blue california

Promise Health Plan

Medi-Cal Health Risk Assessment Survey

Instructions: Please complete and return it in the self-addressed stamped envelope provided. Blue Shield Promise uses this questionnaire to assist in assessing your health status. This information is confidential for Blue Shield Promise use only. If you are filling out this survey for a child under age 18, keep in mind that the questions are about the child, not you.

1. Did you receive your Blue Shield Promise ID card?

☐ Yes ☐ No

2. What is your primary language?

☐ English ☐ Spanish ☐ Other: _____

3. Where do you currently live?

☐ Live in an independent house, apartment, mobile home
☐ Live in an assisted living apartment, or board & care: Name: _____
☐ Live in a nursing home: Name: _____
☐ Other (describe): _____

4. What is your current living arrangement? *(Check each that applies)*

☐ Live alone
☐ With spouse/significant other
☐ With child(ren)
☐ With parent
☐ With other relative(s)
☐ With non-relative(s)
☐ With paid caregiver

5. Do you plan on changing your present living arrangements in the next 6 months?

☐ Yes ➔ *If yes, describe:* _____
☐ No

6. Do you know the name of your current Primary Care Physician (PCP)?

☐ Yes, name: _____
☐ No

7. Have you seen your current PCP in the last 3 months?

☐ Yes ➔ *If Yes, go to Question 8* ☐ No

7a. If no to #7, do you have a scheduled PCP appointment?

☐ Yes ☐ No

8. Have you had any problems getting medical care?

☐ Yes ☐ No ➔ *If No, go to Question 9*

8a. If yes to #8, please select the reasons below.

☐ Problems with transportation or parking
☐ Difficulty with wheelchair access
☐ Language problems such as staff does not speak your language
☐ Other: _____

9. **PLEASE ANSWER ONLY IF YOU ARE FEMALE:** Are you pregnant?

☐ Yes ☐ No

10. Are you under the care of a Specialist?

☐ Yes, name: _____ Specialty: _____

☐ No

11. Have you been to the Emergency Room in the past **6** months?

☐ Yes, how many times: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 or more

☐ No

12. Have you stayed overnight in a hospital in the past **12** months?

☐ Yes, how many times: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 or more

☐ No

13. Have you been in a Skilled Nursing Facility in the past **12** months?

☐ Yes, how many times: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 or more

☐ No

14. In general, would you say your health is: *(Check one answer)*

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

15. Do you need help with any of these actions?

		Yes	**No**
a.	Taking a bath or shower	☐	☐
b.	Going up stairs	☐	☐
c.	Eating	☐	☐
d.	Getting dressed	☐	☐
e.	Brushing teeth, brushing hair, shaving	☐	☐
f.	Making meals or cooking	☐	☐
g.	Getting out of a bed or a chair	☐	☐
h.	Shopping and getting food	☐	☐
i.	Using the toilet	☐	☐
j.	Walking	☐	☐
k.	Washing dishes or clothes	☐	☐
l.	Writing checks or keeping track of money	☐	☐
m.	Getting a ride to the doctor or to see your friends	☐	☐
n.	Doing house or yard work	☐	☐
o.	Going out to visit family or friends	☐	☐
p.	Using the phone	☐	☐
q.	Keeping track of appointments	☐	☐

15aa. If yes, are you getting all the help you need with these actions?

☐ Yes ☐ No

16. If you receive help with any of the actions in question #15, who is the helper?

Name	Relationship	Phone Number

17. Do you use any of the following special equipment or supplies **because of a disability or health problem?**

		Yes	No
a.	Walker	☐	☐
b.	Bedside commode	☐	☐
c.	Wheelchair	☐	☐
d.	Hoyer lift	☐	☐
e.	Cane	☐	☐
f.	Grab bars	☐	☐
g.	Bath bench	☐	☐
h.	Hospital bed	☐	☐
i.	Ramps	☐	☐
j.	Raised toilet seat	☐	☐
k.	Diapers	☐	☐
l.	Formula	☐	☐

