Health Plan of San Joaquin | Mountain Valley Health Plan

Advantage D-SNP

Health Risk Assessment

You are receiving this form because you have enrolled in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP (HMO). Your new plan will use this form to make sure you get needed care.

Please mark the square for the answers that apply to you. Complete one form for each person in your family who enrolled with us.

If you have questions, please call us at **1-888-361-7526 (TTY: 711).** Monday through Friday, 8:00 a.m. to 8:00 p.m. Please return the completed form in a self-addressed stamp envelope to:

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP
ATTN: CASE MANAGEMENT DEPARTMENT
7751 S. Manthey Road, French Camp, CA 95231

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Member ID#: ..... **Enrollment Date:** .....

Member Name: ..... **DOB:** .....

Member Address: .....

City: ..... **State:** ..... **Zipcode:** .....

1. What is your preferred language?
   - ☐ Arabic
   - ☐ Armenian
   - ☐ Chinese
   - ☐ English
   - ☐ Hindi
   - ☐ Hmong
   - ☐ Japanese
   - ☐ Korean
   - ☐ Laotian
   - ☐ Mein
   - ☐ Mon-Khmer, Cambodian
   - ☐ Persian (Farsi)
   - ☐ Punjabi
   - ☐ Russian
   - ☐ Spanish
   - ☐ Tagalog
   - ☐ Thai
   - ☐ Ukrainian
   - ☐ Vietnamese
   - ☐ Other

2. Please select the ethnic category or categories which you most closely identify with:
   - ☐ Hispanic
   - ☐ Non-Hispanic
   - ☐ I choose not to answer

3. Please select the racial category or categories which you most closely identify with:
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or another Pacific Islander
   - ☐ White
   - ☐ Multiracial
   - ☐ Other
   - ☐ I choose not to answer

4. Do you have any preferences or considerations we should be aware of? Please select all that apply.
   - ☐ Preferred Name
   - ☐ Religious/Spiritual/Cultural needs or ?
   - ☐ Hearing difficulty
   - ☐ Vision problems
   - ☐ Information provided in an Alternate Format (large print, audio CD, data CD, or Braille)
   - ☐ None
   - ☐ Other
   - ☐ I choose not to answer

5. Have you ever been diagnosed with any of the following?
   - ☐ Asthma
   - ☐ Cancer (actively being treated) Diabetes
   - ☐ High blood pressure
   - ☐ Heart failure
   - ☐ Stroke
   - ☐ Cognitive (memory concerns, such as Alzheimer's Disease or dementia) and/or development limitations
   - ☐ Blood disorders (including anemia, sickle cell, or clotting deficiencies
   - ☐ Liver disease, such as cirrhosis or ascites
   - ☐ Kidney failure/dialysis/End-State Renal Disease
   - ☐ Neurological disorder (such as epilepsy, multiple sclerosis)
   - ☐ Underweight/Overweight/Other Obesity
   - ☐ COPD (Chronic obstructive pulmonary disease)
   - ☐ Organ transplant
   - ☐ Other
   - ☐ I have never been diagnosed or treated for any health conditions

6. Are you pregnant?
   - ☐ Yes
   - ☐ No

7. If yes, are you currently seeing a doctor for this pregnancy?
   - ☐ Yes
   - ☐ No

8. Do you have any pain that interferes with your daily life?
   - ☐ Yes
   - ☐ No
   - ☐ Unsure
   - ☐ Refuse to answer

9. In the past 6 months, how often have you visited the emergency room or stayed overnight in the hospital?
   - ☐ Not at all
   - ☐ 1 time
   - ☐ 2 to 5 times
   - ☐ More than 6 times
   - ☐ I choose not to answer

10. Do you need assistance for yourself with any of the following?
    - ☐ Taking a bath or shower
    - ☐ Going up or down stairs
    - ☐ Eating
    - ☐ Getting dental care
    - ☐ Getting dressed
    - ☐ Brushing teeth, brushing hair, shaving
    - ☐ Making meals or cooking
    - ☐ Getting up out of a bed or chair
    - ☐ Shopping and getting food
    - ☐ Using the toilet
    - ☐ Walking
    - ☐ Washing dishes or clothes
    - ☐ Writing checks or keeping track of money
    - ☐ Getting a ride to the doctor or to see your friends
    - ☐ Doing house or yard work
    - ☐ Going out to visit family or friends
    - ☐ Using the phone
    - ☐ Keeping track of appointments
    - ☐ No, none of these areas are a problem

11. If yes, are you getting all the help you need with these actions?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

