SFHP Care Plus (HMO D-SNP)

# Health Risk Assessment Form

Completing this Health Risk Assessment form will take just a few minutes. By doing so, you are helping us serve you better. Once you have completed the form, send it back as soon as possible to SFHP Care Plus, P.O. Box 194247, San Francisco, CA 94119. If you prefer, you can provide us with the information over the phone by calling **1(415) 539-2273** or **711** (TTY). Your information is confidential.

**Do you consent to answering the questions in this assessment?**

☐ Yes

☐ No

**Instructions:**

a. Please read each question and mark the box like this: ☑ for your answer.

b. Some questions ask you to write an answer on the line. Please write your answers on the line next to the question.

| | | |
|---|---|---|
| Last Name: | | First Name: |
| SFHP ID #: | | Medicare Beneficiary Identifier (11 digit # on Medicare Card): |
| Phone (home): | Phone (cell): | Text Messaging Allowed:<br>☐ Yes<br>☐ No |
| Email: | | Email Communication Allowed:<br>☐ Yes<br>☐ No |
| Address: | | |

| | | | |
|---|---|---|---|
| City: | | State: | Zip Code: |
| Date of Birth: | Gender: | Pronouns:<br>☐ she/her ☐ he/him<br>☐ they/them ☐ Other: | |



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## GENERAL INFORMATION

**1. Did someone help you fill out this survey?**

☐ Yes, my caregiver ☐ Yes, my legal guardian ☐ Yes, family or friend

☐ No, I completed the survey by myself

☐ Other (please explain): _____

☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. If yes, why do you need help?**

☐ Cannot see well ☐ Do not read well ☐ Do not understand some questions

☐ Other (please explain): _____

☐ Not Applicable ☐ Decline to answer ☐ Unknown

**b. Do you usually need help filling out health forms?**

☐ Yes ☐ No

☐ Not Applicable ☐ Decline to answer ☐ Unknown

**2. What language do you prefer to speak?**

☐ English ☐ Spanish ☐ ASL ☐ Chinese ☐ Russian

☐ Vietnamese ☐ Tagalog ☐ Other: _____

☐ Not Applicable ☐ Decline to answer

**3. Are you deaf, have a hearing problem, or have serious hearing difficulty?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**4. Are you blind or have serious difficulty seeing, even when wearing glasses?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown



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## PAST AND CURRENT HEALTH

**5. In general, how would you rate your health?**

☐ Very good ☐ Good ☐ Fair ☐ Poor
☐ Decline to answer ☐ Unknown

**6. Do you have a Primary Care Provider (PCP)?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. When was the last time you saw your PCP or doctor?**

☐ Less than 6 months ☐ 6–12 months ago ☐ More than 1 year ago ☐ Never
☐ Not Applicable ☐ Decline to answer ☐ Unknown

**b. Is your PCP attentive to your concerns and do they treat you with courtesy and respect?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**7. In the last 6 months, how often were you able to get the care, tests, or treatment as soon as required?**

☐ Often ☐ Sometimes ☐ Rarely ☐ Never
☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. In the past 6 months, how many times have you been to the Emergency Room?**

☐ None ☐ One time ☐ Two or more times
☐ Not Applicable ☐ Decline to answer ☐ Unknown

**8. In the past 12 months, how many times did you stay at the hospital overnight?**

☐ None ☐ One time ☐ Two or more times
☐ Not Applicable ☐ Decline to answer ☐ Unknown

**9. Have you ever been treated for or told you have any of the following conditions?** Select all that apply.

☐ Alzheimer's or other Dementia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bipolar disorder
☐ Cancer
☐ Chronic obstructive pulmonary disease (COPD) or emphysema
☐ Depression
☐ Developmental disability
☐ Diabetes
☐ Dialysis
☐ Epilepsy or seizure disorder
☐ Heart failure
☐ Hepatitis C
☐ High blood pressure
☐ History of Transplant
  ☐ Bone Marrow ☐ Heart
  ☐ Kidney ☐ Liver
  ☐ Other: _____
☐ HIV or AIDS
☐ Kidney disease
☐ Liver problems
☐ Multiple sclerosis
☐ Schizophrenia
☐ Parkinson's disease
☐ Pregnant, Due Date: _____
  Are you receiving prenatal care? ☐ Yes ☐ No
☐ Stroke
☐ Thyroid problems
☐ Other: _____
☐ Decline to answer
☐ Unknown


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**10. Do you feel like any of your health problems are getting worse?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. Which health conditions?** _____

**11. Do you have any wounds, sores, or areas of skin breakdown?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. Where do you have the wounds, sores, or skin breakdown?** _____

**b. Are you getting treatment?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**c. Who is helping with your care?** _____

**12. In the last 6 months, how often did you and your PCP discuss all the prescription medications you were taking?**

☐ Often ☐ Sometimes ☐ Rarely ☐ Never

☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. How many prescribed medications do you take?**

☐ None ☐ 1–5 ☐ 6 or more

☐ Not Applicable ☐ Decline to answer ☐ Unknown

**b. Do you ever forget to take your medications or take them incorrectly?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**c. Do you need any help taking your medications (including picking them up or paying for them)?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**d. If yes, which ones?** _____

**13. Have you had any changes in thinking, remembering, or making decisions?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**14. Do you need help answering questions during a doctor's visit?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown



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## SPECIALISTS CARE

**15. Are you getting care from a specialist now?** (Specialists are doctors such as surgeons, heart doctors, skin doctors, mental health professionals and other doctors who are experts in one area of health care.)

