HealthPlan OF SAN MATEO
Healthy is for everyone

801 Gateway Blvd, Suite 100 | South San Francisco, CA 94080

HPSM Health Risk Assessment (HRA)

INTRODUCTION
Thank you for taking HPSM's Health Risk Assessment (HRA). The assessment takes about 20 minutes to complete. Your answers to these questions will help us understand your health care status and needs. Then we can ensure you get any health care services or supplies you may need.

After you take the HRA, HPSM will create a care plan just for you. You can participate in the meeting in which we start creating this plan. That will ensure your plan has everything you need. It can include your medications, doctor's visits, diet, exercise and more. You can review the care plan with your primary care doctor and also reach out to HPSM for anything you need. Your HRA and care plan are completely confidential.

If you have questions, call (toll free) **1-888-234-6403** or **650-227-4670**.
We are open Monday–Friday 8:00 am to 5:00 pm.

I. Your Personal Information

Date (mm/dd/yyyy) ____________

1: Please provide your personal information	
Member name	Preferred name
Date of birth (mm/dd/yyyy) ____________	HPSM member ID number (located on your HPSM ID card)
Phone number	Email address

2: Who completed this survey?	
Self (Member)	Legal representative
Family member/relative	Hired caregiver
Friend	Other ____________

3: What language do you prefer to speak and read? *Choose one box for your preferred spoken language, and one box for your preferred reading language.*						
English	Read	Speak	Russian	Read	Speak	Other ____________
Spanish	Read	Speak	Chinese *Mandarin*	Read	Speak	Don't know
Tagalog	Read	Speak	Chinese *Cantonese*	Read	Speak	Prefer not to answer

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Choose one answer to each question, unless the question says to choose more answers.

II. Your Health Care

Your answers to these questions will help us understand how you view your own health and how you engage with the health care system.

4a: Do you need help answering questions during a doctor's visit?			
Yes	No	Don't know	Prefer not to answer

4b: Do you need help filling out health forms?			
Yes	No	Don't know	Prefer not to answer

5: How would you rate your overall health over the past 4 weeks?			
Very poor	Poor	Good	Very Good
Excellent	Don't know	Prefer not to answer	

6: Why is your health important to you?	
Is there something you cannot do and want to do because of your health currently? What about your health would you like to improve? What is your biggest concern about your health at this point? ______________________________	Don't know
	Prefer not to answer

7a: What provider/doctor/clinic do you visit the most?	
Name of provider/doctor/clinic ______________________________	Don't know
	Prefer not to answer

7b: Is the provider listed above a PCP, specialist or some other type of provider?		
PCP	Specialist	Clinic
Other ______________	Don't know	Prefer not to answer

II. Your Health Care *Continued*

8a: Do you have any upcoming health care appointments or treatments scheduled?			
Yes	No	Don't know	Prefer not to answer

8b: Do you need HPSM to assist with coordinating your appointments or treatments?			
Yes	No	Don't know	Prefer not to answer

8c: Do you need help getting any of the following services or supplies?	Yes	No	Don't know	Prefer not to answer
Oral/dental healthcare (denture care, cavities, cleanings, pain, etc.)				
Specialist healthcare (heart, lungs, pain, mental health, etc.)				
Sexual healthcare (Ob Gyn, family planning, urology, etc.)				
Medications (prescribed by your provider)				
Incontinence supplies (adult diapers) **and/or treatment**				
Medical supplies (diabetes care, blood pressure, wound care, oxygen, etc.)				
Other				

8d: Do you need help taking your medications?			
Yes	No	Don't know	Prefer not to answer

9: Do you have a plan in case of an emergency-type situation? (Fire, earthquake, public health event, etc.)			
Yes	No	Don't know	Prefer not to answer

II. Your Health Care *Continued*

10a: Do you have a plan for your healthcare if you cannot make decisions?			
Yes	No	Don't know	Prefer not to answer

10b: Do you have someone who makes choices for you, such as a legal representative, or are you able to make your own choices?			
I can make my own choices	I have a person who helps me make choices	Don't know	Prefer not to answer

10c: If you have a legal representative can you provide their name and best contact number below?		
Name	Phone number	Relationship to member

III. Living Environment

This section will help us understand your living situation and how it impacts your health. It will also help us understand whether you need additional equipment or referrals to other resources.

11a: What is your current living/housing situation (past 6 months)?		
House, apartment or trailer	Car or mobile home	Rooming house or shared/ individual room in an assistance type facility
Hotel or Motel	Hospital, treatment facility or nursing home	I do not have housing (in a shelter, outside on the street, on a beach or in a park)
Other ________	Don't know	Prefer not to answer

11b: If you live in a facility, do you want to leave?			
Yes	No	Don't know	Prefer not to answer

III. Living Environment *Continued*

12: Are you worried about your housing?			
Yes	No	Don't know	Prefer not to answer

13: Are you afraid of anyone or is anyone hurting you?			
Yes	No	Don't know	Prefer not to answer

14: Can you live safely and move easily around in your home?			
Yes *Please proceed to **question 16***	No *Please answer **question 15***	Don't know	Prefer not to answer

15: If you answered no to question 14, does the place where you live have:	Yes	No	Don't know	Prefer not to answer
Good lighting				
Good heating				
Good cooling				
Rails for any stairs or ramps				
Hot water				
Indoor toilet				
A door to the outside that locks				
Stairs to get into your home or stairs inside of your home				
Elevator				
Space to use a wheelchair				
Clear ways to exit your home				