12. Do you need help taking your medicine?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

13. Have you had recent changes to your medications (new med, new dose, stopped any meds, etc)?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

14. Do you need help filling out health forms?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

15. Do you need help answering questions during a doctor's visit?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

16. Have you fallen in the last month?
    - ☐ Yes
    - ☐ No

17. Are you afraid of falling?
    - ☐ Yes
    - ☐ No

18. Are you currently enrolled to receive any services or resources through the Community, the County, or the State?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

19. Are you receiving all of the services you're supposed to receive?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

20a. How would you describe your current living situation?
    - ☐ 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)
    - ☐ I was recently incarcerated and came back to my home
    - ☐ I was recently in a Nursing Home and came back to my home

20b. Choose one:
    - ☐ Live in a home that I own
    - ☐ Live in a home/apartment that I rent
    - ☐ Live with family member
    - ☐ Live in a shelter
    - ☐ Live in a group home or sober living home
    - ☐ Live in assisted living facility
    - ☐ I am currently homeless/unsheltered
    - ☐ Something else
    - ☐ I choose not to answer

21. Think about the place you live. Do you have problems with any of the following?
    - ☐ Pests such as bugs, ants, or mice
    - ☐ Mold
    - ☐ Lead paint or lead pipes
    - ☐ Lack of good heating
    - ☐ Oven or stove not working
    - ☐ Smoke detectors missing or not working
    - ☐ Water Leaks
    - ☐ None of the above

22. Can you live safely and move easily around in your home?
    - ☐ Yes
    - ☐ No
    - ☐ Other

23. If no, does the place where you live have:
    - ☐ Good lighting
    - ☐ Good heating
    - ☐ Good cooling
    - ☐ Rails for any stairs or ramps
    - ☐ Hot water
    - ☐ Indoor toilet
    - ☐ A door to th outside that locks
    - ☐ Stairs to get into your home or stairs inside your home
    - ☐ Elevator
    - ☐ Space to use a wheelchair
    - ☐ Clear ways to exit your home
    - ☐ Explain other difficulty

24. Have you noticed any changes in thinking, remembering or making decisions?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

25. Do you have family members or others willing and able to help you when you need it?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

26. Do you ever think your caregiver has a hard time giving you the help you need?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

27. Are you afraid of anyone or is anyone hurting you?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

28. Is anyone using your money without your OK?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

29. Have you been diagnosed with or are currently being treated for any of the following behavioral health conditions? Please select all that apply.
    - ☐ I have never been diagnosed or treated for any behavioral health conditions
    - ☐ ADHD (attention deficit hyperactivity disorder)
    - ☐ Anxiety
    - ☐ Autism
    - ☐ Bipolar Disorder
    - ☐ Depression
    - ☐ Psychotic Disorder (schizophrenia)
    - ☐ Substance use disorder
    - ☐ Other:

30. Do you need any assistance getting connected to any mental or behavioral health services?
    - ☐ Yes
    - ☐ No

31. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?
    - ☐ Not at all
    - ☐ Several days
    - ☐ More than half the days
    - ☐ Nearly every day

32. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?
    - ☐ Not at all
    - ☐ Several days
    - ☐ More than half the days
    - ☐ Nearly every day

33. Over the last weeks, how often have you been bothered by little interest or pleasure in doing things?
    - ☐ Not at all
    - ☐ Several days
    - ☐ More than half the days
    - ☐ Nearly every day

34. Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?
    - ☐ Not at all
    - ☐ Several days
    - ☐ More than half the days
    - ☐ Nearly every day

35. Over the past month (30 days), how many days have you felt lonely?
    - ☐ None - I never feel lonely
    - ☐ Less than 5 days
    - ☐ More than half the days (more than 15)
    - ☐ Most days - I always feel lonely

36. Have you ever felt that you ought to cut down on your drinking or drug use?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

37. Do you currently use any tobacco products (smoke, vape, chew)?
    - ☐ Yes
    - ☐ No

38. In the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needing for daily living?
    - ☐ Yes
    - ☐ No

39. Do you sometimes run out of money to pay for food, rent, bills, and medicine?
    - ☐ Yes
    - ☐ No

40. 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
    - ☐ I choose not to answer

41. 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
    - ☐ I choose not to answer

42. Do you have a living will or an advanced directive in place (a document of your medical care wishes if you are unable to provide them)?
    - ☐ Yes
    - ☐ No
    - ☐ Unsure
    - ☐ Refuse to answer

43. Do you want information on living wills and advanced directives?
    - ☐ Yes
    - ☐ No

Signature: ..... Date: .....

Thank you for completing this form. Next step is to discuss your responses to this assessment and create a care plan.