888-472-4463**.

Los mercados de salud son un aspecto clave de la ACA. Los mercados de seguros son lugares en línea donde puede buscar y comparar opciones de seguro médico. California tendrá su propio mercado llamado Covered California. La cobertura no comenzará hasta enero; sin embargo, la inscripción en línea comenzó el 1° de octubre de 2013. Este período abierto de inscripciones termina el 31 de marzo de 2014, por lo que debe cerciorarse de actuar antes de esa fecha. Visite **www.coveredca.com** para obtener más información.

Los créditos de impuestos pueden ayudar a muchos a comprar seguro. Esos créditos estarán disponibles para personas cuyos ingresos están entre 138 y 400 por ciento del nivel de pobreza que no puedan pagar la cobertura en otro lugar. Usted califica para un crédito de impuestos que reducirá el monto de su prima mensual si gana entre $28,726 y $45,960. Si es una familia de cuatro con ingresos entre $32,500 y $58,874, sus hijos califican para Medi-Cal y los padres pueden recibir un subsidio y/o crédito de impuestos que reducirá el monto de las primas mensuales.

No se puede rechazar cobertura a causa de condiciones preexistentes. Esta protección corresponde si busca nueva cobertura o renueva una póliza existente.

Se prohibirán los topes de beneficios anuales. Esto significa que las compañías de seguros ya no pueden poner límites a los beneficios que reciba en un año dado.

Si tener mejor salud es uno de sus propósitos de Año Nuevo, la ACA puede ayudarle a cumplirlo. Así que en nombre de todos en GCHP, ¡le deseamos felices fiestas y un saludable año nuevo!

Michael Engelhard
Presidente, Gold Coast Health Plan

DIABETES

Los inicios del buen cuidado

Cuando su Proveedor le informa que usted tiene diabetes, no es fácil aceptarlo. Enojo. Miedo. Incredulidad. Estos son algunos de los sentimientos que puede experimentar.

Es posible que le resulte abrumador en el momento, pero no está solo. Su equipo de atención médica le puede ayudar. Puede enseñarle muchas maneras de tomar control de su diabetes, y así podrá aprender a manejarla. Al hacerlo, puede ayudar a evitar los graves problemas de salud que puede ocasionar la diabetes.

Lo que debe saber. Su equipo de atención médica le ayudará a aprender cómo verificar sus niveles de azúcar (glucosa) en la sangre. Esto es esencial para manejar la diabetes. Puede usar los resultados para ajustar el nivel de su cuidado. Esto podría significar, por ejemplo, que cambie sus hábitos alimenticios o de ejercicio. Puede usar un medidor de glucosa muchas veces al día para verificar sus niveles.

Además, dos veces al año debe hacerse una prueba de laboratorio llamado A1C. La prueba ayudará a que usted y su Proveedor sepan cuán bien se está controlando su diabetes.

Su equipo de atención médica también le enseñará cómo:

Usar un plan alimentario. La elección inteligente de alimentos puede ayudarle a controlar su azúcar en la sangre y a proteger su corazón. Su plan incluirá alimentos sanos, como: ■ Frutas. ■ Verduras. ■ Granos. ■ Frijoles. ■ Pollo sin piel. ■ Leche baja en grasa.

Aún así podrá comer muchos de los alimentos que más le gustan. Pregunte cómo los puede incluir en su plan alimentario.

Ser activo. El ejercicio habitual le ayudará a controlar el azúcar en la sangre. Mayor actividad física también puede ayudar a mejorar su salud en otros aspectos. Es tan sencillo como salir a caminar o a pasear en bicicleta. Pregunte a su Proveedor cómo empezar. Al principio es posible que solo necesite unos minutos al día.

Tomar las medicinas según le indiquen. Esto puede incluir medicinas para diabetes, presión arterial o colesterol.

No deje de visitar regularmente a su Proveedor. Los chequeos pueden ayudarle a controlar su diabetes.

Fuentes: American Diabetes Association; National Diabetes Education Program

» TOME MEDIDAS Llame a Servicios para Miembros al **888-301-1228** para saber qué cubrimos para la atención y el manejo de la diabetes.

» AGENCIAS CON CENTROS DE DISTRIBUCIÓN DE ALIMENTOS EN EL CONDADO DE VENTURA Hay muchos lugares en todo el Condado de Ventura donde puede obtener alimentos si necesita ayuda. Comuníquese con Food Share al **805-983-7100** o visite *www.foodshare.com/gethelp.aspx* para encontrar despensas de alimentos cerca de usted.

Aviso de Prácticas de Privacidad de Gold Coast Health Plan: Se han aplicado nuevos cambios en la legislación federal a sus derechos de privacidad. Gold Coast Health Plan debe notificarle los cambios y su impacto para usted. Recibirá un aviso por correo. Puede obtener una copia si llama a nuestro departamento de Servicios para Miembros al **888-301-1228** o si visita nuestro sitio web en *www.goldcoasthealthplan.org*.

salud para triunfar

SALUD PARA TRIUNFAR se publica como un servicio a la comunidad para los amigos y clientes de GOLD COAST HEALTH PLAN, 2220 E. Gonzales Road, Oxnard, CA 93036, teléfono 888-301-1228.

La información de SALUD PARA TRIUNFAR proviene de una gran variedad de expertos médicos. Si tiene alguna inquietud o pregunta sobre el contenido específico que pueda afectar su salud, sírvase comunicarse con su Proveedor de atención médica.

Se pueden utilizar modelos en fotos e ilustraciones.

Servicios para Miembros Luis Aguilar
Educación de Salud Lupe Gonzalez, PhD, MPH
Editor Steven Lalich
Director Médico Charles Cho, MD

Consejos para un embarazo saludable

Usted desea darle a su bebé el mejor comienzo posible.

Puede hacerlo si cuida bien de su propio cuerpo. Esto puede ayudar a que su bebé sea saludable, y ayudarle a usted a quedar embarazada más pronto.

Algunas medidas clave:

Consuma suficiente ácido fólico. Debe ingerir 400 microgramos diariamente. Puede ayudar a evitar ciertos defectos congénitos.

Estos alimentos tienen alto contenido de ácido fólico:

- Verduras de hojas oscuras, como la espinaca.
- Cítricos, como la naranja.
- Frijoles.
- Panes y cereales con ácido fólico agregado.

Quizás deba tomar un suplemento para asegurarse de ingerir suficiente ácido fólico. Su Proveedor puede decirle cuánto necesita.

Mantenga un peso saludable. Consulte con su Proveedor. Es posible que deba subir o bajar de peso antes de quedar embarazada.

Atienda cualquier problema de salud que tenga. Si tiene un problema continuo de salud, su Proveedor puede ayudarla a controlarlo. Esto incluye:

- Asma.
- Diabetes.
- Presión arterial alta.

Vacúnese. Asegúrese de tener todas las vacunas al día. Pueden ayudarla a protegerse usted misma y al bebé de enfermedades graves.

Elija los mejores alimentos. Coma muchas frutas, vegetales, granos integrales y lácteos bajos en grasa.

Su Proveedor le puede ayudar a tener un embarazo sano.

Haga ejercicio a diario. Trate de hacer al menos 30 minutos de actividad moderada casi todos los días. Caminar es una buena opción. El ejercicio puede ayudarle a sentirse más cómoda durante el embarazo.

No fume ni beba alcohol. Esto puede hacerle más difícil quedar embarazada, y podría dañar a su bebé.

Visite a su Proveedor antes de quedar embarazada. Él o ella podrán ayudarle a tener un buen comienzo.

Fuente: American College of Obstetricians and Gynecologists

VIAJES SIN RIESGOS PARA EL BEBÉ

Lo básico del asiento para el auto

Muchos bebés disfrutan pasear en auto. Asegúrese de que el paseo siempre sea seguro.

1. Elija el asiento adecuado.

Todos los bebés deben viajar en un asiento mirando hacia atrás hasta que tengan al menos 2 años de edad. O utilice el asiento orientado hacia atrás hasta que su bebé sobrepase los límites de estatura y peso del asiento.

Los asientos orientados hacia atrás tienen cinturones. El cinturón debe ceñir bien a la altura del pecho del bebé. El cinturón debe pasar por las ranuras que están a la altura de los hombros del bebé o más abajo.

2. Instálelo correctamente.

- Lea todas las instrucciones del asiento del bebé. Le indicarán cómo asegurar el asiento en el auto. Algunos cinturones de seguridad de autos requieren hebillas especiales.
- Asegúrese de ajustar bien el asiento. No debe moverse más de 1 pulgada de lado a lado o hacia adelante y atrás.
- Ponga el asiento en la parte trasera. Los bebés que viajan en asientos orientados hacia atrás nunca deben ir en un asiento delantero con bolsa de aire. Incluso en un choque leve, la bolsa se puede inflar y causar lesiones graves.

Fuente: American Academy of Pediatrics

» BOLETÍN ELECTRÓNICO SOBRE EMBARAZO Y PARA NUEVOS PADRES

Es fácil inscribirse para recibir los boletines electrónicos sobre *El Embarazo* y para *Nuevos Padres*. En el sitio web de Gold Coast Health Plan, seleccione "En Español," visite la página "Servicios de Salud" y registre su dirección de correo electrónico. Comenzará a recibir el boletín casi de inmediato. ¡Hágalo hoy mismo! Visite *www.goldcoasthealthplan.org*.

lo que debe saber

Planificar una recuperación sin problemas

Una buena recuperación requiere buena planificación, por eso comenzamos lo más pronto posible a pensar en el momento en que podrá salir del hospital.

Es posible que se dirija a su casa o a otro lugar. De cualquier forma, queremos que siga mejorando después de salir del hospital. Eso significa darle la información que necesita para ayudarle a sanar.

Antes de irse, usted y su familia sabrán:

- Cuál es su diagnóstico.
- Cómo está actualmente.
- Los tipos de medicinas que debe tomar.
- El tipo de cuidados y servicios que puede necesitar.
- Dónde puede obtener ayuda.
- Cualquier consulta con el médico o prueba que se haya programado.
- De qué síntomas debe estar pendiente.
- A quién llamar si tiene dudas.

¿Alguien le cuidará en casa? Hágaselo saber a su Proveedor para que pueda incluir a esa persona en los planes para cuando le den de alta.

Queremos que se vaya sin una sola duda. Si no es así, háganoslo saber. Estamos aquí para ayudar.

¿Recibió una factura de un Proveedor?

No se deberá facturar a los Miembros de Medi-Cal por los servicios cubiertos.

Si recibe una factura de un Proveedor de Medi-Cal por un servicio cubierto, llámenos tan pronto como sea posible al **888-301-1228** (TTY **888-310-7347**).

Cuando llame, tenga una copia de la factura con la siguiente información: la fecha del servicio médico, el nombre del doctor u hospital, la cantidad de la factura y su número de identificación de Gold Coast Health Plan (GCHP).

Lleve siempre consigo su tarjeta de identificación de Miembro de GCHP. Muestre su tarjeta en cada consulta con el doctor para asegurarse que los servicios estén cubiertos y para evitar que le envíen una factura por error.