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**If yes, who are you seeing, and what are you seeing them for?** Example: Jane Smith, Oncology

_____

_____

**a. In the last 6 months, how often were you able to get an appointment with a specialist as soon as you needed?**

☐ Often ☐ Sometimes ☐ Rarely ☐ Never

☐ Not Applicable ☐ Decline to answer ☐ Unknown

**16. When was the last time you saw a specialist?**

☐ Less than 6 months ☐ 6–12 months ago ☐ More than 1 year ago ☐ Never

☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. Are you happy with your specialists?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**b. Did your PCP seem informed and up to date about the care you received from all your specialists?**

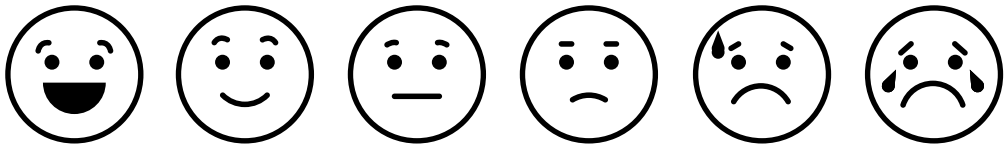
☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**17. Do you have pain that impacts your daily activities?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. If yes, where do you feel pain?** _____

**b. On a scale of 0 to 10, how would you rate your pain using the scale below?** _____



**0** No Hurt

**2** Hurts Little Bit

**4** Hurts Little More

**6** Hurts Even More

**8** Hurts Whole Lot

**10** Hurts Worse



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## LIVING ARRANGEMENT AND DAILY FUNCTIONING

**18. What is your current living arrangement?**

☐ Live alone
☐ Live with family, friend, or partner
☐ Live with paid caregiver
☐ Worried about losing it within 2 months
☐ Other (list): _____
☐ Experiencing homelessness
☐ Hotel/Motel
☐ Assisted living facility
☐ Decline to answer ☐ Unknown

**19. Can you live safely in your home and move around easily?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**If no, does the place where you live have:**

| | | |
|---|---|---|
| Good lighting | ☐ Yes | ☐ No |
| Good heating | ☐ Yes | ☐ No |
| Good cooling | ☐ Yes | ☐ No |
| Rails for any stairs or ramps | ☐ Yes | ☐ No |
| Hot water | ☐ Yes | ☐ No |
| Indoor toilet | ☐ Yes | ☐ No |
| A door to the outside that locks | ☐ Yes | ☐ No |
| Stairs to get into your home or stairs inside your home | ☐ Yes | ☐ No |
| Elevator | ☐ Yes | ☐ No |
| Space to use a wheelchair | ☐ Yes | ☐ No |
| Clear ways to exit your home | ☐ Yes | ☐ No |

**20. Do you need help with any of these actions?** ☐ Decline to answer ☐ Unknown

| | | | |
|---|---|---|---|
| Taking a bath or shower | ☐ Yes | ☐ No | ☐ Not Applicable |
| Going up stairs | ☐ Yes | ☐ No | ☐ Not Applicable |
| Eating | ☐ Yes | ☐ No | ☐ Not Applicable |
| Getting dressed | ☐ Yes | ☐ No | ☐ Not Applicable |
| Brushing teeth, brushing hair, shaving | ☐ Yes | ☐ No | ☐ Not Applicable |
| Making meals or cooking | ☐ Yes | ☐ No | ☐ Not Applicable |
| Getting out of bed or chair | ☐ Yes | ☐ No | ☐ Not Applicable |
| Shopping and getting food | ☐ Yes | ☐ No | ☐ Not Applicable |
| Using the toilet | ☐ Yes | ☐ No | ☐ Not Applicable |
| Walking | ☐ Yes | ☐ No | ☐ Not Applicable |
| Washing dishes or clothes | ☐ Yes | ☐ No | ☐ Not Applicable |
| Writing checks or keeping track of money | ☐ Yes | ☐ No | ☐ Not Applicable |
| Getting a ride to the doctor or to see your friends | ☐ Yes | ☐ No | ☐ Not Applicable |
| Doing house or yard work | ☐ Yes | ☐ No | ☐ Not Applicable |
| Going out to visit family and friends | ☐ Yes | ☐ No | ☐ Not Applicable |
| Using the phone | ☐ Yes | ☐ No | ☐ Not Applicable |
| Keeping track of appointments | ☐ Yes | ☐ No | ☐ Not Applicable |


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**a. If yes, are you getting all the help you need with these actions?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**21. Have you fallen in the last 3 months?** (A fall is when your body goes to the ground without being pushed.)

