Health Risk Assessment for IEHP DualChoice (HMO D-SNP) Members

At IEHP DualChoice (HMO D-SNP), we want to give you the best care we can. Please complete this Health Risk Assessment to help us know your health care needs. Your answers will not affect your benefits in any way. We may tell you to skip over some questions. You can complete this survey in one of four ways:

1. **In Person:** An IEHP Team Member can meet with you to help you fill out the form.
2. **By Phone:** An IEHP Team Member can call you to fill out the form.
3. **By Mail:** You can fill out the form and return it in the reply envelope provided.
4. **Online:** You can complete your assessment online using the Member Portal.

If you would like to fill out this form in person or over the phone, please call IEHP DualChoice Member Services and ask to fill out a "Health Risk Assessment." The number to call is 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays. TTY/TDD users should call 1-800-718-4347. Please keep your IEHP DualChoice Member ID number handy when you call.

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's 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
- ☐ C-Pap or Bi-Pap
- ☐ 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

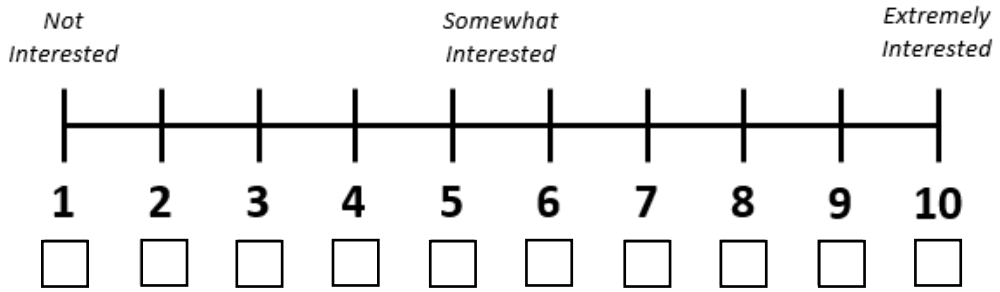
9. In the past 3 months, how many times did you go to the Emergency Room?

- ☐ 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 yard work	☐	☐
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. A. Have you fallen in the last month?

- ☐ Yes
- ☐ No

B. Are you afraid of falling?

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

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

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

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

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

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

- ☐ Food assistance
- ☐ Housing/homeless assistance
- ☐ Transportation services
- ☐ Caregiver services
- ☐ IEHP Community Resource Center
- ☐ Health education
- ☐ Energy assistance programs
- ☐ Services 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

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

- ☐ Yes
- ☐ No

26. Given all that was covered here, what would you say are your main concerns right now?

(Briefly list up to three)

1._____

2._____

3._____

27. A. Do you have a family member, friend, or emergency back-up 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

28. 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 to:

INLAND EMPIRE HEALTH PLAN
ATTENTION: HEALTH RISK ASSESSMENT TEAM
10801 6th Street,
Rancho Cucamonga, CA 91730