Cuando tiene una queja

Queremos que esté contento con nuestro servicio.

Pero si no lo está, háganoslo saber.

Puede hacer que su voz se escuche de varias formas diferentes.

Si la queja es sobre el consultorio de su Proveedor, quizás quiera intentar allí primero.

Infórmele a alguien del personal lo que sucedió. Pídale que lo ayude a resolver el problema.

Haga lo mismo si la queja es sobre la atención hospitalaria. Pida hablar con un enfermero o trabajador social.

Para preguntas sobre costos, quizás desee llamar al departamento de cobranzas.

Pero si lo prefiere, puede simplemente llamar a Servicios para Miembros.

Puede traernos su queja en cualquier momento. Llame a Servicios para Miembros al **888-301-1228**. También puede escribirnos a P.O. Box 9176, Oxnard, CA 93031.

Descríbanos el problema lo mejor que pueda.

Queremos saber de usted.

Want to Quit Smoking?

- Talk to your doctor today!
- Ask about tobacco treatment support groups and educational programs.
- Call **1-888-301-1228**
- If you are pregnant and want to quit smoking, talk to your doctor first.
- Make an appointment to see your doctor before starting a treatment to quit smoking.
- Take action now, call to learn which program is best for you at 1-888-301-1228.

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The Health Education Department is here to help you find the right program for you, call us at **1-888-301-1228**.
For more information visit our website at:
www. goldcoasthealthplan.org

Health Education, Cultural and Linguistic Services
1-888-301-1228

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Gold Coast Health Plan℠
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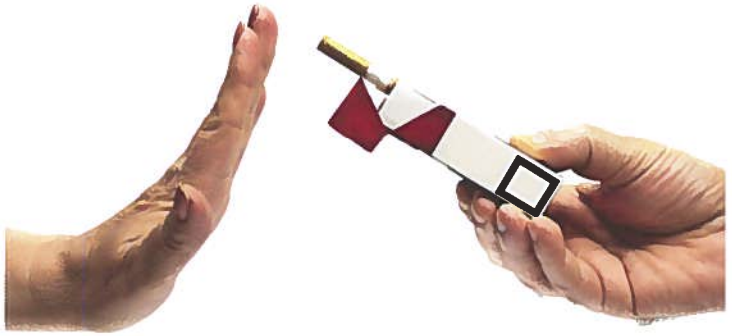
Health Education Resources

A Community Guide to Health Education Resources and Programs



Want to Quit Smoking?

Tobacco Education & Quit Smoking Program Resource Guide

Member Service Call Center
1-888-301-1228
www.goldcoasthealthplan.org

Health Education Guide to Tobacco Prevention and Quit Smoking

Gold Coast Health Plan is committed to helping our members stay well.

We work with our health care providers to promote health education programs and classes.

Tobacco use is the most common preventable cause of death. Quitting smoking is important to your health.

Take action now, call to learn what program is best for you.

California Smoker's Helpline, Call Today:

- **1-800-NO-BUTTS (1-800-662-8887)**
- **Ask about $20 Gift Card (limited time only)**
- **For Counseling and Support Groups Call 1-800-622-8887**

Hospital Based Support Groups

Community Memorial Hospital: HealthAware Program

- 805-667-2818

Simi Valley Hospital Adventist Health

- 805-955-6890 to learn about health classes and support groups

St. John's Regional Medical Center offers quit smoking support groups

- 805-988-2500 for more information

Ventura County Health Care Agency: Medical Center & Santa Paula Hospitals

- 805-677-5261 for more information

Los Robles Hospital & Medical Center

- 1-877-888-5746

Additional Community Health Care Resources

Clinicas del Camino Real, Inc.

- 805-647-6322

Ventura County Public Health Tobacco Education & Control Program

- Call Helpline to quit smoking at 805-201-STOP (7867)

Helpful Website Information

- www.californiasmokershelpline.org
- www.dhcs.ca.gov

Gold Coast Health Plan Health Education Department

Call Member Services if you have any questions about the information in this resource guide.

- 1-888-301-1228

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www.goldcoasthealthplan.org
2220 East Gonzales Road, Suite 200, Oxnard, CA 93036

¿Quiere dejar de fumar?

- ¡Hable hoy con su doctor!
- Pregunte sobre grupos de apoyo para tratamiento contra el tabaco y programas educativos
- Llame al **1-888-301-1228**
- Si está embarazada y quiere dejar de fumar, primero hable con su doctor.
- Haga una cita para ver a su doctor antes de comenzar un tratamiento para dejar de fumar.
- Tome acción ahora, llame para saber cual es el mejor programa para usted al 1-888-301-1228.

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El Departamento de Educación sobre la Salud está aquí para ayudarle a encontrar el programa correcto para usted, llámenos al **1-888-301-1228**.
Para mayor información visite nuestro portal: www. goldcoasthealthplan.org

Servicios de Educación sobre la Salud, Culturales y Lingüísticos
1-888-301-1228

Gold Coast Health Plan℠
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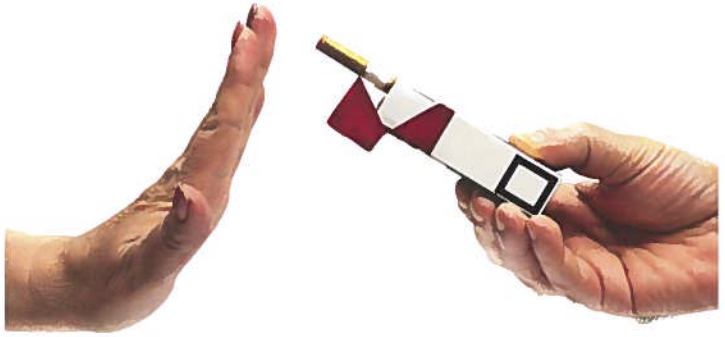
Recursos de Educación sobre la Salud

Guía Comunitaria de la Educación sobre la Salud Recursos y Programas



¿Quiere dejar de fumar?

Educación sobre el uso del Tabaco y cómo dejar de fumar

Guía de Recursos del Programa

Centro de Llamadas al Servicio de los Miembros 1-888-301-1228
www.goldcoasthealthplan.org

Guía de Educación sobre salud para la Prevención del Consumo del Tabaco y Dejar de Fumar

Gold Coast Health Plan está comprometido a ayudar al bienestar de nuestros miembros.

Trabajamos con nuestros proveedores de cuidados de la salud para promover programas y clases de educación sobre la salud.

El uso del Tabaco es la causa prevenible más frecuente de muerte. El dejar de fumar es importante para su salud.

Actúe ahora, llame para aprender cual es el mejor programa para usted.

Línea de Ayuda para los Fumadores de California, Llame Hoy:

- **1-800-NO-BUTTS (1-800-662-8887)**
- **Pregunte sobre la tarjeta de regalo de $20 (por tiempo limitado)**
- **Si desea Consejería y Grupos de Apoyo Llame al 1-800-622-8887**

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Grupos de Apoyo ubicados en el Hospital

Community Memorial Hospital: HealthAware Program

- 805-667-2818

Simi Valley Hospital Adventist Health

- 805-955-6890 para aprender acerca de clases de salud y grupos de apoyo

St. John's Regional Medical Center offers quit smoking support groups

- 805-988-2500 para mayor información

Ventura County Health Care Agency: Medical Center & Santa Paula Hospitals

- 805-677-5261 para mayor información

Los Robles Hospital & Medical Center

- 1-877-888-5746

Recursos de Salud Adicionales para la Comunidad

Clinicas del Camino Real, Inc.

- 805-647-6322

Salud Pública del Condado de Ventura Programa de Control y Educación del Tabaco

- Llame a la Línea de Ayuda para dejar de fumar 805-201-STOP (7867)

Información de Portales útiles

- www.californiasmokershelpline.org
- www.dhcs.ca.gov

Gold Coast Health Plan Departamento de Educación de la Salud

Llame a Servicio a Miembros si tiene Los Robles Hospital & Medical Center preguntas sobre la información en esta guía de recursos.

- 1-888-301-1228

www.goldcoasthealthplan.org
2220 East Gonzales Road, Suite 200, Oxnard, CA 93036

STAYING HEALTHY ASSESSMENT (SHA)

Instruction Sheet for the Provider Office

SHA PERIODICITY TABLE

Questionnaire Age Groups	Administer	Administer /Re-Administer		Review
	Within 120 Days of Enrollment	1st Scheduled Exam *(after entering new age group)*	Every 3-5 Years	Annually *(Intervening Years)*
0 - 6 Mo	√			
7 - 12 Mo	√	√		
1 - 2 Yrs	√	√		√
3 - 4 Yrs	√	√		√
5 - 8 Yrs	√	√		√
9 -11 Yrs	√	√		√
12 - 17 Yrs	√	√		√
Adult	√		√	√
Senior	√		√	√

SHA COMPLETION BY MEMBER

- Explain the SHA's purpose and how it will be used by the PCP.
- Offer SHA translation, interpretation, and accommodation for any disability if needed.
- Assure patient that SHA responses will be kept confidential in patient's medical record, and that patient's has the right to skip any question.
- A parent/guardian must complete the SHA for children under 12.
- Self-completion is the preferred method of administering the SHA because it increases the likely hood of obtaining accurate responses to sensitive or embarrassing questions.
- If preferred by the patients or PCP, the PCP or other clinic staff may verbally asked questions and record responses on the questionnaire or electronic format.

PATIENT REFUSAL TO COMPLETE THE SHA

- How to document the refusal on the SHA:
  1) Enter the patient's name and "date of refusal" on first page
  2) Check the box "SHA Declined by Patient" (last page page)
  3) PCP must sign, print name and date the back page
- Patients who previously refused/declined to complete the SHA should be encouraged to complete an age appropriate SHA questionnaire each subsequent year during scheduled exams.
- PCP must sign, print name and date an age appropriate SHA each subsequent year verifying the patient's continued refusal to complete the SHA.

SHA RECOMMENDATIONS

Adolescents (12-17 Years)

- ☐ Annual re-administration is highly recommended for adolescents due to frequently changing behavioral risk factors for this age group.
- ☐ Adolescents should begin completing the SHA on their own at the age of 12 (without parent/guardian assistance) or at the earliest age possible. The PCP will determine the most appropriate age, based on discussion with the family and the family's ethnic/cultural/community background.

Adults and Seniors

- ☐ The PCP should select the assessment (Adult or Senior) best suited for the patient's health & medical status, e.g., biological age, existing chronic conditions, mobility limitations, etc.
- ☐ Annual re-administration is highly recommended for seniors due to frequently changing risk factors that occur in the senior years.

PCP RESPONSIBILITIES TO PROVIDE ASSISTANCE AND FOLLOW-UP

- PCP must review and discuss newly completed SHA with patient. Other clinic staff may assist if under supervision of the PCP, and if medical issues are referred to the PCP.
- If responses indicate risk factor(s) (boxes checked in the middle column), the PCP should prioritize patient's health education needs and willingness to make life style changes, provide tailored health education counseling, interventions, referral and follow-up.
- Annually, PCP must review & discuss previously completed SHA with patient (intervening years) and provide appropriate counseling and follow-up on patient's risk reduction plans, as needed.

