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 **650-616-5035** or **1-888-783-3035** (toll free). We are open Monday – Friday 8:00 am to 5:00 pm.

Please completely fill in the bubble like this example:

Right	Wrong
●	◔ ✓ ✗ ○

Survey begins on page 2 ↪

OFFICE USE ONLY

PROCESSED BY: RECEIVED: SENT:

Today's Date _____

Personal Information

1. Please provide your personal information.			
Member name		Date of birth	
Home phone number		HPSM member ID number	
Cell phone number		Alternate phone number	
Email address			

2. Who completed this survey?			
◯ Self (Member)	◯ Representative	◯ Family member/relative	◯ Caregiver
◯ Friend	◯ Other		

3. How was the survey completed?		
◯ Mailed by Member/Caregiver/Representative	◯ Completed by phone	◯ Completed in person

Survey continues on page 3 ↪

Health Care

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

◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

5. Do you need help filling out health forms?

◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

6. 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

7. What provider/doctor/clinic do you visit the most?

Name of provider/doctor/clinic _____

	◯ Don't know	◯ Prefer not to answer

8. Is the provider listed above a PCP, Specialist or Clinic?

◯ PCP	◯ Specialist	◯ Clinic	
		◯ Don't know	◯ Prefer not to answer

9. Do you have any upcoming health care appointments that HPSM can assist with coordinating?

◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

Survey continues on page 4 ↪

Health Care *Continued*

10. Do you currently NEED HELP getting any of the following services or supplies?	Yes	No	Don't know	Prefer not to answer
Oral/Dental Care (dentures, cavities, cleanings, pain, etc.)	○	○	○	○
Specialist Care (heart, lungs, pain, mental health, etc.)	○	○	○	○
Vision (glasses, contacts etc.)	○	○	○	○
Hearing (hearing aids)	○	○	○	○
Medications (prescribed by your provider)	○	○	○	○
Sexual Health Care (OB/GYN, family planning, urology, etc.)	○	○	○	○
Incontinence Supplies (adult diapers) and/or Treatment	○	○	○	○
Medical Equipment and/or Supplies (cane, walker, wheelchair, diabetes care, blood pressure, wound care, oxygen, etc.)	○	○	○	○
Interpreter Services	○	○	○	○

11. Do you need help taking your medications?

○ Yes	○ No	○ Don't know	○ Prefer not to answer

12. Do you know what to do in the event of an emergency (fire, earthquake, public health event, etc.)**?**

○ Yes	○ No	○ Don't know	○ Prefer not to answer

Survey continues on page 5

Health Care *Continued*

13. Do you have a plan for your health care if you cannot make decisions?

◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

13a. If no, do you have someone who makes choices for you, such as a 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

13b. If you have a representative or someone who acts on your behalf, can you give their name and best contact number?

Name _____

Phone Number _____ Relationship to member _____

Survey continues on page 6

Living Environment

14. What is your living situation today?

☐ I have a steady place to live: (*Choose one that applies*)

- ◯ Car or Mobile home
- ◯ Hospital, treatment facility or nursing home
- ◯ Hotel or motel
- ◯ House, apartment, or trailer
- ◯ Rooming house or shared/individual room in an assistance type facility

☐ I have a steady place to live today but I am worried about losing it in the future

☐ I do not have a steady place to live (staying with others, in a hotel, in a shelter, living outside on the street, on the beach, in a car, in park)

☐ Don't know

☐ Prefer not to answer

15. Think about the place <u>where</u> you live. Do you have problems with any of the following? (*Choose all that apply*)

- ☐ Pests such as bugs, ants, or mice
- ☐ Lead paint or pipes
- ☐ Oven or stove not working
- ☐ Water leaks
- ☐ Mold
- ☐ Lack of heat
- ☐ Smoke detectors missing or not working
- ☐ None of the above
- ☐ Don't know
- ☐ Prefer not to answer

