Health Partners
Medicare

The plan you need. The care you deserve.

Health Risk Assessment

This survey is about your health. It is important that you complete the survey.
Your answers will help your care providers learn about your health.
Your health care benefits will not be affected in any way by your responses.
A family member can complete the survey for you if you are unable.

Member Information

Date ______________________ Name ______________________________

Member ID#____________________ Member DOB_____________________________

Address____

City_______________________________State__________________________

Phone Number____________________Cell Phone Number________________________

Can we send you a text message? **Yes** **No**

Can we send you an email message? **Yes** **No**

Email ____

Wellness Health Planning

1. Do you have an Advance Directive **Yes** **No**
2. Do you have a Medical Power of Attorney? **Yes** **No**
3. If you answered “yes” to either of the above questions, does your doctor have a copy of your:
   a. Advance Directive **Yes** **No**
   b. Medical Power of Attorney **Yes** **No**

Health Information

1. How many times have you been admitted to the hospital in the past 6 months?
   No Admission **1 Admission** **2 Admissions** **3 or more Admissions**

2. How many times have you been to the Emergency Room in the past 6 months?
   0 to 1 time **2 to 4 times** **5 or more times**

3. Do you have any planned future Admissions? **Yes** **No**
   If yes, what for?____

4. Rate your overall health
   Excellent **Very Good** **Good** **Fair** **Poor**

5. Do you have any of the following conditions? Check all that apply:

- **Alcohol Dependency/Misuse**
- **Alzheimer's/Dementia**
- **Anxiety**
- **Any falls within 6 months**
- **Arthritis**
- **Asthma**
- **Bladder Issues**
- **Cancer**
- **Chronic Obstructive Pulmonary Disease (COPD)**
- **Chronic Pain**
- **Congestive Heart Failure (CHF)**
- **Depression**
- **Diabetes**
- **End-Stage Renal Disease (ESRD)**
- **Hearing Impairment**
- **Heart Disease**
- **High Blood Pressure**
- **HIV/AIDS**
- **Memory Problems**
- **Obesity**
- **Opioid Dependency/Misuse**
- **Organ Transplant**
- **Parkinson's Disease**
- **Paralysis**
- **Peripheral Vascular Disease (PVD)**
- **Schizophrenia**
- **Seizures**
- **Smoking Dependency/Misuse**
- **Stroke**
- **Substance Abuse**
- **Thyroid Disease**
- **Vision Impairment**

6. Over the past two (2) weeks have you had little interest or pleasure in doing things?
   Not at All **Several Days** **More than One Half of the Days** **Nearly Every Day**

7. Over the past two (2) weeks have you been feeling sad, depressed or blue?
   Not at All **Several Days** **More than One Half of the Days** **Nearly Every Day**

8. Have you seen your primary care doctor in the past 12 months? **Yes** **No**

9. Do you use four (4) or more medications? **Yes** **No**

10. Do you have problems taking your medications prescribed by your doctor? **Yes** **No**

11. If yes, choose one of the following:
    - **I cannot get to a pharmacy**
    - **Costs too much money**
    - **I forget to take**
    - **I decline to take medications**
    - **Health plan benefit does not cover it**
    - **I do not like the way it makes me feel**
    - **I do not know why I need to take it**

Living Arrangements

1. Where do you currently live?

Homeless	**Shelter**	**Rented Room**
Boarding Home	**House**	**Apartment**
Assisted Living Facility	**Long-Term Care Facility**	**Group Home**

2. Who do you live with?

Alone	**Family Member**	**Spouse/Significant Other**
Friend	**Paid Help**	

Functional Status

1. Are the following activities of daily living difficult for you?

Bathing/Toileting	**No Difficulty**	**Some Difficulty**	**Unable to Do without Help**
Dressing	**No Difficulty**	**Some Difficulty**	**Unable to Do without Help**
Eating/Preparing Meals	**No Difficulty**	**Some Difficulty**	**Unable to Do without Help**
Getting up from sitting position	**No Difficulty**	**Some Difficulty**	**Unable to Do without Help**
Walking	**No Difficulty**	**Some Difficulty**	**Unable to Do without Help**
Taking Medications	**No Difficulty**	**Some Difficulty**	**Unable to Do without Help**
Getting in and out of bed/chair	**No Difficulty**	**Some Difficulty**	**Unable to Do without Help**
Housekeeping Chores	**No Difficulty**	**Some Difficulty**	**Unable to Do without Help**
Shopping	**No Difficulty**	**Some Difficulty**	**Unable to Do without Help**
Transportation	**No Difficulty**	**Some Difficulty**	**Unable to Do without Help**

Barriers

1. Do you know how to access your transportation benefit?	**Yes**	**No**
2. Are you concerned about being left homeless over the next 12 months?	**Yes**	**No**
3. Do you have any problems reading?	**Yes**	**No**
4. Do you leave your home at least once a week? `	**Yes**	**No**
5. Do you have a support person that you can rely on?	**Yes**	**No**
6. Do you have trouble buying food?	**Yes**	**No**

Goals

What are three (3) goals we could help you with to improve your health?

Goal 1______________________________________

Goal 2______________________________________

Goal 3______________________________________

Emergency Contact

Do you have an Emergency Contact Person?	**Yes**	**No**
Can we contact your Emergency Contact Person if we are not able to get in contact with you?	**Yes**	**No**

Name of Emergency Contact Person______________________________

Phone Number of Emergency Contact______________________________

Thank you for taking this survey. Please give us the best number to reach you and the best time of day to reach you to go over this information.

Name______________________________

Phone number______________________________

Best time of day to reach you______________________________

Please mail the survey back in the enclosed postage-paid, self-addressed reply envelope to:

Clark Resources
2771 Paxton Street
Harrisburg, PA 17111

Please call the Health Risk Assessment Unit at 1-855-748-3415 (TTY 1-877-454-8477), Monday – Friday, 9 a.m. – 9 p.m. and Saturday, 9 a.m. – 3 p.m., if you need help or have any questions about this survey.

Health Partners Medicare is an HMO plan with Medicare and Pennsylvania State Medicaid program contracts. Enrollment in Health Partners Medicare depends on contract renewal.

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