REQUIRED PCP DOCUMENTATION

- PCP must sign, print name and date the newly administered SHA to verify it was reviewed with patient and assistance/follow-up was provided as needed.
- PCP must check appropriate boxes in "Clinical Use Only" section to indicate topics and type of assistance provided to patient (last page).
- For subsequent annual reviews, PCP must sign, print name and date "SHA Annual Review" section (last page) to verify the annual review was conducted and discussed with the patient.
- Signed SHA must be kept in patient's medical record.

OPTIONAL CLINIC USE DOCUMENTATION

- Shaded "Clinic Use Only" sections (right column next to questions) and "Comments" section (last page) may be used by PCP/clinic staff for notation of patient discussion and recommendations.

Adult Questions by Age Group

	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Adult 18–55+	Senior 56 & Up
Nutrition			Question	Numbers
Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Q1	Q1
Do you eat fruits and vegetables every day?	Yes	No	Q2	Q2
Do you limit the amount of fried food or fast food that you eat?	Yes	No	Q3	Q3
Are you easily able to get enough healthy food?	Yes	No	Q4	Q4
Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Q5	Q5
Do you often eat too much or too little food?	No	Yes	Q6	Q6
Do you have difficulty chewing or swallowing?	No	Yes		Q7
Are you concerned about your weight?	No	Yes	Q7	Q8
Physical Activity				
Do you exercise or spend time doing activities, such as walking, gardening or swimming for at least ½ hour per day?	Yes	No	Q8	Q9
Safety				
Do you feel safe where you live?	Yes	No	Q9	Q10
Do you often have trouble keeping track of your medicines?	No	Yes		Q11
Are family members or friends worried about your driving?	No	Yes		Q12
Have you had any car accidents lately?	No	Yes	Q10	Q13
Do you sometimes fall and hurt yourself, or is it hard for you to get up?	No	Yes		Q14
Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Q11	Q15
Do you always wear a seat belt when driving or riding in a car?	Yes	No	Q12	
Do you keep a gun in your house or place where you live?	No	Yes	Q13	Q16
Dental				
Do you brush and floss your teeth daily?	Yes	No	Q14	Q17

Mental Health				
Do you often feel sad, hopeless, angry, or worried?	No	Yes	Q15	Q18
Do you often have trouble sleeping?	No	Yes	Q16	Q19
Do you or others think that you are having trouble remembering things?	No	Yes		Q20
Alcohol, Tobacco, Drug Use (Tobacco Smoke Exposure)				
Do you smoke or chew tobacco?	No	Yes	Q17	Q21
Do friends or family members smoke in your house or place where you live?	No	Yes	Q18	Q22
Do you drink 2 or more alcoholic drinks per day?	No	Yes	Q19	Q23
Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Q20	Q24
Sexual Issues				
Do you think you or your partner could be pregnant?	No	Yes	Q21	
Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Q22	Q25
Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Q23	
Have you or your partner(s) had sex with other people in the past year?	No	Yes	Q24	Q26
Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Q25	Q27
Have you ever been forced or pressured to have sex?	No	Yes	Q26	Q28
Independent Living				
Do you have someone to help you make decisions about your health and medical care?	Yes	No		Q29
Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes		Q30
Do you have someone to call when you need help in an emergency?	Yes	No		Q31
Last Question (Open Ended)				
Do you have any other questions or concerns about your health? If yes, please describe:	No	Yes	Q27	Q32
QUESTION TOTALS FOR EACH ASSESSMENT:			**27**	**32**

Pediatric Questions by Age Group

Pediatric Questions by Age Group	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0-6	7-12	1-2	3-4	5-8	9-11	12-17
Nutrition									
Do you breastfeed your baby?	Yes	No	Q1	Q1					
Do you breastfeed your child?	Yes	No			Q1				
Does your baby drink or eat 3 servings of calcium rich foods daily, such as formula, milk, cheese, yogurt, soy milk, or tofu?	Yes	No		Q2					
Does your child drink or eat 3 servings of calcium rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No			Q2	Q1	Q1	Q1	
Do you drink or eat 3 servings of calcium rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No							Q1
Does your child eat fruits and vegetables at least two times per day?	Yes	No			Q3	Q2	Q2	Q2	
Do you eat fruits and vegetables at least two times per day?	Yes	No							Q2
Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes			Q4	Q3	Q3	Q3	
Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes							Q3
Does your child drink more than one small cup (4 - 6 oz.) of juice per day?	No	Yes			Q5	Q4	Q4		
Does your child drink more than one cup (8 oz.) of juice per day?	No	Yes						Q4	
Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes			Q6	Q5	Q5	Q5	
Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes							Q4

Pediatric Questions by Age Group

	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0–6	7–12	1–2	3–4	5–8	9–11	12–17
Physical Activity									
Does your child play actively most days of the week?	Yes	No			Q7	Q6			
Does your child exercise or play sports most days of the week?	Yes	No					Q6	Q6	
Do you exercise or play sports most days of the week?	Yes	No							Q5
Are you concerned about your baby's weight?	No	Yes	Q2	Q3					
Are you concerned about your child's weight?	No	Yes			Q8	Q7	Q7	Q7	
Are you concerned about your weight?	No	Yes							Q6
Does your baby watch any TV?	No	Yes	Q3	Q4					
Does your child watch TV or play video games?	No	Yes			Q9				
Does your child watch TV or play video games less than 2 hours per day?	Yes	No				Q8	Q8	Q8	
Do you watch TV or play video games less than 2 hours per day?	Yes	No							Q7
Safety									
Does your home have a working smoke detector?	Yes	No	Q4	Q5	Q10	Q9	Q9	Q9	Q8
Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Q5	Q6	Q11	Q10	Q10		
If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Q6	Q7	Q12	Q11			

Pediatric Questions by Age Group

	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0-6	7-12	1-2	3-4	5-8	9-11	12-17
Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Q7	Q8	13	Q12			
Does your home have the phone number of the poison control center (800-222-1222) posted by your phone?	Yes	No	Q8	Q9	Q14	Q13	Q11	Q10	Q9
Do you always put your baby to sleep on her/his back?	Yes	No	Q9	Q10					
Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Q10	Q11					
Do you always stay with your child when she/he is in the bathtub?	Yes	No			Q15	Q14			
Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Q11	Q12					
Do you always place your child in a rear facing car seat in the back seat?	Yes	No			Q16				
Do you always place your child in a forward facing car seat in the back seat?	Yes	No				Q15			
Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?	Yes	No					Q12		
Does your child always use a seat belt in the back seat (or use a booster seat if under 4'9").	Yes	No						Q11	
Is the car seat you use the right one for the age and size of your baby?	Yes	No	Q12	Q13					
Is the car seat you use the right one for the age and size of your child?	Yes	No			Q17	Q16			
Do you always wear a seatbelt when riding in a car?	Yes	No							Q10
Do you always check for children before backing your car out?	Yes	No			Q18	Q17			

Pediatric Questions by Age Group

	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0–6	7–12	1–2	3–4	5–8	9–11	12–17
Does your baby spend time near a swimming pool, river, or lake?	No	Yes		Q14					
Does your child spend time near a swimming pool, river, or lake?	No	Yes			Q19	Q18	Q13	Q12	
Does your baby spend time in a home where a gun is kept?	No	Yes	Q13	Q15					
Does your child spend time in a home where a gun is kept?	No	Yes			Q20	Q19	Q14	Q13	
Do you spend time in a home where a gun is kept?	No	Yes							Q11
Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes					Q15	Q14	
Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes							Q12
Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No			Q21	Q20	Q16	Q15	
Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No							Q13
Has your child ever witnessed or been a victim of abuse or violence?	No	Yes				Q21	Q17	Q16	
Have you ever witnessed abuse or violence?	No	Yes							Q14
Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes							Q15
Has your child been hit or has your child hit someone in the past year?	No	Yes					Q18	Q17	

Pediatric Questions by Age Group

Pediatric Questions by Age Group	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0-6	7-12	1-2	3-4	5-8	9-11	12-17
Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes					Q19	Q18	
Have you ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes							Q16
Dental									
Do you give your baby a bottle with anything in it except formula, milk, or water?	No	Yes	Q14	Q16					
Do you help your child brush and floss her/his teeth daily?	Yes	No			Q22	Q22			
Does your child brush and floss her/his teeth daily?	Yes	No					Q20	Q19	
Do you brush and floss your teeth daily?	Yes	No							Q17
Mental Health									
Does your child often seem sad or depressed?	No	Yes					Q21	Q20	
Do you often feel sad, down, or hopeless?	No	Yes							Q18
Alcohol, Tobacco, Drug Use (Tobacco Exposure)									
Does your baby spend time with anyone who smokes?	No	Yes	Q15	Q17					
Does your child spend time with anyone who smokes?	No	Yes			Q23	Q23	Q22	Q21	
Do you spend time with anyone who smokes?	No	Yes							Q19
Has your child ever smoked cigarettes or chewed tobacco?	No	Yes						Q22	
Do you smoke cigarettes or chew tobacco?	No	Yes							Q20

Pediatric Questions by Age Group

	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months			Pediatric			
			0–6	7–12	1–2	3–4	5–8	9–11	12–17
Are you concerned your child may be using or sniffing substances, such as glue, to get high?	No	Yes						Q23	
Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, methamphetamine (meth), ecstasy, etc.?	No	Yes							Q21
Do you use medicines not prescribed for you?	No	Yes							Q22
Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes						Q24	
Do you drink alcohol once a week or more?	No	Yes							Q23
If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes							Q24
Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes						Q25	
Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes							Q25
Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes							Q26
Sexual Issues									
Has your child started dating or "going out" with boyfriends or girlfriends?	No	Yes						Q26	
Do you think your child might be sexually active?	No	Yes						Q27	
Have you ever been forced or pressured to have sex?	No	Yes							Q27
Have you ever had sex (oral, vaginal, anal)? *If no, skip to question 35.*	No	Yes							Q28

Pediatric Questions by Age Group

	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0-6	7-12	1-2	3-4	5-8	9-11	12-17
Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes							Q29
Have you or your partner(s) had sex with other people in the past year?	No	Yes							Q30
Have you or your partner(s) had sex without using birth control in the past year?	No	Yes							Q31
The last time you had sex, did you use birth control?	Yes	No							Q32
Have you or your partner(s) had sex without a condom in the past year?	No	Yes							Q33
Did you or your partner use a condom the last time you had sex?	Yes	No							Q34
Do you have concerns about liking someone of the same sex?	No	Yes							Q35
Last Question (Open Ended)									
Do you have any other questions or concerns about your baby's health, development, or behavior? If yes, please describe:	No	Yes	Q16	Q18					
Do you have any other questions or concerns about your child's health, development, or behavior? If yes, please describe:	No	Yes			Q24	Q24			
Do you have any other questions or concerns about your child's health or behavior? If yes, please describe:	No	Yes					Q23	Q28	
Do you have any other questions or concerns about your health? If yes, please describe:	No	Yes							Q36
Question Totals per Age Group			16	18	24	24	23	28	36