18. Are you currently being treated for any of the following health conditions? For any yes answers, please describe.

		Yes	No	
a.	Dialysis	☐	☐	_____
b.	Memory loss	☐	☐	_____
c.	Arthritis	☐	☐	_____
d.	Urinary problems	☐	☐	_____
e.	Breathing problems	☐	☐	_____
f.	High blood pressure	☐	☐	_____
g.	Cancer	☐	☐	_____
h.	Circulation problems	☐	☐	_____
i.	Osteoporosis	☐	☐	_____
j.	Stomach/Bowel problems	☐	☐	_____
k.	Recent fracture (last 12 months)	☐	☐	_____
l.	Parkinson's	☐	☐	_____
m.	Ankle/Leg swelling	☐	☐	_____
n.	Uncorrected hearing loss	☐	☐	_____
o.	Congestive Heart Failure	☐	☐	_____
p.	If you have Congestive Heart Failure, have you been hospitalized for it in the last 12 months?	☐	☐	_____
q.	Other (describe):	☐		_____

18a. Have you ever been treated for the following conditions? If yes, describe.

		Yes	No	
a.	Stroke	☐	☐	_____
b.	Heart attack	☐	☐	_____
c.	Chest pain	☐	☐	_____
d.	AIDS	☐	☐	_____

19. Do you have Diabetes?

☐ Yes ☐ No ➔ *If No, go to Question 20*

19a. If yes, have you had a Diabetic Eye Exam done in the **past year**?

☐ Yes ☐ No/Don't know

20. How is your eyesight? (while wearing glasses or contacts, if applicable)

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Blind

20a. I would like to ask you about how you think you are managing your health conditions:

		Yes	No
a.	Are you taking medications on a regular basis?	☐	☐
b.	Do you need help taking your medicines?	☐	☐
c.	Are you having difficulties filling your medications?	☐	☐
d.	Do you need help filling out health forms?	☐	☐
e.	Do you need help answering questions during a doctor's visit?	☐	☐

21. Are you currently receiving any of the following services from an agency?

		Yes	No
a.	Home Health nurse	☐	☐
b.	Physical, occupational, speech therapy at home	☐	☐
c.	Home Health aide	☐	☐
d.	Social worker	☐	☐
e.	Adult day care center	☐	☐
f.	Assistance with transportation	☐	☐
g.	Other: _____		

22. Do you currently use or receive any of the following?

		Yes	No
a.	Feeding tube	☐	☐
b.	Oxygen	☐	☐
c.	Colostomy care	☐	☐
d.	Catheter care	☐	☐
e.	Other: _____		

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

☐ Yes ➔ *If Yes, go to Question 24* ☐ No

23a. If no, does the place where you live have:

		Yes	No
a.	Good lighting	☐	☐
b.	Good heating	☐	☐
c.	Good cooling	☐	☐
d.	Rails for any stairs or ramps	☐	☐
e.	Hot water	☐	☐
f.	Indoor toilet	☐	☐
g.	A door to the outside that locks	☐	☐
h.	Stairs to get into your home or stairs inside your home	☐	☐
i.	Elevator	☐	☐
j.	Space to use a wheelchair	☐	☐
k.	Clear ways to exit your home	☐	☐

24. Do you need help at **home because of health problems** and are unable to get help?

☐ Yes ☐ No

25. Do you receive In Home Supportive Services (IHSS)?

☐ Yes ☐ No

26. Do you receive services from any of the following agencies?

		Yes	No
a.	California Children Service (CCS)	☐	☐
b.	Regional Center	☐	☐
c.	Veterans Administration	☐	☐
d.	Family Planning, Access, Care and Treatment Program (Family PACT)	☐	☐
e.	Other programs not listed: _____		

27. Have you completed an Advance Directive? (A document that directs your health care wishes in the event you become ill)

☐ Yes ☐ No ➔ *If No, go to Question 27b*

27a. If yes to #27, is it on file with your PCP?