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. Are you afraid of falling?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**b. Did you talk with your PCP about falling or problems with balance or walking?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**c. Has your PCP recommended any of the following?**

☐ Cane or walker ☐ Exercise or physical therapy program ☐ Vision test ☐ Hearing test
☐ Not Applicable ☐ Decline to answer ☐ Unknown

**22. Do you have family members or others willing and able to help you when you need it?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. If yes, provide the name and relationship of the caregiver:**

_____

**23. Do you ever think your caregiver has a hard time giving you all the help you need?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. If yes, what support do you think your caregiver needs?**



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## SERVICES RECEIVED

**24. Do you use any of these aids? Select all that apply.**

- ☐ Braces or artificial limbs
- ☐ Catheter
- ☐ CPAP or BiPAP (a machine to help you sleep)
- ☐ Diabetes supplies (glucose meter, etc.)
- ☐ Diapers or incontinence supplies
- ☐ Hearing aids
- ☐ Hospital bed
- ☐ Infusions (intravenous [IV] medication)
- ☐ Ostomy bags or supplies
- ☐ Oxygen
- ☐ Tracheostomy (trach) or suction supplies
- ☐ Tube feeding supplies
- ☐ Walker or cane
- ☐ Wheelchair
- ☐ Not Applicable
- ☐ Decline to answer
- ☐ Unknown

**a. If you are not using any of these, do you need any aids?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**b. If yes, please list:** _____

**25. Within the past 12 months, have you sometimes run out of money to pay for food, rent, bills, and medicine?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**26. Is anyone using your money without your OK?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**27. Do you currently access any Medi-Cal services?**

- ☐ Transportation help
- ☐ County alcohol or drug outpatient services
- ☐ County mental health
- ☐ Food assistance programs (Meals on Wheels, CalFresh, food banks)
- ☐ Help paying utility bills
- ☐ In-Home Supportive Services (IHSS)
- ☐ Regional center
- ☐ Housing Services
- ☐ Dental
- ☐ Other community resource: _____
- ☐ Decline to answer
- ☐ Unknown



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## MENTAL WELL-BEING

**28. In the past 2 weeks, have you felt down, depressed, or hopeless?**

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday
☐ Not Applicable ☐ Decline to answer ☐ Unknown

**29. In the past 2 weeks, have you had little interest or pleasure in doing things?**

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday
☐ Not Applicable ☐ Decline to answer ☐ Unknown

**30. Over the past 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
☐ Not Applicable ☐ Decline to answer ☐ Unknown

**31. In the past year, have you been afraid of anyone hurting you?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**32. Have you had thoughts of harming yourself or others?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

## SOCIAL HISTORY

**33. Do you smoke, vape, or use tobacco?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. If yes, do you want help to quit?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**34. How often do you drink alcohol?**

☐ Never ☐ 1 time or less per month ☐ 2 to 4 times per month
☐ 2 to 3 times per week ☐ 4 or more times per week
☐ Not Applicable ☐ Decline to answer ☐ Unknown

**35. On a typical day when you drink, how many alcoholic beverages do you have?**

☐ 1 to 2 ☐ 3 to 4 ☐ 5 or more
☐ Not Applicable ☐ Decline to answer ☐ Unknown


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## HEALTH CARE PLANNING

**36. Do you have someone who makes health care and other choices for you?**

☐ No, I can make my own choices

☐ Yes, I have a friend or family member Name and relationship _____

☐ Yes, I have a legal guardian Name and relationship _____

☐ Not Applicable ☐ Decline to answer ☐ Unknown

**37. Do you have an advance healthcare directive?** (This is a document that tells doctors and hospitals what to do in case you are not able to speak for yourself.)

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**a. If yes, what kind?**

☐ Living will ☐ Durable power of attorney for health care

☐ Healthcare proxy ☐ Physician orders for life-sustaining treatment (POLST)

☐ Not Applicable ☐ Decline to answer ☐ Unknown

**b. If no, would you like to talk to someone about getting an advance healthcare directive?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

**38. Do you have any cultural and religious beliefs that affect your treatment choices?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown

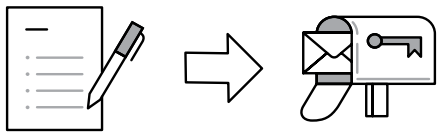
**39. In what format do you prefer to get health information?**

☐ Written (print) ☐ Written (large print) ☐ Braille

☐ Not Applicable ☐ Decline to answer ☐ Unknown

**40. This assessment will create goals to help us manage your care needs. Would you like a copy of these goals mailed to you after a major update?**

☐ Yes ☐ No ☐ Not Applicable ☐ Decline to answer ☐ Unknown



**Thank you for taking the time to share your healthcare experience with us.**

Please return this survey to:
SFHP Care Plus
P.O. Box 194247
San Francisco, CA 94119

Again, welcome to SFHP Care Plus. We are pleased to have you as a member.

You may request this document in alternative formats like braille, large size print, and audio. To request other formats, or for help with reading this document and other SFHP materials, please call Customer Service at **1(415) 539-2273** or toll-free at **1(833) 530-7327.** If you are hearing impaired, please call **711** for TTY.



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