Staying Healthy Assessment

0 – 6 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

1	Do you breastfeed your baby?	Yes	No	Skip	Nutrition
2	Are you concerned about your baby's weight?	No	Yes	Skip	Physical Activity
3	Does your baby watch any TV?	No	Yes	Skip	
4	Does your home have a working smoke detector?	Yes	No	Skip	Safety
5	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
6	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
7	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
8	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
9	Do you always put your baby to sleep on her/his back?	Yes	No	Skip	
10	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	

11	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
12	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
13	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
14	Do you give your baby a bottle with anything except formula, milk, or water?	No	Yes	Skip	Dental Health
15	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
16	Do you have any other questions or concerns about your baby's health, development or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature: Print Name: Date:

Staying Healthy Assessment

7 – 12 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

					Nutrition
1	Do you breastfeed your baby?	Yes	No	Skip	
2	Does your baby drink or eat 3 servings of calcium-rich foods daily, such as formula, milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
					Physical Activity
3	Are you concerned about your baby's weight?	No	Yes	Skip	
4	Does your baby watch any TV?	No	Yes	Skip	
					Safety
5	Does your home have a working smoke detector?	Yes	No	Skip	
6	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
7	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
8	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always put your baby to sleep on her/his back?	Yes	No	Skip	

11	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	
12	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
13	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
14	Does your baby spend time near a swimming pool, river, or lake?	No	Yes	Skip	
15	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
16	Do you give your baby a bottle with anything except formula, milk, or water?	No	Yes	Skip	Dental Health
17	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
18	Do you have any other questions or concerns about your baby's health, development or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

1 –2 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
					Nutrition
1	Do you breastfeed your child?	Yes	No	Skip	
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
3	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
4	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
5	Does your child drink more than one small cup (4 – 6 oz.) of juice per day?	No	Yes	Skip	
6	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
					Physical Activity
7	Does your child play actively most days of the week?	Yes	No	Skip	
8	Are you concerned about your child's weight?	No	Yes	Skip	
9	Does your child watch TV or play video games?	No	Yes	Skip	
					Safety
10	Does your home have a working smoke detector?	Yes	No	Skip	
11	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
12	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
13	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
14	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	

15	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
16	Do you always place your child in a rear facing car seat in the back seat?	Yes	No	Skip	
17	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
18	Do you always check for children before backing your car out?	Yes	No	Skip	
19	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
20	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
21	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's health, development or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:

Staying Healthy Assessment

3 – 4 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

					Nutrition
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one small cup (4 – 6 oz. cup) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
					Physical Activity
6	Does your child play actively most days of the week?	Yes	No	Skip	
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
					Safety
9	Does your home have a working smoke detector?	Yes	No	Skip	
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
12	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
13	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
14	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
15	Do you always place your child in a forward facing car seat in the back seat?	Yes	No	Skip	

16	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
17	Do you always check for children before backing your car out?	Yes	No	Skip	
18	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
19	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
20	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
21	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's development, health or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:
PCP's Signature	**Print Name:**	**Date:**

Staying Healthy Assessment

5 – 8 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School?
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

Clinic Use Only:

1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one small cup (4 - 6 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	Safety
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
12	Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?	Yes	No	Skip	
13	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
14	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	

15	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
16	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
17	Has your child ever witnessed or been victim of abuse or violence?	No	Yes	Skip	
18	Has your child been hit or hit someone in the past year?	No	Yes	Skip	
19	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
20	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
21	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
22	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
23	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:
SHA ANNUAL REVIEW		
PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:

Staying Healthy Assessment

9 – 11 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	*Nutrition*
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one cup (8 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	Safety
10	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
11	Does your child always use a seat belt in the back seat (or use a booster seat if under 4'9")?	Yes	No	Skip	
12	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
13	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
14	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
15	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
16	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
17	Has your child been hit or has your child hit someone in the past year?	No	Yes	Skip	

18	Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
19	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
20	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
21	Does your child spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Has your child ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	
23	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?	No	Yes	Skip	
24	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
25	Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Has your child started dating or "going out" with boyfriends or girlfriends?	No	Yes	Skip	Sexual Issues
27	Do you think your child might be sexually active?	No	Yes	Skip	
28	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

12 – 17 Years

Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables at least 2 times per day?	Yes	No	Skip	
3	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes	Skip	
5	Do you exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
6	Are you concerned about your weight?	No	Yes	Skip	
7	Do you watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
8	Does your home have a working smoke detector?	Yes	No	Skip	Safety
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always wear a seatbelt when riding in a car?	Yes	No	Skip	
11	Do you spend time in a home where a gun is kept?	No	Yes	Skip	
12	Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
13	Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
14	Have you ever witnessed abuse or violence?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes	Skip	
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, down, or hopeless?	No	Yes	Skip	Mental Health
19	Do you spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
20	Do you smoke cigarettes or chew tobacco?	No	Yes	Skip	
21	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	No	Yes	Skip	

22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	

Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.

Sexual Issues

27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
28	Have you ever had sex (oral, vaginal, or anal)? *If no, skip to question 35.*	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have concerns about liking someone of the same sex?	No	Yes	Skip	
36	Do you have any other questions or concerns about your health?	Yes	No	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)* ☐ Family Member ☐ Friend ☐ Other *Please specify:*			Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	Do you drink 2 or more alcoholic drinks per day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

Senior

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *Please specify:*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	

20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	
21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	Do you drink 2 or more alcoholic drinks per day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	Yes	No	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Evaluación de Salud

(Staying Healthy Assessment)

0 – 6 meses *(0 – 6 Months)*

Nombre del niño (primer nombre y apellido)	Fecha de nacimiento	☐ Mujer ☐ Hombre	Fecha de hoy	¿Asiste a una guardería? ☐ Sí ☐ No
Persona que completa el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			¿Necesita ayuda para completar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe la respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre algún punto de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

Clinic Use Only:

1	¿Amamanta a su bebé? *(Breastfeeds baby?)*	Sí	No	Omitir	Nutrition
2	¿Le preocupa el peso de su bebé? *(Concerned about baby's weight?)*	No	Sí	Omitir	Physical Activity
3	¿Su bebé mira televisión? *(Baby watches any TV?)*	No	Sí	Omitir	
4	En su hogar, ¿hay un detector de humo que funcione? *(Home has working smoke detector?)*	Sí	No	Omitir	Safety
5	¿Ha cambiado la temperatura del agua a tibia (menos de 120 grados)? *(Water temperature turned down to low-warm?)*	Sí	No	Omitir	
6	Si en su hogar hay más de un piso, ¿tiene protección de seguridad en las ventanas y accesos a las escaleras? *(Safety guards on window and gates for stairs in multi-level home?)*	Sí	No	Omitir	
7	En su hogar, ¿los materiales de limpieza, medicamentos y fósforos están en un lugar cerrado con llave? *(Cleaning supplies, medicines and matches locked away?)*	Sí	No	Omitir	
8	En su hogar, ¿está pegado cerca del teléfono el número del Centro de intoxicaciones (800-222-1222)? *(Home has phone # of the Poison Control Center posted by phone?)*	Sí	No	Omitir	
9	¿Siempre acuesta a su bebé boca arriba para dormir? *(Always puts baby to sleep on her/his back?)*	Sí	No	Omitir	
10	Cuando su bebé está en la tina, ¿permanece con él en todo momento? *(Always stays with baby in the bathtub?)*	Sí	No	Omitir	

11	¿Su bebé siempre viaja en un asiento de seguridad para automóvil orientado hacia atrás, en el asiento de atrás? *(Always places baby in a rear facing car seat in the back seat?)*	Sí	No	Omitir	
12	¿El asiento de seguridad para automóvil que utiliza es el adecuado para la edad y el tamaño de su bebé? *(Car seat used is correct size for age and size of baby?)*	Sí	No	Omitir	
13	¿Su bebé pasa tiempo en un hogar donde hay un revólver? *(Baby spends time in home where a gun is kept?)*	No	Sí	Omitir	
14	En el biberón de su bebé, ¿coloca algo que no sea fórmula, leche o agua? *(Gives baby a bottle with anything in it except formula, milk or water?)*	No	Sí	Omitir	Dental Health
15	¿Su bebé pasa tiempo con alguna persona que fuma? *(Baby spends time with anyone who smokes?)*	No	Sí	Omitir	Tobacco Exposure
16	¿Tiene alguna pregunta o inquietud sobre la salud, el desarrollo o el comportamiento de su bebé? *(Any other questions or concerns about baby's health, development or behavior?)*	No	Sí	Omitir	

Si la respuesta es afirmativa, describa:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
Nutrition					
Physical Activity					
Safety					
Dental Health					
Tobacco Exposure					

☐ **Patient Declined the SHA**

PCP's Signature: Print Name: Date:

Evaluación de Salud

(Staying Healthy Assessment)

7 – 12 meses *(7 – 12 Months)*

Nombre del niño (nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	¿Asiste a una guardería? ☐ Sí ☐ No
Persona que llena el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			¿Necesita ayuda para llenar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre cualquier sección de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only
					Nutrition
1	¿Amamanta a su bebé? *(Breastfeeds baby?)*	Sí	No	Omitir	
2	¿Su bebé bebe o come 3 porciones al día de alimentos ricos en calcio, como fórmula, leche, queso, yogur, leche de soja o tofu? *(¿Baby drinks/eats 3 servings of calcium rich foods daily?)*	Sí	No	Omitir	
					Physical Activity
3	¿Le preocupa el peso de su bebé? *(Concerned about baby's weight?)*	No	Sí	Omitir	
4	¿Su bebé ve televisión? *(Baby watches any TV?)*	No	Sí	Omitir	
					Safety
5	En su hogar, ¿hay un detector de humo que funcione? *(Home has working smoke detector?)*	Sí	No	Omitir	
6	*¿Ha cambiado la temperatura del agua a tibia (menos de 120 grados)?* *(Water temperature turned down to low-warm?)*	Sí	No	Omitir	
7	Si en su hogar hay más de un piso, ¿tiene protección de seguridad en las ventanas y accesos a las escaleras? *(Safety guards on windows and gates for stairs in multi-level home?)*	Sí	No	Omitir	
8	En su hogar, ¿los artículos de limpieza, medicamentos y fósforos están en un lugar cerrado con llave? *(Cleaning supplies, medicines, and matches locked away?)*	Sí	No	Omitir	
9	En su hogar, ¿está pegado cerca del teléfono el número del Centro de control de intoxicaciones (800-222-1222)? *(Home has phone # of Poison Control Center posted by phone?)*	Sí	No	Omitir	