☐ Yes ➔ *If Yes, go to Question 27c* ☐ No ➔ *If No, go to Question 27c*

27b. If no to #27, are you interested in receiving information on Advance Directive?

☐ Yes ☐ No

27c. Have you fallen in the last month?

☐ Yes ☐ No

28. Have you fallen in the last 12 months?

☐ Yes ☐ No

28a. Are you afraid of falling?

☐ Yes ☐ No

29. Do you have any wounds, sores or skin breakdown?

☐ Yes ➔ *If yes, describe:* _____

☐ No

30. Do you currently have any pain?

☐ Yes ➔ *If yes, describe:* _____

☐ No ➔ *If No, go to Question 30d*

30a. Pain Severity Scale: 1-10, 10 being the most severe

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1	2	3	4	5	6	7	8	9	10

30b. Do you take medicine for pain?

☐ Yes ➔ *If yes, name of medicine(s):* _____

☐ No ➔ *If No, go to Question 30d*

30c. Does the pain medicine provide adequate relief of your pain?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ None of the time

30d. Have you had any changes in thinking, remembering, or making decisions?

☐ Yes ☐ No

30e. Over the past month (30 days), how many days have you felt lonely? (Check One)

☐ None – I never feel lonely ☐ More than half the days (more than 15)

☐ Less than 5 days ☐ Most Days – I always feel lonely

31. Do you see a doctor for a mental health condition such as:

		Yes	**No**
a.	Depression	☐	☐
b.	Bipolar disorder	☐	☐
c.	Schizophrenia	☐	☐
d.	Other: _____		

31e. If you answered no to any of the above: Do you feel you need to be evaluated by a mental health provider?

☐ Yes ☐ No

32. Do you feel you have a problem with:

		Yes	**No**
a.	Alcohol abuse	☐	☐
b.	Drug abuse	☐	☐

32c. If you answered yes to question #32a and/or #32b, are you presently getting care for your substance abuse?

☐ Yes ➔ *If Yes, go to Question 33* ☐ No

32d. If you answered no to question #32c, do you want assistance in getting care for your substance abuse?

☐ Yes ☐ No

33. Do you smoke?

☐ Yes ☐ No ➔ *If No, go to Question 34*

33a. If yes, are you interested in a Smoking Cessation Program?

☐ Yes ☐ No

34. Do you routinely get a flu shot every year?

☐ Yes ☐ No/Don't know

35. Are you a caregiver? (for a spouse or someone else)

☐ Yes ☐ No

36. Is there a friend, relative or neighbor who would take care of you for a few days, if necessary?

☐ Yes ☐ No ➔ *If No, go to Question 37*

36a. If yes, name, relationship, and day-phone of the person who could take care of you.

Name Relationship Phone Number

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

☐ Yes ☐ No

37a. Do you ever think your caregiver has a hard time giving you all the help you need?

☐ Yes ☐ No

37b. Are you afraid of anyone or is anyone hurting you?

☐ Yes ☐ No

37c. Do you sometimes run out of money to pay for food, rent, bills, and medicine?

☐ Yes ☐ No

37d. Is anyone using your money without your ok?

☐ Yes ☐ No

38. Do you receive home delivered meals or food from a food bank?

☐ Yes ➔ *If Yes, go to Question 39* ☐ No

38a. If no, would you like information for these programs?

☐ Yes ☐ No

39. Are you receiving any Energy Assistance Programs for your utilities?

☐ Yes ➔ *If Yes, go to Question 40* ☐ No

39a. If no, would you like information for these programs?

☐ Yes ☐ No

40. This survey was completed by:

- ☐ Member
- ☐ Parent: Name: _____ Phone #: _____
- ☐ Spouse: Name: _____ Phone #: _____
- ☐ Caregiver: Name: _____ Phone #: _____
- ☐ Other: Name: _____ Phone #: _____

41. Is there anything else you would like us to know about you?

_____

_____

_____

_____

Thank you for your time in completing this survey
Please mail the survey back in the enclosed postage-paid, self-addressed reply envelope.
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