Health Risk Assessment

DualChoice

At IEHP DualChoice (HMO D-SNP), we want to give you the best care we can. This health assessment will help us understand and improve your care. Your answers will not affect your benefits.

Please take this survey in one of four ways:

1. **In Person:** With the help of one of our team members.
2. **By Phone:** By calling Member Services.
3. **By Mail:** Filling out the form and returning it in the reply envelope.
4. **Online:** By logging into your IEHP secure Member Portal, going to "My Health Records," and clicking "Health Risk Assessment."

To fill out this form in person or over the phone, please call Member Services and ask to fill out a "Health Risk Assessment." Keep your member number handy when you call.

1-877-273-IEHP (4347)
TTY 1-800-718-IEHP (4347)
8am-8pm (PST)
7 days a week, including holidays

YOUR HEALTH

1. What language do you prefer to speak and read?

	Speaking	Reading
English	☐	☐
Spanish	☐	☐
American Sign Language (ASL)	☐	☐
Other	_____	_____

2. Do you have any problems seeing, hearing or speaking? (Please check all that apply)

- ☐ Seeing
- ☐ Hearing
- ☐ Speaking
- ☐ None

3. In general, how would you rate your health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

4. Do you have, or have you been treated for, any of these conditions in the past 12 months? (Please check all that apply)

- ☐ Arthritis
- ☐ Asthma
- ☐ Depression/Anxiety
- ☐ Cancer
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Developmental Disability
  Example: Autism, Cerebral Palsy, Down Syndrome
- ☐ Diabetes
- ☐ Eating Disorder
  Example: Anorexia, Bulimia
- ☐ Heart Problems
  Example: Congestive Heart Failure, Coronary Artery Disease, Arrhythmia
- ☐ High Blood Pressure
- ☐ Infectious Disease
  Example: Hepatitis, HIV/AIDS
- ☐ Kidney Disease
  Example: Dialysis, End Stage Renal Disease
- ☐ Liver Disease
- ☐ Memory Problems
  Example: Dementia, Alzheimer's
- ☐ Organ Transplant
- ☐ Pregnancy
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Other (please specify):

  _____
- ☐ None

5. How many different medications are you taking?

- ☐ 0
- ☐ 1-5
- ☐ 6-10
- ☐ 11+

6. A) During the past four weeks, how much did pain interfere with your normal activities?

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

B) Are you currently receiving treatment for pain?

- ☐ Yes
- ☐ No

7. A) Are you using any of these supplies or equipment right now? (Please check all that apply)

- ☐ Cane/crutches
- ☐ Walker
- ☐ Wheelchair
- ☐ Prosthetics
- ☐ Portable Toilet
- ☐ Hospital Bed/Hoyer Lift
- ☐ Tube feeding supplies
- ☐ Diabetes supplies
- ☐ Incontinence supplies
- ☐ Ostomy supplies
- ☐ Nebulizer
- ☐ Suction supplies
- ☐ Wound care supplies
- ☐ CPAP or BiPAP
- ☐ Ventilator
- ☐ Oxygen
- ☐ Blood pressure monitor
- ☐ Eyeglasses/Contacts
- ☐ Hearing Aids
- ☐ Other (please specify) _____
- ☐ None

B) Do you need help with getting any supplies or equipment at this time?

- ☐ Yes
- ☐ No

8. In the past year, have you seen your primary care doctor?

- ☐ Yes
- ☐ No

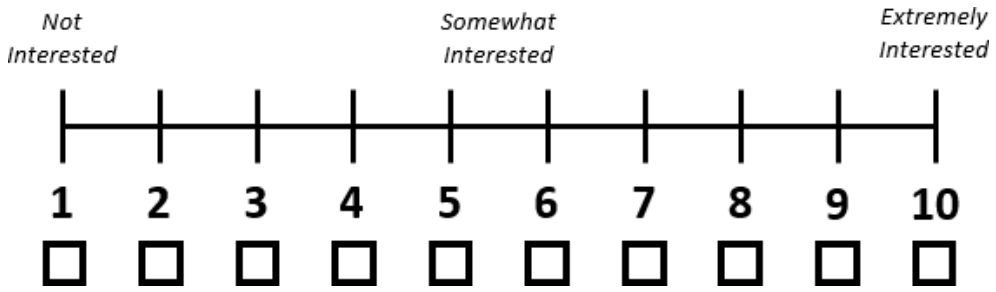
9. In the past 3 months, how many times did you go to the emergency room?