10	¿Siempre acuesta a su bebé boca arriba para dormir? *(Always puts baby to sleep on her/his back?)*	Sí	No	Omitir	
11	Cuando su bebé está en la tina, ¿permanece con él en todo momento? *(Always stays with baby when in the bathtub?)*	Sí	No	Omitir	
12	¿Su bebé siempre viaja en un asiento de seguridad para automóvil orientado hacia atrás, en el asiento de atrás? *(Always places baby in a rear facing car seat in the back seat?)*	Sí	No	Omitir	
13	¿El asiento de seguridad para automóvil que utiliza es el adecuado para la edad y el tamaño de su bebé? *(Car seat used is correct size for age and size of baby?)*	Sí	No	Omitir	
14	¿Su bebé pasa tiempo cerca de una piscina, río o lago? *(Baby spends time near a swimming pool, river, or lake?)*	No	Sí	Omitir	
15	¿Su bebé pasa tiempo en un hogar donde hay un arma de fuego? *(Baby spends time in a home where a gun is kept?)*	No	Sí	Omitir	
16	En el biberón de su bebé, ¿coloca algo que no sea fórmula, leche o agua? *(Gives baby a bottle with anything in it except formula, milk, or water?)*	No	Sí	Omitir	Dental Health
17	¿Su bebé pasa tiempo con alguna persona que fuma? *(Baby spends time with anyone who smokes?)*	No	Sí	Omitir	Tobacco Exposure
18	¿Tiene alguna pregunta o inquietud sobre la salud, el desarrollo o la conducta de su bebé? *(Any other questions or concerns about baby's health, development, or behavior?)*	No	Sí	Omitir	

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature: Print Name: Date:

Evaluación de Salud

(Staying Healthy Assessment)

1 – 2 años *(1 – 2 Years)*

Nombre del niño (nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	¿Asiste a una guardería? ☐ Sí ☐ No
Persona que llena el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			¿Necesita ayuda para llenar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre cualquier sección de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
					Nutrition
1	¿Amamanta a su hijo? *(Breastfeeds child?)*	Sí	No	Omitir	
2	¿Su hijo bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *(Child drinks/eats 3 servings of calcium rich foods daily?)*	Sí	No	Omitir	
3	¿Su hijo come frutas y verduras, al menos, 2 veces al día? *(Child eats fruits and vegetables at least 2 times per day?)*	Sí	No	Omitir	
4	¿Su hijo come alimentos con alto contenido de grasa, como alimentos fritos, papitas, helado o pizza más de una vez por semana? *(Child eats high fat foods more than once per week?)*	No	Sí	Omitir	
5	¿Su hijo bebe más de una pequeña taza (4 - 6 oz.) de jugo al día? *(Child drinks more than one small cup of juice per day?)*	No	Sí	Omitir	
6	¿Su hijo toma refresco, jugos, bebidas deportivas, bebidas energizantes u otras bebidas endulzadas más de una vez por semana? *(Child drinks soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?)*	No	Sí	Omitir	
					Physical Activity
7	¿Su hijo juega activamente la mayoría de los días de la semana? *(Child plays actively most days of the week?)*	Sí	No	Omitir	
8	¿Le preocupa el peso de su hijo? *(Concerned about child's weight?)*	No	Sí	Omitir	
9	¿Su hijo ve televisión o juega juegos de video? *(Child watches TV or plays video games?)*	No	Sí	Omitir	
					Safety
10	En su hogar, ¿hay un detector de humo que funcione? *(Home has working smoke detector?)*	Sí	No	Omitir	
11	¿Ha cambiado la temperatura del agua a tibia (menos de 120 grados)? *(Water temperature turned down to low-warm?)*	Sí	No	Omitir	
12	Si en su hogar hay más de un piso, ¿tiene protección de seguridad en las ventanas y accesos a las escaleras? *(Safety guards on windows and gates for stairs in multi-level home?)*	Sí	No	Omitir	
13	En su hogar, ¿los materiales de limpieza, medicamentos y fósforos están en un lugar cerrado con llave? *(Cleaning supplies, medicines, and matches locked away?)*	Sí	No	Omitir	

14	En su hogar, ¿está pegado cerca del teléfono el número del Centro de control de intoxicaciones (800-222-1222)? *(Home has phone # of Poison Control Center posted by phone?)*	Sí	No	Omitir	
15	Cuando su hijo está en la tina, ¿permanece usted con él en todo momento? *(Always stays with child when in the bathtub?)*	Sí	No	Omitir	
16	¿Su hijo siempre viaja en un asiento de seguridad para automóvil orientado hacia atrás, en el asiento de atrás? *(Always places child in a rear facing car seat in the back seat?)*	Sí	No	Omitir	
17	¿El asiento de seguridad para automóvil que utiliza es el adecuado para la edad y el tamaño de su hijo? *(Car seat used is correct size for age and size of child?)*	Sí	No	Omitir	
18	¿Se fija usted siempre que no haya niños al retroceder en el automóvil al salir de su cochera? *(Always checks for children before backing car out?)*	Sí	No	Omitir	
19	¿Su hijo pasa tiempo cerca de una piscina, río o lago? *(Child spends time near a swimming pool, river, or lake?)*	No	Sí	Omitir	
20	¿Su hijo pasa tiempo en un hogar donde hay un arma de fuego? *(Child spends time in home where a gun is kept?)*	No	Sí	Omitir	
21	¿Su hijo siempre usa casco al montar en bicicleta, patineta o *scooter*? *(Child always wears a helmet when riding a bike, skateboard, or scooter?)*	Sí	No	Omitir	
22	¿Su hijo se cepilla los dientes y los limpia con hilo dental todos los días? *(Child is helped to brush and floss teeth daily?)*	Sí	No	Omitir	Dental Health
23	¿Su hijo pasa tiempo con alguna persona que fuma? *(Child spends time with anyone who smokes?)*	No	Sí	Omitir	Tobacco Exposure
24	¿Tiene alguna otra pregunta o inquietud sobre la salud, el desarrollo o la conducta de su hijo? *(Any other questions or concerns about child's health, development or behavior?)*	No	Sí	Omitir	

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:

Evaluación de Salud

(Staying Healthy Assessment)

3 – 4 años *(3 –4 Years)*

Nombre del niño (nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	¿Asiste a una guardería? ☐ Sí ☐ No
Persona que llena el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			¿Necesita ayuda para llenar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda.
Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder.
Asegúrese de hablar con el médico si tiene preguntas sobre alguna sección de este formulario.
Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

Clinic Use Only:

	Nutrition				
1	¿Su hijo bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *(Child drinks/eats 3 servings of calcium rich foods daily?)*	Sí	No	Omitir	
2	¿Su hijo come frutas y verduras, al menos, 2 veces al día? *(Child eats fruits and vegetables at least 2 times per day?)*	Sí	No	Omitir	
3	¿Su hijo come alimentos con alto contenido de grasa, como alimentos fritos, papitas, helado o pizza más de una vez por semana? *(Child eats high fat foods more than once per week?)*	No	Sí	Omitir	
4	¿Su hijo bebe más de una taza pequeña (taza de 4 a 6 oz.) de jugo al día? *(Child drinks more than one small cup of juice per day?)*	No	Sí	Omitir	
5	¿Su hijo toma refresco, jugos, bebidas deportivas, bebidas energizantes u otras bebidas endulzadas más de una vez por semana? *(Child drinks soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?)*	No	Sí	Omitir	
	Physical Activity				
6	¿Su hijo hace ejercicio o juega deportes la mayoría de los días? *(Child plays actively most days of the week?)*	Sí	No	Omitir	
7	¿Le preocupa el peso de su hijo? *(Concerned about child's weight?)*	No	Sí	Omitir	
8	¿Su hijo ve televisión o juega juegos de video menos de 2 horas al día? *(Child watches TV or plays video games less than 2 hours per day?)*	Sí	No	Omitir	
	Safety				
9	En su hogar, ¿hay un detector de humo que funcione? *(Home has a working smoke detector?)*	Sí	No	Omitir	
10	¿Ha cambiado la temperatura del agua a tibia (menos de 120 grados)? *(Water temperature turned down to low-warm?)*	Sí	No	Omitir	
11	Si en su hogar hay más de un piso, ¿tiene protección de seguridad en las ventanas y accesos a las escaleras? *(Safety guards on windows and gates for stairs in multi-level home?)*	Sí	No	Omitir	
12	En su hogar, ¿los materiales de limpieza, medicamentos y fósforos están en un lugar cerrado con llave? *(Cleaning supplies, medicines, and matches locked away?)*	Sí	No	Omitir	
13	En su hogar, ¿está pegado cerca del teléfono el número del Centro de control de intoxicaciones (800-222-1222)? *(Home has phone # of the Poison Control Center posted by phone?)*	Sí	No	Omitir	

14	Cuando su hijo está en la tina, ¿permanece con él en todo momento? *(Always stays with child when in the bathtub?)*	Sí	No	Omitir	
15	¿Su hijo siempre viaja en un asiento de seguridad para automóvil orientado hacia delante, en el asiento de atrás? *(Always places child in a forward facing car seat in the back seat?)*	Sí	No	Omitir	
16	¿El asiento de seguridad para automóvil que utiliza es el adecuado para la edad y el tamaño de su hijo? *(Car seat used is correct size for age and size of child?)*	Sí	No	Omitir	
17	¿Se fija usted siempre que no haya niños al retroceder en el automóvil al salir de su cochera? *(Always checks for children before backing car out?)*	Sí	No	Omitir	
18	¿Su hijo pasa tiempo cerca de una piscina, río o lago? *(Child spends time near a swimming pool, river, or lake?)*	No	Sí	Omitir	
19	¿Su hijo pasa tiempo en un hogar donde hay un arma de fuego? *(Child spends time in home where a gun is kept?)*	No	Sí	Omitir	
20	¿Su hijo siempre usa casco al montar en bicicleta, patineta o *scooter*? *(Child always wears a helmet when riding a bike, skateboard, or scooter?)*	Sí	No	Omitir	
21	¿Su hijo ha presenciado o ha sido víctima de abuso o violencia? *(Child ever witnessed or been victim of abuse or violence?)*	No	Sí	Omitir	
22	¿Su hijo se cepilla los dientes y los limpia con hilo dental todos los días? *(Child is helped to brush and floss teeth daily?)*	Sí	No	Omitir	Dental Health
23	¿Su bebé pasa tiempo con alguna persona que fuma? *(Child spends time with anyone who smokes?)*	No	Sí	Omitir	Tobacco Exposure
24	¿Tiene alguna pregunta o inquietud sobre la salud, el desarrollo o el comportamiento de su bebé? *(Any other questions or concerns about child's health or behavior?)*	No	Sí	Omitir	

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature | Print Name: | Date:

SHA ANNUAL REVIEW

PCP's Signature | Print Name: | Date:

PCP's Signature | Print Name: | Date:

Evaluación de Salud

(Staying Healthy Assessment)

