



Health Survey

Please complete this survey. The goal of this survey is to help us understand your health and specific health care needs so we can work together to help provide you the services to reach your health goal(s).

Your answers **WILL NOT** affect your benefits. We may share your information with your primary care provider. If you have any questions regarding this please contact Customer Care - 1-844-280-5555 (TTY: 711) 8:00 AM-8:00 PM, 7 days a week, (Oct 1-Mar 31), 8:00 AM-8:00 PM, Monday-Friday (April 1-Sept 30).

Date: _____ **Agent name and ID (if agent assisted):** _____

Name: _____ **Gender:** Male Female

DOB: _____ **Marital Status:** Single Married Separated Divorced Widow

Phone number: _____ **Application/Member ID:** _____

1. What is your race?

- White Black or African American Native Hawaiian Samoan Other Pacific Islander
- Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian
- Guamanian or Chamorro I choose not to answer

2. What is your Ethnicity?

- Not Hispanic, Latino/a or Spanish Origin Cuban Mexican, Mexican American, Chicano/a
- Puerto Rican Another Hispanic, Latino or Spanish Origin I choose not to answer

3. What is your primary language?

- English Spanish Other: _____ I choose not to answer

4. Please check whether you have ever had or have been treated for any of the following Chronic Conditions.

- Alzheimer's Disease/Dementia Autoimmune Disease (Multiple Sclerosis/Myasthenia Gravis)
- Asthma Arthritis or Pain in Joints Cancer Congestive Heart Failure COVID-19 Diabetes
- Cardiovascular Disease/Coronary Artery Disease/Peripheral Vascular Disease Depression/Mental Illness
- Epilepsy/Seizures Heart Problems/Heart Disease/Heart Attack High Blood Pressure
- High Cholesterol/Triglycerides Kidney Disease/Failure Immune Disorder (HIV or AIDS)
- Lung Disease (Emphysema, Chronic Obstructive Pulmonary Disease-COPD)
- Neurodegenerative Disease (Parkinson's/Huntington's Disease) Organ Transplant (Liver, Kidney, etc.)
- Stroke

5. Please check the following conditions you are currently experiencing or receiving medical treatment for:

- Foot/Ankle/Leg Swelling Sudden Increase in Weight Renal Dialysis Open Sores, Wounds, or Ulcers on Your Skin

6. Health Care Access and Treatment

c0In the past 12 months, has lack of reliable transportation ngr vyou from medical appointments, meetings, work or from getting things needed for daily living?

Yes No

d0Have you had a face-to-face (in-person or virtual) visit with your doctor for an Annual Physical Exam or Wellness Visit in the past 12 months?

Yes No

c. Are you currently enrolled in hospice?

Yes No

d. How many times have you been to the emergency room in the past 12 months?

None 1-3 times More than 3

e. How many times have you been admitted to the hospital in the past 12 months?

None 1-3 times More than 3

f. When was your last complete dilated eye exam?

Never Less than 12 months ago More than 12 months ago

g. Do you feel your healthcare has been impacted by your age, income, education, race, gender or ethnicity?

Yes No

7. Activities of Daily Living

- a. Do you need help with bathing, dressing yourself, preparing meals, feeding yourself, or using the bathroom? Yes No
- b. Do you need help walking, getting up from a chair or getting out of bed? Yes No
- c. Do you need help taking your medications as prescribed? Yes No
- d. Do you currently use assistive devices and/or durable equipment to walk, bathe, shower, or use the bathroom, i.e., a wheelchair, walker, cane, raised toilet seat, etc.? Yes No
- e. Do you have a caregiver to assist with your needs? Yes No
- f. In the past 12 months, how many times have you fallen: Never Once More than once
- g. If you are currently bothered with pain, please tell us how bad the pain is. (1-3 being very little pain, 4-6 being moderate pain, and 7-10 being severe pain) I have no pain 1-3 4-6 7-10

8. Behavioral and Social

- a. In the past 3 months, have you felt sad, blue or depressed? Yes No
- b. In the past 3 months, have you experienced changes in thinking, remembering or decision making? Yes No
- c. Does forgetfulness (such as forgetting to pay bills or take your medications) cause problems in your daily life? Yes No
- d. Do you smoke? Yes No
- e. If you answered yes to the Question D, would you like to receive information to help you quit smoking? Yes No
- f. Do you drink more than two alcoholic beverages each day? Yes No
- g. In the last 12 months, have you used illegal drugs or substances? Yes No
- h. If you answered yes to Question G, would you like to receive information about controlling this problem? Yes No
- i. Do you socialize with others regularly? Yes No
- j. Do you exercise regularly? Yes No
- k. Do you currently feel threatened or that you are being physically, mentally, or sexually abused? Yes No
- l. Do you experience feelings of stress related to your health, finances, family or social relationships, work, etc.? Yes No
- m. In general, how would you rate your overall health? Excellent/Very Good Good Fair Poor
- n. In the past 3 months, have you had difficulty meeting your living expenses? Yes No
- o. Within the past 12 months, you worried that your food would run out before you got money to buy more?
 Often true Sometimes true Never true
- p. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
 Often true Sometimes true Never true
- q. 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.)
- r. Are you able to afford your medications? Yes No
- s. Would you like to receive information regarding advanced directives or living wills? Yes No
- t. What is the highest level of education you completed?
 Grade School High School Vocational School College
- u. How well can you read? Very Well Well Not Well I cannot read
- v. Are you able to access and understand your health information electronically? Yes No

9. Medical Treatment/Vaccinations

- a. How many different medications do you take every day? 1-3 4-6 More than 6 None
- b. When was your last flu shot? Never Within the last 12 months More than 12 months ago
- c. When was your last pneumonia shot? Never Less than 10 years ago More than 10 years ago
- d. Have you received the COVID-19 vaccinations? Yes No
- e. If you have received the COVID-19 vaccinations, have you received the booster vaccinations? Yes No

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