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3+

10. A) Do you smoke or use tobacco now (including cigarettes, chew, pipes, cigars or vapor cigarettes)?

- ☐ Yes
- ☐ No *(Go to Question 11)*
- ☐ Used to smoke *(Go to Question 11)*

B) How interested are you in quitting smoking or tobacco use, on a scale of 1-10? *(1 means not interested, and 10 means extremely interested)*



11. How often do you have five or more alcoholic drinks on one occasion?

- ☐ Never
- ☐ Monthly
- ☐ Weekly
- ☐ Daily (or almost daily)

12. Are you using any drugs or taking prescription medications in a way that's not prescribed?

- ☐ Yes
- ☐ No *(If you also answered "Never" in Question 11, please go to Question 14)*

13. Please answer the following questions:

	Yes	No
a. Have you ever thought you should cut down on your drinking or other drug use?	☐	☐
b. Have you ever felt annoyed when people comment on your alcohol or other drug use?	☐	☐
c. Have you ever felt bad or guilty about your alcohol or other drug use?	☐	☐
d. Have you ever used alcohol or other drugs to ease withdrawal symptoms or get rid of a hangover?	☐	☐

YOUR SUPPORT

14. A) Do you need help with any of these actions? (Yes/No to each individual action)

	YES	NO
a. Taking a bath or shower	☐	☐
b. Going up stairs	☐	☐
c. Eating	☐	☐
d. Getting dressed	☐	☐
e. Brushing teeth, brushing hair, shaving	☐	☐
f. Making meals or cooking	☐	☐
g. Getting out of a bed or a chair	☐	☐
h. Shopping and getting food	☐	☐
i. Using the toilet	☐	☐
j. Walking	☐	☐
k. Washing dishes or clothes	☐	☐
l. Writing checks or keeping track of money	☐	☐
m. Getting a ride to the doctor or to see your friends	☐	☐
n. Doing house or yardwork	☐	☐
o. Going out to visit family or friends	☐	☐
p. Using the phone	☐	☐
q. Keeping track of appointments	☐	☐

B) If yes, are you getting the help you need with these actions?

☐ Yes

☐ No

15. A) Can you live safely and move easily around in your home?

☐ Yes *(Go to Question 16)*

☐ No

B) If no, does the place where you live have: (Yes/No to each individual item)

	YES	NO
a. Good lighting	☐	☐
b. Good heating	☐	☐
c. Good cooling	☐	☐
d. Rails for any stairs or ramps	☐	☐
e. Hot water	☐	☐
f. Indoor toilet	☐	☐
g. A door to the outside that locks	☐	☐
h. Stairs to get into your home or stairs inside your home	☐	☐
i. Elevator	☐	☐
j. Space to use a wheelchair	☐	☐
k. Clear ways to exit your home	☐	☐

16. I want to ask you about how you think you are managing your health conditions.

	Yes	No
a. Do you need help taking your medicines?	☐	☐
b. Do you need help filling out health forms?	☐	☐
c. Do you need help answering questions during a doctor's visit?	☐	☐

17. Do you have family members or others willing and able to help you when needed?

- ☐ Yes
- ☐ No *(Go to Question 19)*

18. Do you ever think your caregiver has a hard time giving you the help you need?

- ☐ Yes
- ☐ No

19. A) Are you afraid of anyone, or is anyone hurting you?

- ☐ Yes
- ☐ No

B) Is anyone using your money without your ok?

- ☐ Yes
- ☐ No

20. Have you had any changes in thinking, remembering or making decisions?

- ☐ Yes
- ☐ No

21. Are you currently receiving Palliative Care Services?

- ☐ Yes
- ☐ No

22. A) Have you fallen in the last month?

- ☐ Yes
- ☐ No

B) Are you afraid of falling?

- ☐ Yes
- ☐ No

23. Do you sometimes run out of money to pay for food, rent, bills and medicine?

- ☐ Yes
- ☐ No

24. Within the past 12 months, have you worried that your food would run out before you got money to buy more?

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

25. What is your living situation today?

- ☐ I have a steady place to live
- ☐ I have a place to live today but I am worried about losing it in the future
- ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

26. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- ☐ Yes
- ☐ No

27. Over the past month (30 days), how many days have you felt lonely? (Check one)

- ☐ None – I never felt lonely
- ☐ Less than 5 days
- ☐ More than half the days (more than 15)
- ☐ Most days – I always feel lonely

28. Over the past month (30 days), how often have you felt tense, anxious or depressed?

- ☐ Almost every day
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

29. Are you getting any of these resources in your community? (Please check all that apply)

- ☐ Caregiver Services
- ☐ IEHP Community Resource Center
- ☐ Health Education
- ☐ Energy Assistance Programs
- ☐ Service for Seniors
- ☐ Services for People with Disabilities
- ☐ Dental Services
- ☐ Vision Services
- ☐ Support Groups
  Example: 12 Step Program, Cancer Support Group, etc.
- ☐ Mental Health Services/ Substance Use Services Veterans' Services
- ☐ Other (please specify)

  _____
- ☐ None
- ☐ I don't know/understand

30. Are you interested in getting information about resources in your community?

- ☐ Yes
- ☐ No

31. Given all that was covered here, what would you say are your main concerns right now? (Briefly list up to three)

1._____

2._____

3._____

32. A) Do you have a family member, friend, or emergency backup caregiver to help you at home if you become sick, or are not able to care for yourself, or if your In-Home Supportive Services (IHSS) Provider is not available?

- ☐ Yes
- ☐ No

Name:_____

Telephone:_____

Relationship to you:_____

B) Can IEHP staff speak with the person (caregiver) named above about your health care needs or plan of care?

- ☐ Yes
- ☐ No

33. Do you have a living will or Advance Care Directive?

- ☐ Yes
- ☐ No
- ☐ I don't know

Thank you for filling out this assessment. Please mail it back in the enclosed pre-paid, self-addressed reply envelope.