5 – 8 años *(5 – 8 Years)*

Nombre del niño (nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	¿Año escolar?
Persona que llena el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			Asistencia escolar ¿Regular? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre cualquier sección de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
1	¿Su hijo bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *(Child drinks/eats 3 servings of calcium-rich foods daily?)*	Sí	No	Omitir	Nutrition
2	¿Su hijo come frutas y verduras, al menos, 2 veces al día? *(Child eats fruits and vegetables at least two times per day?)*	Sí	No	Omitir	
3	¿Su hijo come alimentos con alto contenido de grasa, como alimentos fritos, papitas, helado o pizza más de una vez por semana? *(Child eats high fat foods more than once per week?)*	No	Sí	Omitir	
4	¿Su hijo bebe más de una pequeña taza (4 - 6 oz.) de jugo al día? *(Child drinks more than one small cup of juice per day?)*	No	Sí	Omitir	
5	¿Su hijo toma refresco, jugos, bebidas deportivas, bebidas energizantes u otras bebidas endulzadas más de una vez por semana? *(Child drinks soda, juice/ sports/ energy drinks, or other sweetened drinks more than once per week?)*	No	Sí	Omitir	
6	¿Su hijo hace ejercicio o juega deportes la mayoría de los días de la semana? *(Child exercises or plays sports most days of the week?)*	Sí	No	Omitir	Physical Activity
7	¿Le preocupa el peso de su hijo? *(Concerned about child's weight?)*	No	Sí	Omitir	
8	¿Su hijo ve televisión o juega juegos de video menos de 2 horas al día? *(Child watches TV or plays video games less than 2 hours per day?)*	Sí	No	Omitir	
9	En su hogar, ¿hay un detector de humo que funcione? *(Home has a working smoke detector?)*	Sí	No	Omitir	Safety
10	¿Ha cambiado la temperatura del agua a tibia (menos de 120 grados)? *(Water temperature turned down to low-warm?)*	Sí	No	Omitir	
11	En su hogar, ¿está pegado cerca del teléfono el número del Centro de control de intoxicaciones (800-222-1222)? *(Home has phone # of the Poison Control Center posted by phone?)*	Sí	No	Omitir	
12	¿Coloca usted siempre a su hijo en un asiento para niños en el en el asiento de atrás (o usa un cinturón de seguridad si su hijo mide más de 4'9")? *(Always places child in booster seat in back seat (or uses a seat belt) if child is over 4'9")?*	Sí	No	Omitir	
13	¿Su hijo pasa tiempo cerca de una piscina, río o lago? *(Child spends time near a swimming pool, river, or lake?)*	No	Sí	Omitir	

1

14	¿Su hijo pasa tiempo en un hogar donde hay un arma de fuego? *(Child spends time in home where a gun is kept?)*	No	Sí	Omitir	
15	¿Su hijo pasa tiempo con alguna persona que lleve un arma de fuego, un cuchillo u otra arma? *(Child spends time with anyone who carries a gun, knife, or other weapon?)*	No	Sí	Omitir	
16	¿Su hijo siempre usa casco al montar en bicicleta, patineta o *scooter*? *(Child always wears a helmet when riding a bike, skateboard, or scooter?)*	Sí	No	Omitir	
17	¿Su hijo ha presenciado o ha sido víctima de abuso o violencia? *(Child ever witnessed or been victim of abuse or violence?)*	No	Sí	Omitir	
18	¿A su hijo le ha pegado alguien o le ha pegado él a alguien durante el año pasado? *(Has child been hit or hit someone in the past year?)*	No	Sí	Omitir	
19	¿Su hijo ha sido acosado alguna vez o se sintió inseguro en la escuela o en su vecindario (o lo acosaron por Internet)? *(Has child ever been bullied or felt unsafe at school/neighborhood (or been cyber-bullied)?*	No	Sí	Omitir	
20	¿Su hijo se cepilla los dientes y los limpia con hilo dental todos los días? *(Child brushes and flosses teeth daily?)*	Sí	No	Omitir	Dental Health
21	¿Su hijo parece a menudo triste o deprimido? *(Child often seems sad or depressed?)*	No	Sí	Omitir	Mental Health
22	¿Su hijo pasa tiempo con alguna persona que fuma? *(Child spends time with anyone who smokes?)*	No	Sí	Omitir	Tobacco Exposure
23	¿Tiene alguna pregunta o inquietud sobre la salud, el desarrollo o el comportamiento de su bebé? *(Any other questions or concerns about child's health or behavior?)*	No	Sí	Omitir	

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:

Evaluación de Salud

(Staying Healthy Assessment)

9 – 11 años *(9 – 11 Years)*

Nombre del niño (nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	¿Año escolar?
Persona que llena el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			Asistencia escolar ¿Regular? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre cualquier sección de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

Clinic Use Only:

1	¿Su hijo bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *(Child drinks/eats 3 servings of calcium-rich foods daily?)*	Sí	No	Omitir
2	¿Su hijo come frutas y verduras, al menos, 2 veces al día? (Child eats fruits and vegetables at least two times per day?)	Sí	No	Omitir
3	¿Su hijo come alimentos con alto contenido de grasa, como alimentos fritos, papitas, helado o pizza más de una vez por semana? (Child eats high fat foods more than once per week?)	No	Sí	Omitir
4	¿Su hijo bebe más de una taza (8 oz.) de jugo al día? (Child drinks more than one cup of juice per day?)	No	Sí	Omitir
5	¿Su hijo toma refresco, jugos, bebidas deportivas, bebidas energizantes u otras bebidas endulzadas más de una vez por semana? (Child drinks soda, juice/sports/energy drinks or other sweetened drinks more than once per week?)	No	Sí	Omitir
6	¿Su hijo hace ejercicio o juega deportes la mayoría de los días de la semana? (Child exercises or plays sports most days of the week?)	Sí	No	Omitir
7	¿Le preocupa el peso de su hijo? (Concerned about child's weight?)	No	Sí	Omitir
8	¿Su hijo ve televisión o juega juegos de video menos de 2 horas al día? (Child watches TV or plays video games less than 2 hours per day?)	Sí	No	Omitir
9	En su hogar, ¿hay un detector de humo que funcione? (Home has a working smoke detector?)	Sí	No	Omitir
10	En su hogar, ¿está pegado cerca del teléfono el número del Centro de control de intoxicaciones (800-222-1222)? (Home has phone # of the Poison Control Center posted by phone?)	Sí	No	Omitir
11	¿Su hijo siempre usa cinturón de seguridad en el asiento trasero (o usa un asiento para niños si mide menos de 4'9")? (Child always uses a seat belt in the back seat (or booster seat) if under 4'9")?	Sí	No	Omitir

1

12	¿Su hijo pasa tiempo cerca de una piscina, río o lago? *(Child spends time near a swimming pool, river, or lake?)*	No	Sí	Omitir	
13	¿Su hijo pasa tiempo en un hogar donde hay un arma de fuego? *(Child spends time in home where a gun is kept?)*	No	Sí	Omitir	
14	¿Su hijo pasa tiempo con alguna persona que lleve un arma de fuego, un cuchillo u otra arma? *(Child spends time with anyone who carries a gun, knife, or other weapon?)*	No	Sí	Omitir	
15	¿Su hijo siempre usa casco cuando monta en bicicleta, patineta o *scooter*? *(Child always wears a helmet when riding a bike, skateboard, or scooter?)*	Sí	No	Omitir	
16	¿Su hijo ha presenciado o ha sido víctima de abuso o violencia? *(Has child ever witnessed or been a victim of abuse or violence?)*	No	Sí	Omitir	
17	¿Su hijo ha golpeado a alguien o alguien lo ha golpeado en el último año? *(Has child been hit or has he/she hit someone in the past year?)*	No	Sí	Omitir	
18	¿A su hijo alguna vez lo han acosado o se sintió inseguro en la escuela o su vecindario (o lo acosaron por Internet)? *(Has child ever been bullied, felt unsafe at school/neighborhood (or been cyber-bullied)?*	No	Sí	Omitir	
19	¿Su hijo se cepilla los dientes y los limpia con hilo dental todos los días? *(Child brushes and flosses teeth daily?)*	Sí	No	Omitir	
20	¿Su hijo con frecuencia parece triste o deprimido? *(Child often seems sad or depressed?)*	No	Sí	Omitir	Dental Health
21	¿Su hijo pasa tiempo con alguna persona que fuma? *(Child spends time with anyone who smokes?)*	No	Sí	Omitir	Mental Health
22	¿Su hijo ha fumado alguna vez cigarrillos o mascado tabaco? *(Has child ever smoked cigarettes or chewed tobacco?)*	No	Sí	Omitir	
23	¿Le preocupa a usted que su hijo pueda estar usando drogas, u oliendo sustancias tales como pegamento, para drogarse? *(Concerned that child may be using drugs or sniffing substances to get high?)*	No	Sí	Omitir	Tobacco Exposure
24	¿Le preocupa que su hijo pueda estar tomando alcohol, tal como cerveza, vino, refrescos con contenido de alcohol o licor? *(Concerned that child may be drinking alcohol?)*	No	Sí	Omitir	
25	¿Su hijo tiene amigos o familiares que tienen problemas con las drogas o el alcohol? *(Child has friends/family members who have problems with drugs or alcohol?)*	No	Sí	Omitir	

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26	¿Su hijo o hija ha empezado a salir con novios o novias? *(Child started dating or "going out" with boyfriends or girlfriends?)*	No	Sí	Omitir
25	¿Su hijo tiene amigos o familiares que tienen problemas con las drogas o el alcohol? *(Child has friends/family members who have problems with drugs or alcohol?)*	No	Sí	Omitir
26	¿Su hijo o hija ha empezado a salir con novios o novias? *(Child started dating or "going out" with boyfriends or girlfriends?)*	No	Sí	Omitir
27	¿Cree que su hijo pueda estar sexualmente activo? *(Thinks child might be sexually active?)*	No	Sí	Omitir
28	¿Tiene alguna otra pregunta o inquietud sobre la salud o conducta de su hijo? *(Questions or concerns about child's health or behavior?)*	No	Sí	Omitir

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:

Evaluación de Salud

(Staying Healthy Assessment)

12 – 17 años *(12 – 17 Years)*

Nombre (primer nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	Año escolar:
Persona que completa el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			Asistencia escolar ¿Regular? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no conoce una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre algún punto de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
					Nutrition
1	¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *(Drinks/eats 3 servings of calcium-rich foods daily?)*	Sí	No	Omitir	
2	¿Come frutas y verduras, al menos, 2 veces al día? *(Eats fruits and vegetables at least 2 times per day?)*	Sí	No	Omitir	
3	¿Come comidas con alto contenido de grasa, como comidas fritas, papitas, helado o pizza más de una vez por semana? *(Eats high fat foods more than once per week?)*	No	Sí	Omitir	
4	¿Bebe más de 12 oz (1 lata de refresco) por día de jugo, bebida deportiva, bebida energizante o bebida de café endulzada? *(Drinks more than 12 oz. per day of juice/sports/energy drink, or sweetened coffee drink?)*	No	Sí	Omitir	
					Physical Activity
5	¿Hace ejercicio o deporte la mayoría de los días? *(Exercises or plays sports most days of the week?)*	Sí	No	Omitir	
6	¿Le preocupa su peso? *(Concerned about weight?)*	No	Sí	Omitir	
7	¿Mira televisión o juega juegos de video menos de 2 horas al día? *(Watches TV or plays video games less than 2 hours per day?)*	Sí	No	Saltar	
					Safety
8	En su hogar, ¿hay un detector de humo que funcione? *(Home has working smoke detector?)*	Sí	No	Omitir	
9	En su hogar, ¿está pegado cerca del teléfono el número del Centro de intoxicaciones (800-222-1222)? *(Home has phone # of the Poison Control Center posted by phone?)*	Sí	No	Omitir	
10	¿Siempre usa cinturón de seguridad cuando viaja en automóvil? *(Always wears a seatbelt when riding in a car?)*	Sí	No	Omitir	
11	¿Pasa tiempo en un hogar donde hay un revólver? *(Spends time in a home where a gun is kept?)*	No	Sí	Omitir	
12	¿Pasa tiempo con alguna persona que lleve un revólver, un cuchillo u otra arma? *(Spends time with anyone who carries a gun, knife, or other weapon?)*	No	Sí	Omitir	

