

## 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).



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 or African American ☐ 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 Pressure ☐ High 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