Survey continues on page 7

Living Environment *Continued*

16. Does the place where you live have:	Yes	No	Does not apply to the place where I live	Don't know	Prefer not to answer
Rails for any stairs or ramps	○	○	○	○	○
Space to use a wheelchair	○	○	○	○	○
Stairs to get into your home or stairs inside of your home	○	○	○	○	○
Elevator	○	○	○	○	○
A door to the outside that locks	○	○	○	○	○
Clear ways to exit your home	○	○	○	○	○
Good lighting	○	○	○	○	○
Good heating	○	○	○	○	○
Good cooling	○	○	○	○	○
Hot water	○	○	○	○	○
Indoor toilet	○	○	○	○	○

17. Are you afraid of anyone or is anyone hurting you?

○ Yes	○ No	○ Don't know	○ Prefer not to answer

Survey continues on page 8 ↪

Function

18. 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?	○	○	○	○
Hearing: Has anyone ever suggested you may need your hearing tested?	○	○	○	○
Oral health: Do you have concerns regarding your teeth/mouth?	○	○	○	○

19. 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 or down the 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	○	○	○	○

Survey continues on page 9

Function *Continued*

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

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

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

24. Have you fallen in the last month?			
◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

Survey continues on page 10 ↪

Utilities/Finances

25. Is anyone using your money without your okay?			
◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

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

27. 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	
		◯ Don't know	◯ Prefer not to answer

28. 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	
		◯ Don't know	◯ Prefer not to answer

Survey continues on page 11 ↪

Transportation

29. What is your primary mode of transportation?			
○ Car	○ Bus/Public transit	○ Taxi/Ride-share	○ Bicycle
○ Walking		○ Don't know	○ Prefer not to answer

30. Do you put off or neglect going to the doctor because of distance or transportation?			
○ Yes	○ No	○ Don't know	○ Prefer not to answer

31. Has lack of transportation kept you from getting to medical appointments, meetings, work or getting things needed for daily living?			
○ Yes	○ No	○ Does not apply to me	
		○ Don't know	○ Prefer not to answer

Survey continues on page 12 ↪

Wellness

32. Do you exercise for 2 to 3 hours every week (brisk walking for 30 minutes a day, 5 days a week)**?**

◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

33. 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	

34. 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	

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

◯ None	◯ Less than 5 days	◯ More than 15 days	◯ Nearly every day
		◯ Don't know	◯ Prefer not to answer

36. Over the past two weeks (14 days), how often have you had little interest or pleasure doing things?

◯ None	◯ Less than 5 days	◯ More than 7 days	◯ Nearly every day
		◯ Don't know	◯ Prefer not to answer

37. Over the past two weeks (14 days), how often have you felt down, depressed or hopeless?

◯ None	◯ Less than 5 days	◯ More than 7 days	◯ Nearly every day
		◯ Don't know	◯ Prefer not to answer

Survey continues on page 13 ↪

Wellness *Continued*

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

◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

39. Do you currently use any tobacco products (smoke, vape, chew)**?**

◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

If yes, I use the following tobacco product(s): *(Choose all that apply)*

☐ Smoke ☐ Vape ☐ Chew

40. Does anyone in your household currently use any tobacco products (smoke, vape, chew)**?**

◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

If yes, someone in my household uses the following tobacco product(s): *(Choose all that apply)*

☐ Smoke ☐ Vape ☐ Chew

41. How often do you have a drink containing alcohol?

◯ Never	◯ Monthly or less	◯ 2 to 4 times a month	◯ 2 to 3 times a week
◯ 4 or more times a week		◯ Don't know	◯ Prefer not to answer

42. Has anyone ever commented on your drinking, smoking, and/or drug use?

◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

Survey continues on page 14 ↪

About You

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

44. Are there any immediate needs that you would like us to follow up on?			
◯ Yes	◯ No	◯ Don't know	◯ Prefer not to answer

44a. If yes, provide your preferred contact information:

Phone _____

Save Form

Thank you for taking the survey.