GlobalHealth
MEDICARE ADVANTAGE PLANS

Medicare Advantage Plans
210 Park Ave. | Suite 2900 | Oklahoma City, OK 73102-5621

<GenerationDate>

<FirstName> <MiddleInitial> <LastName>
<Address1>
<Address2>
<City>, <State> <Zip>

Dear <FirstName> <LastName>,

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

The information submitted in this survey will be used internally by our Care Management Department and may be shared with your Primary Care Physician (PCP) if there are gaps in care that need to be addressed.

Any information provided will not be used against you in any way or impact the services you obtain from the health plan.

Completion and submission of the confidential Health Survey implies consent to its stated use; however, you do have the option to decline completion of this survey. This survey can also be completed on the GlobalHealth website.

- **Translation Services:** We offers interpretation services for our members. Professional Certified Medical Interpreters allow our members access to culturally sensitive translation services when speaking to our health plan staff. Call our Customer Care call center at 1-844-280-5555 between 8:00 AM to 8:00 PM, seven days a week (October 1 - March 31) and 8:00 AM and 8:00 PM, Monday through Friday (April 1 – September 30). TTY users may call 711.

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 with 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, seven days a week, (Oct 1-Mar 31), 8:00 AM-8:00 PM, Monday-Friday (April 1-Sept 30).

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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's your race?

☐ White ☐ Black ☐ American Indian ☐ Alaska Native ☐ 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 ☐ Stroke ☐ Kidney Disease
☐ High Blood PressureHigh Cholesterol/Triglycerides ☐ 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.)

5. Please check the following conditions you are currently experiencing:

☐ Foot/Ankle/Leg Swelling ☐ Sudden change in Weight ☐ Open Sores, Wounds, or Ulcers on Your Skin

A. If checked yes, please check the following conditions you are receiving medical treatment for:

☐ Foot/Ankle/Leg Swelling ☐ Sudden Change in Weight ☐ Open Sores, Wounds, or Ulcers on Your Skin

6. Health Care Access and Treatment:

a. 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

b. Have 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. Are you currently receiving renal dialysis treatment? ☐ Yes ☐ No

e. How many times have you been to the emergency room in the past 12 months? ☐ None ☐ 1-3 times ☐ More than 3

f. How many times have you been admitted to the hospital in the past 12 months? ☐ None ☐ 1-3 times ☐ More than 3

g. When was your last complete dilated eye exam? ☐ Never ☐ Less than 12 months ago ☐ More than 12 months ago

h. Do you feel the healthcare you have received has been negatively 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 have a caregiver to assist with meeting your needs listed above? ☐ Yes ☐ No ☐ N/A

e. In the past 12 months, how many times have you fallen: ☐ Never ☐ Once ☐ More than once

f. 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

g. Are you currently bothered with pain? Please rate your pain. (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 chronically felt sad, and/or depressed? ☐ Yes ☐ No

b. In the past 3 months, have you experienced changes in thinking, remembering or decision making? ☐ Yes ☐ No

Does this impact your daily activity? ☐ Yes ☐ No

c. Do you use tobacco products? ☐ Yes ☐ No

d. If you answered yes to the Question C, would you like to receive educational information to help quit tobacco use? ☐ Yes ☐ No

e. Do you drink more than two alcoholic beverages each day? ☐ Yes ☐ No

f. In the last 12 months, have you used illegal drugs or substances? ☐ Yes ☐ No

g. If you answered yes to Question F, would you like assistance to address illegal drug/substance use? ☐ Yes ☐ No

h. Do you socialize with others regularly? ☐ Yes ☐ No

i. Do you engage in exercise regularly, as tolerated? ☐ Yes ☐ No

j. Do you currently feel threatened or that you are being physically, mentally, or sexually abused? ☐ Yes ☐ No

k. Do you experience feelings of stress related to your health, finances, family or social relationships, work, etc.? ☐ Yes ☐ No

l. In general, how would you rate your overall health? ☐ Excellent/Very Good ☐ Good ☐ Fair ☐ Poor

m. In the past 3 months, have you had difficulty meeting your living expenses? ☐ Yes ☐ No

n. Within the past 12 months, you worried that your food would run out before you got money to buy more? ☐ Yes ☐ No

☐ Often true ☐ Sometimes true ☐ Never true

o. 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

p. 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.)

q. Are you able to afford your medications? ☐ Yes ☐ No

r. Do you have an advanced directive or living will? ☐ Yes ☐ No

s. What is the highest level of education you completed? ☐ Grade School ☐ High School ☐ Vocational School ☐ College

t. How well can you read? ☐ Very Well ☐ Well ☐ Not Well ☐ I cannot read

u. 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 daily? ☐ 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, are you up to date on your booster? ☐ Yes ☐ No