13	¿Siempre usa casco cuando va en bicicleta, patineta o *scooter*? *(Always wears a helmet when riding a bike, skateboard, or scooter?)*	Sí	No	Omitir	
14	¿Alguna vez ha presenciado un acto de abuso o violencia? *(Ever witnessed abuse or violence?)*	No	Sí	Omitir	
15	Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente (o ha lastimado usted a alguien)? *(Been hit, slapped, kicked, or physically hurt by someone (or has he/she hurt someone) in the past year?)*	No	Sí	Omitir	
16	¿Alguna vez lo han intimidado o se sintió inseguro en su escuela o barrio (o lo intimidaron por Internet)? *(Ever been bullied or felt unsafe at school/neighborhood (or been cyber-bullied)?*	No	Sí	Omitir	
17	¿Se cepilla los dientes y los limpia con hilo dental todos los días? *(Brushes and flosses teeth daily?)*	Sí	No	Omitir	Dental Health
18	¿Con frecuencia se siente triste, deprimido o desesperanzado? *(Often feels sad, down, or hopeless?)*	No	Sí	Omitir	Mental Health
19	¿Pasa tiempo con alguna persona que fuma? *(Spends time with anyone who smokes?)*	No	Sí	Omitir	Alcohol, Tobacco, Drug Use
20	¿Fuma cigarrillos o mastica tabaco? *(Smokes cigarettes or chews tobacco?)*	No	Sí	Omitir	
21	¿Consume o aspira alguna sustancia para drogarse, como marihuana, cocaína, *crack*, metanfetamina ("*meth*"), éxtasis, etc.? *(Uses or sniffs any substance to get high?)*	No	Sí	Omitir	
22	¿Utiliza medicamentos que no fueron recetados para usted? *(Uses medicines not prescribed for her/him?)*	No	Sí	Omitir	
23	¿Bebe alcohol una vez a la semana o más? *(Drinks alcohol once a week or more?)*	No	Sí	Omitir	
24	Si bebe alcohol, ¿bebe hasta emborracharse o desmayarse? *(If she/he drinks alcohol, drinks enough to get drunk or pass out?)*	No	Sí	Omitir	
25	¿Tiene amigos o familiares que tienen problemas con las drogas o el alcohol? *(Has friends/family members who have problems with drugs or alcohol?)*	No	Sí	Omitir	
26	¿Conduce un automóvil después de beber, o viaja en un automóvil conducido por una persona que ha bebido o consumido drogas? *(Drives a car after drinking, or rides in a car driven by someone who has been drinking or using drugs?)*	No	Sí	Omitir	

Sus respuestas sobre relaciones sexuales o planificación familiar no serán divulgadas a nadie, ni siquiera a sus padres, sin su permiso.

27	¿Alguna vez lo forzaron o presionaron para tener relaciones sexuales? *(Ever been forced or pressured to have sex?)*	No	Sí	Omitir	Sexual Issues
28	¿Alguna vez ha tenido relaciones sexuales (orales, vaginales o anales)? *(Ever had sex (oral, vaginal, or anal)? Si la respuesta es "no", pase a la pregunta 35.*	No	Sí	Omitir	
29	¿Cree que usted o su pareja pueden tener una infección de transmisión sexual (sexually transmitted infection, STI), como clamidia, gonorrea, verrugas genitales, etc.? *(Thinks she/he or partner could have a STI)?*	No	Sí	Omitir	

30	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales con otras personas en el último año? *(She/he or partner(s) had sex with other people in the past year?)*	No	Sí	Omitir
31	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin utilizar un método anticonceptivo en el último año? *(She/he or partner(s) had sex without using birth control in the past year?)*	No	Sí	Omitir
32	La última vez que tuvo relaciones sexuales, ¿utilizó un método anticonceptivo? *(Used birth control the last time she/he had sex?)*	Sí	No	Omitir
33	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin condón en el último año? *(She/he or partner(s) had sex without a condom in the past year?)*	No	Sí	Omitir
34	¿Usted o su pareja usaron un condón la última vez que tuvieron relaciones sexuales? *(She/he or partner used a condom the last time they had sex?)*	Sí	No	Omitir
35	¿Le preocupa que le pueda gustar una persona del mismo sexo? *(Concerns about liking someone of the same sex?)*	No	Sí	Omitir
36	¿Tiene alguna otra pregunta o inquietud sobre su salud? *(Any other questions or concerns about health?)*	Sí	No	Omitir

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Evaluación de Salud

(Staying Healthy Assessment)

Adulto *(Adult)*

Nombre del paciente (nombre y apellido)	Fecha de nacimiento	☐ Mujer ☐ Hombre	Fecha de hoy
Persona que llena el formulario *(si el paciente necesita ayuda)*	☐ Familiar ☐ Amigo ☐ Otro *Especifique:*		¿Necesita ayuda para llenar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre alguna sección de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

Clinic Use Only:

1	¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *(Drinks or eats 3 servings of calcium-rich foods daily?)*	Sí	No	Omitir	Nutrition
2	¿Come frutas y verduras todos los días? *(Eats fruits and vegetables every day?)*	Sí	No	Omitir	
3	¿Limita la cantidad de alimentos fritos o comida rápida que come? *(Limits the amount of fried food or fast food eaten?)*	Sí	No	Omitir	
4	¿Tiene la posibilidad de comer suficientes alimentos saludables? *(Easily able to get enough healthy food?)*	Sí	No	Omitir	
5	¿La mayoría de los días bebe un refresco, jugo, bebida deportiva o bebida energizante? *(Drinks a soda, juice/sports/energy drink most days of the week?)*	No	Sí	Omitir	
6	Por lo general, ¿come demasiado o muy poco? *(Often eats too much or too little food?)*	No	Sí	Omitir	
7	¿Le preocupa su peso? *(Concerned about weight?)*	No	Sí	Omitir	
8	¿Hace ejercicio o realiza actividades, como caminar, jardinería o nadar durante, al menos, ½ hora al día? *(Exercises or spends time doing moderate activities for at least ½ hour a day?)*	Sí	No	Omitir	Physical Activity
9	¿Se siente seguro donde vive? *(Feels safe where she/he lives?)*	Sí	No	Omitir	Safety
10	¿Ha tenido accidentes automovilísticos últimamente? *(Had any car accidents lately?)*	No	Sí	Omitir	

11	Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente? *(Been hit, slapped, kicked, or physically hurt by someone in the last year?)*	No	Sí	Omitir	
12	¿Siempre usa cinturón de seguridad cuando conduce o viaja en automóvil? *(Always wears a seat belt when driving or riding in a car?)*	Sí	No	Omitir	
13	¿Tiene un arma de fuego en su hogar o en el lugar donde vive? *(Keeps a gun in house or place where she/he lives?)*	No	Sí	Omitir	
14	¿Se cepilla los dientes y los limpia con hilo dental todos los días? *(Brushes and flosses teeth daily?)*	Sí	No	Omitir	Dental Health
15	¿Con frecuencia se siente triste, desesperanzado, enojado o preocupado? *(Often feels sad, hopeless, angry, or worried?)*	No	Sí	Omitir	Mental Health
16	¿Con frecuencia tiene dificultades para dormir? *(Often has trouble sleeping?)*	No	Sí	Omitir	
17	¿Fuma o masca tabaco? *(Smokes or chews tobacco?)*	No	Sí	Omitir	Alcohol, Tobacco, Drug Use
18	¿Sus amigos o familiares fuman en su hogar o en el lugar donde usted vive? *(Friends/family members smoke in house or place where she/he lives?)*	No	Sí	Omitir	
19	¿Bebe 2 o más bebidas alcohólicas al día? *(Drinks 2 or more alcoholic drinks per day?)*	No	Sí	Omitir	
20	¿Consume drogas o medicamentos para ayudarlo a dormir, relajarse, calmarse, sentirse mejor o perder peso? *(Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?)*	No	Sí	Omitir	
21	Do you think you or your partner could be pregnant? *(Thinks she/he or partner could be pregnant?)*	No	Sí	Omitir	Sexual Issues
22	¿Cree que usted o su pareja pueden tener una infección de transmisión sexual (sexually transmitted infection, STI), como clamidia, gonorrea, verrugas genitales, etc.? *(Thinks she/he or partner could have an STI?)*	No	Sí	Omitir	
23	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin utilizar un método anticonceptivo en el último año? *(She/he or partner(s) had sex without using birth control in the past year?)*	No	Sí	Omitir	
24	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales con otras personas en el último año? *(She/he or partner(s) had sex with other people in the past year?)*	No	Sí	Omitir	

25	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin condón en el último año? *(She/he or partner(s) had sex without a condom in the past year?)*	No	Sí	Omitir
26	¿Alguna vez lo forzaron o presionaron para tener relaciones sexuales? *(Ever been forced or pressured to have sex?)*	No	Sí	Omitir
27	¿Tiene alguna otra pregunta o inquietud sobre su salud? *(Any other questions or concerns about health?)*	No	Sí	Omitir

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Evaluación de Salud

(Staying Healthy Assessment)

Personas mayores *(Senior)*

Nombre del paciente (primer nombre y apellido)	Fecha de nacimiento	☐ Mujer ☐ Hombre	Fecha de hoy
Persona que completa el formulario *(si el paciente necesita ayuda)*	☐ Familiar ☐ Amigo ☐ Otro *Especifique:*		¿Necesita ayuda para completar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no conoce una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre algún punto de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
					Nutrition
1	¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *(Drinks/eats 3 servings of calcium-rich foods daily?)*	Sí	No	Omitir	
2	¿Come frutas y verduras todos los días? *(Eats fruits and vegetables every day?)*	Sí	No	Omitir	
3	¿Limita la cantidad de alimentos fritos o comida rápida que come? *(Limits the amount of fried food or fast food eaten?)*	Sí	No	Omitir	
4	¿Tiene la posibilidad de comer suficientes alimentos saludables? *(Easily able to get enough healthy food?)*	Sí	No	Omitir	
5	¿La mayoría de los días bebe un refresco, jugo, bebida deportiva o bebida energizante? *(Drinks a soda, juice/sports/energy drink most days of the week?)*	No	Sí	Omitir	
6	Por lo general, ¿come demasiado o muy poco? *(Often eats too much or too little food?)*	No	Sí	Omitir	
7	¿Tiene dificultades para masticar o tragar? *(Has difficulty chewing or swallowing?)*	No	Sí	Omitir	
8	¿Le preocupa su peso? *(Concerned about weight?)*	No	Sí	Omitir	
					Physical Activity
9	¿Hace ejercicios o realiza actividades, como caminar, jardinería o nadar durante, al menos, ½ hora al día? *(Exercises or spends time doing moderate activities for at least ½ hour a day?)*	Sí	No	Omitir	
					Safety
10	¿Se siente seguro donde vive? *(Feels safe where she/he lives?)*	Sí	No	Omitir	
11	Por lo general, ¿tiene dificultades para llevar un registro de sus medicamentos? *(Often has trouble keeping track of medicines?)*	No	Sí	Omitir	