III. Living Environment *Continued*

16: Do you eat balanced meals daily (variety of vegetables, protein, healthy grains)?			
Yes	No	Don't know	Prefer not to answer

17: Do you exercise for 2 to 3 hours every week? (for example: brisk walking for 30 minutes a day, 5 days a week)			
Yes	No	Don't know	Prefer not to answer

18a: What is your primary mode of transportation?			
Car	Bus/Public transit	Taxi/Ride-share	Bicycle
Walking	Other ______	Don't know	Prefer not to answer

18b: If a seat belt is available how often do you use it?			
Always	Most times	Sometimes	Rarely
Never	Don't know	Prefer not to answer	

19: Are you currently affected by any of the following issues?	Yes	No	Don't know	Prefer not to answer
Seeing: do you bump into things around your house?				
Do you use/need help getting glasses/contacts?				
Hearing: has anyone ever suggested you get your hearing tested?				
Do you use/need help getting hearing aids?				
Do you use/need help getting a cane, walker or wheelchair?				
If yes, please specify which	Cane	Walker	Wheel chair	Other ______
Oral health (dental care, dentures, concerns regarding teeth/mouth)				
Do you use/need help getting dentures?				

III. Living Environment *Continued*

20a: Do you need help with any of these actions?	Yes	No	Don't know	Prefer not to answer
Taking a bath or shower				
Going up stairs				
Making meals or cooking				
Shopping and getting food				
Eating				
Getting Dressed				
Brushing hair, brushing teeth, shaving				
Getting out of a bed or a chair				
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				

20b: If you answered yes to any actions in the question 20a, are you getting all the help you need with these actions?			
Yes	No	Don't know	Prefer not to answer

III. Living Environment *Continued*

21: Do you have family members or others willing and able to help you when you need it?			
Yes	No	Don't know	Prefer not to answer

22: Do you ever think your caregiver has a hard time giving you all the help you need?			
Yes	No	Don't know	Prefer not to answer

23a: Are you afraid of falling?			
Yes	No	Don't know	Prefer not to answer

23b: Have you fallen in the last month?			
Yes	No	Don't know	Prefer not to answer

24a: Is anyone using your money without your ok?			
Yes	No	Don't know	Prefer not to answer

24b: Do you sometimes run out of money to pay for food, rent, bills and medicine?			
Yes	No	Don't know	Prefer not to answer

Continue to ***IV. Well-being***

IV. Well-being

This section will help us understand how you feel physically, mentally and emotionally.

25: How much does PAIN interfere with your ability to complete daily tasks?									
1 Not at all	2	3	4	5	6	7	8	9	10 All the time
				Don't know			Prefer not to answer		

26: How much does FATIGUE interfere with your ability to complete daily tasks?									
1 Not at all	2	3	4	5	6	7	8	9	10 All the time
				Don't know			Prefer not to answer		

27: Over the past month (30 days), how many days have you felt lonely?					
None (I never feel lonely)	Less than 5 days	More than 15 days	Most days (I always feel lonely)	Don't know	Prefer not to answer

28: Over the past two weeks, how often have you had little interest or pleasure in doing things?					
Not at all	Several days	More than half the days	Nearly every day	Don't know	Prefer not to answer

29: Over the past two weeks, how often have you felt down, depressed or hopeless?					
Not at all	Several days	More than half the days	Nearly every day	Don't know	Prefer not to answer

30: Have you had any changes in thinking, remembering or making decisions?			
Yes	No	Don't know	Prefer not to answer

IV. Well-being *Continued*

31a: Do you currently use any tobacco products (smoke, vape, chew, etc.)? *Choose all that apply.*		
I do not use tobacco products	Yes, I use the following tobacco product(s): Smoke Vape Chew Other ____________	Don’t know Prefer not to answer

31b: Does anyone in your household currently use any tobacco products (smoke, vape, chew, etc.)? *Choose all that apply.*		
No one in my household uses tobacco products	Yes, someone uses the following tobacco product(s): Smoke Vape Chew Other ____________	Don’t know Prefer not to answer

32: In the past year, how often did you drink any type of alcoholic beverage?		
Never	Few times a year	Monthly
A few times a month	Weekly	A few times a week
Daily	Don’t know	Prefer not to answer

33: Has anyone ever commented on your drinking/smoking/drug use?			
Yes	No	Don’t know	Prefer not to answer

*Continue to **V. About You***

V. About You

This section will help us understand more about your personal background.

34: What is your race and/or ethnicity? *Choose all that apply.*		
White	Black/African American	American Indian or Alaska Native
Hispanic or Latino *please specify below:* Mexican, Mexican American, Chicano Salvadoran Guatemalan Cuban Puerto Rican Other ______	Asian *please specify below:* Asian Indian Cambodian Chinese Filipino Hmong Japanese Korean Laotian Vietnamese Other ______	Native Hawaiian or Other Pacific Islander *please specify below:* Native Hawaiian Guamanian or Chamorro Samoan Other ______
Other race and/or ethnicity ______	Don't know	Prefer not to answer

35: How do you identify?			
Male	Female	Transgender man/ trans man/female-to-male (FTM)	Transgender woman/ trans woman/male-to-female (MTF)
Neither exclusively male nor female; genderqueer/gender nonconforming	Additional gender category (or other) *please specify:* ______	Don't know	Prefer not to answer

36: Are you a U.S. Armed Forces veteran?			
Yes	No	Don't know	Prefer not to answer

V. About You *Continued*

37: Do you have any final thoughts or are there any immediate needs that you would like us to follow up on?

Thank you!

Enclosure: Non-Discrimination Notice and Language Assistance