12	¿Sus familiares o amigos se preocupan por la forma en que conduce? *(Family members/friends worried about her/his driving?)*	No	Sí	Omitir	
13	¿Ha tenido accidentes automovilísticos últimamente? *(Had any car accidents lately?)*	No	Sí	Omitir	
14	¿A veces se cae y se lastima, o le resulta difícil ponerse de pie? *(Sometimes falls and hurts self, or has difficulty getting up?)*	No	Sí	Omitir	
15	Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente? *(Been hit, slapped, kicked, or physically hurt by someone in past year?)*	No	Sí	Omitir	
16	¿Tiene un revólver en su hogar o en el lugar donde vive? *(Keeps a gun in house or place where she/he lives?)*	No	Sí	Omitir	
17	¿Se cepilla los dientes y los limpia con hilo dental todos los días? *(Brushes and flosses teeth daily?)*	Sí	No	Omitir	Dental Health
18	¿Con frecuencia se siente triste, desesperanzado, enojado o preocupado? *(Often feels sad, hopeless, angry, or worried?)*	No	Sí	Omitir	Mental Health
19	¿Con frecuencia tiene dificultades para dormir? *(Often has trouble sleeping?)*	No	Sí	Omitir	
20	¿Usted u otras personas creen que tiene problemas para recordar cosas? *(Thinks or others think that she/he is having trouble remembering things?)*	No	Sí	Omitir	
21	¿Fuma o masca tabaco? *(Smokes or chews tobacco?)*	No	Sí	Omitir	Alcohol, Tobacco, Drug Use
22	¿Sus amigos o familiares fuman en su hogar o en el lugar donde vive? *(Friends/family members smoke in house or place where she/he lives?)*	No	Sí	Omitir	
23	¿Bebe 2 o más bebidas alcohólicas al día? *(Drinks 2 or more alcoholic drinks per day?)*	No	Sí	Omitir	
24	¿Consume drogas o medicamentos para ayudarlo a dormir, relajarse, calmarse, sentirse mejor o perder peso? *(Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?)*	No	Sí	Omitir	
25	¿Cree que usted o su pareja pueden tener una infección de transmisión sexual (sexually transmitted infection, STI), como clamidia, gonorrea, verrugas genitales, etc.? *(Thinks she/he or partner could have an STI?)*	No	Sí	Omitir	Sexual Issues

26	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales con otras personas en el último año? *(She/he or partner(s) had sex with other people in the past year?)*	No	Sí	Omitir	
27	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin condón en el último año? *(She/he or your partner(s) had sex without a condom in the past year?)*	No	Sí	Omitir	
28	¿ Lo han forzado o presionado a tener relaciones sexuales, alguna vez? *(Ever been forced or pressured to have sex?)*	No	Sí	Omitir	
29	¿Cuenta con alguien que lo ayude a tomar decisiones sobre su salud o su atención médica? *(Has someone to help make decisions about her/his health and medical care?)*	Sí	No	Omitir	Independent Living
30	¿Necesita ayuda para bañarse, comer, caminar, vestirse o ir al baño? *(Needs help bathing, eating, walking, dressing, or using the bathroom?)*	No	Sí	Omitir	
31	¿Tiene a quién llamar cuando necesita ayuda en una emergencia? *(Has someone to call when she/he needs help in an emergency?)*	Sí	No	Omitir	
32	¿Tiene alguna otra pregunta o inquietud sobre su salud? *(Any other questions or concerns about your health?)*	Sí	No	Omitir	

Si la respuesta es afirmativa, por favor describa:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

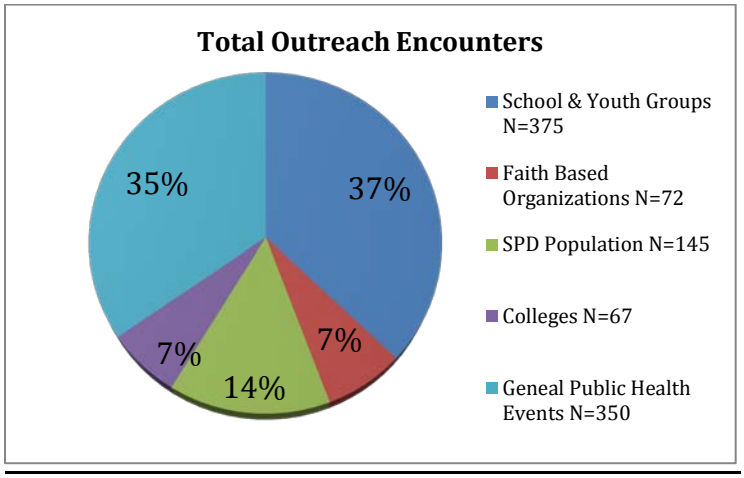
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Outreach Activity Progress Report

Summary of Community Outreach and Education Activities
Gold Coast Health Plan participated in 30 outreach activities and seven (7) community collaborative meetings:

Date	Event/Activities
11/1	La Hermandad – Food Distribution at Oxnard PAL Center
11/2	2013 Senior Summit at CSU Channel Island – Resource Fair
11/7	2nd Annual Ventura County Agricultural Networking Night at Santa Paula Agricultural Museum
11/12	VCMC Baby Steps- OB Celebration Resource Fair
11/17	Jornadas Dominicales at Oxnard Mexican Consulate
11/19	GCHP Member Orientation Meeting – English Session
11/20	West Park Community Center Food Distribution – Resource Fair
11/21	GCHP Member Orientation Meeting – Spanish Session
10/4	La Hermandad Community Food Distribution – Resource Booth
10/8	Ventura County Medical Center – Baby Steps
10/16	Sheridan Elementary School –Family Resource Fair
1018	Rainbow Connection – Ocean View Pavilion, Port Huemene
10/19	Ventura College, Binational Health Week – Market Place Resource Fair
10/22	GCHP New Member Orientation Meeting – English Session
10/23	Ventura County Area Agency on Aging – Outreach Fair
10/24	Food Day 2013 Vegetable Garden – Resource Booth
10/24	GCHP Member Orientation Meeting – Spanish Session
10/26	Empowering the Caregiver Resource Fair at Oxnard Family Circle
10/26	MICOP Food Distribution and Community Family Event, El Rio Elementary School
10/27	Our Lady of Guadalupe Church, Sai-Baba Health Fair
10/27	Jornadas Dominicales at Oxnard Mexican Consulate
9/7	Mexican Consulate – Resource Fair Jornades Sabatinas
9/10	Ventura County Medical Center – Baby Step Resource Fair
9/13	La Hermandad Community Food Distribution – Resource Booth
9/14	Ventura County Public Health Agency- Health Fair La Colonia Del Sol 5K Walk
9/17	GCHP New Member Orientation Meeting – English Session
9/19	GCHP New Member Orientation Meeting – Spanish Session
9/21	Day for Kids Community Health and Resource Fair
9/26	Ventura County Human Service Agency – ACA Outreach Meeting
9/28	MICOP Family Community Fair

In summary, health education and outreach staff reached over 1000 individuals and families during the reporting months. The chart below highlights the groups and organizations reached during the reporting period. Additionally, over 1400 pieces of health education materials was distributed and approximately 639 ACA related literature was handed out during the reported events. Approximately 46% of all outreach events related to information about health care reform and the Medi-Cal Program.



Community Collaborative Meetings

11/7	Ventura County Public Health - Healthy Communities Collaborative
11/12	Affordable Care Act Coverage Seminar – St. John's Networking
11/14	Ventura County Children's Oral Health Collaborative
11/14	Low-Income Health Program – GCHP/VCHCA Communication Meeting
10/8	St. John's Networking Community Meeting
9/10	St. John's Networking Community Meeting
9/23	VC Public Health – Covered California Team Meeting

Affordable Care Act (ACA) and Community Collaborative Efforts

Outreach and education staff attended the Ventura County Health Care Reform Communications Committee meeting in September. This meeting was sponsored by Ventura County Human Service Agency. Community partners discussed information about outreach efforts related to the Medi-Cal Program eligibility and health care reform changes.

Additionally, GCHP prepared a response to an outreach and enrollment survey conducted by the Department of Health Care Services (DHCS). DHCS received funding from the California Endowment for statewide outreach and education efforts to increase awareness of the Medi-Cal Program changes. GCHP participated in the survey, which is being coordinated by Ventura County Human Service Agency (VCHSA).

Future ACA and Low Income Health Program (LIHP) Outreach Strategies

GCHP's outreach and health education team will continue to participate and collaborate in community health events and resource fairs. However, to continue to increase awareness about the changes to the Medi-Cal Program and health care reform, staff has identified alternative venues including shopping malls, public libraries, farmers market, childcare centers, employment centers, affordable housing authorities, and other key locations throughout the county to reach the general community about the expanded Medi-Cal Program and resources about ACA.

Community Outreaching Events – December 2013

Sunday, December 1, 2013
Word AIDS Day 2013 – Ventura County Public Health
Location: 3147 Loma Vista Road, Ventura
Time: 10:00am – 2:00pm

Friday, December 6, 2013
La Hermandad – Food Distribution at Oxnard Police Activities League (PAL) Center
Location: 350 S. K Street, Oxnard
Time: 10:00am - 12:00pm

Saturday, December 7, 2013
Jornadas Sabatinas at Oxnard Mexican Consulate
Location: 3151 W. Fifth Street, Oxnard
Time: 9:00am – 3:00pm

Tuesday, December 10, 2013
VCMC Baby Steps – OB Celebration at VCMC Cafeteria
Location: 3291 Loma Vista Road, Ventura
Time: 5:00pm – 6:00pm

Tuesday, December 10, 2013
GCHP- New Member Orientation Meeting (English)
Location: 2240 E. Gonzales Road, Ste. 200, Oxnard
Time: 6:00pm – 7:00pm

Thursday, December 12, 2013
GCHP- New Member Orientation Meeting (Spanish)
Location: 2240 E. Gonzales Road, Ste. 200, Oxnard
Time: 6:00pm - 7:00pm

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Community Outreaching Events – December 2013

Tuesday, December 17, 2013
ELAC Parent Meeting at Freemont Intermediate School
Location: 1130 North M Street, Oxnard
Time: 8:00am – 9:00am

Wednesday, December 18, 2013
Food Distribution Program and Health Screenings Fair
Location: 450 W. Harrison Avenue, Ventura
Time: 4:30pm - 6:00pm