Santa Clara Family Health Plan™

Health Risk Assessment (HRA) Form

MEMBER INFORMATION

Today's Date: _____

Member Name: _____

SCFHP ID Number: _____

Date of Birth: _____

Address: _____

Telephone Number: _____ Email: _____

Name of Person Completing HRA: _____

Telephone Number: _____

Relationship to Member: _____

MEMBER DEMOGRAPHICS

1. **Gender:** ☐ Male ☐ Female ☐ Transgender male/trans man/female-to-male (FTM) ☐ Transgender female/trans woman/male-to-female (MTF) ☐ Genderqueer, neither exclusively male nor female ☐ Prefer not to Disclose ☐ Additional gender category or other (please specify): _____

2. **Gender Assigned at Birth:** ☐ Male ☐ Female ☐ Unknown ☐ Prefer not to Disclose

3. **Pronouns:** ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other (please specify): _____

4. **Sexual Orientation:** ☐ Straight or Heterosexual ☐ Gay or Lesbian or Homosexual ☐ Bisexual ☐ Don't know ☐ Prefer not to Disclose ☐ Something else (please specify): _____

5. **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

6. **Height:** _____ ft. _____ in. **Weight:** _____ lbs.

7. **Race/Ethnicity:**

☐ White ☐ Black or African American ☐ Asian

☐ Hispanic ☐ Alaska Native or Native American ☐ Native Hawaiian or Pacific Islander

☐ Unknown ☐ Other: _____

8. Preferred Language:

Spoken

☐ English ☐ Spanish ☐ Tagalog
☐ Mandarin ☐ Cantonese ☐ Farsi
☐ Vietnamese ☐ Hindi ☐ Other: _____

Written

☐ English ☐ Spanish ☐ Tagalog
☐ Traditional Chinese ☐ Simplified Chinese ☐ Vietnamese
☐ Other: _____

9. Would you like to choose someone to be your authorized representative with Santa Clara Family Health Plan (SCFHP)?

An authorized representative is someone who you can choose to speak on your behalf with SCFHP regarding your healthcare. Your authorized representative may use, receive, or disclose your Protected Health Information with SCFHP. If Yes, an Authorized Representative Form will be mailed to you to complete and return.

☐ Yes ☐ No

10. Do you have a legal document that gives someone permission to make health care decisions for you if you are unable to?

☐ Yes ☐ No

If Yes, please select the type of document that you have.

Please check all that apply:

☐ Durable Power of Attorney ☐ Do not resuscitate (DNR)
☐ Guardianship/Conservatorship ☐ Advance Directive
☐ Other: _____

If No, have you discussed Advanced Directives with your Primary Care Provider (PCP)?

☐ Yes ☐ No

MEDICAL HISTORY

11. PCP Name: _____

Date last seen by your PCP: _____

Specialty Physicians (if applicable)**:**

a) Specialty: _____ b) Specialty: _____

Name: _____ Name: _____

Date of Last Appointment: _____ Date of Last Appointment: _____

c) Specialty: _____ d) Specialty: _____

Name: _____ Name: _____

Date of Last Appointment: _____ Date of Last Appointment: _____

12. How would you describe your physical health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

13. How would you describe your mental health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

14. Do you see a doctor or therapist regularly for a mental health condition?

☐ Yes ☐ No

15. Have you been diagnosed or treated for any of these conditions?
Please check all that apply:

☐ Arthritis
☐ Asthma
☐ Cancer
☐ Chronic Pain
☐ COPD (Chronic Obstructive Pulmonary Disease)
☐ Congestive Heart Failure
☐ Coronary Artery Disease: Examples: High blood pressure, Heart attack, Heart surgery, Chest pain
☐ Depression
☐ Diabetes
☐ Developmental Disability Examples: Autism, Cerebral Palsy, Down Syndrome
☐ Hearing Problem
☐ High Cholesterol
☐ Infectious Disease Examples: Hepatitis, HIV/AIDS, Tuberculosis
☐ Kidney Disease Examples: End Stage Renal Disease, Dialysis
☐ Limited Vision
☐ Liver Disease
☐ Memory Problems Examples: Dementia, Alzheimer's
☐ Organ Transplant
☐ Schizophrenia/Bipolar Disorder
☐ Seizures
☐ Stroke
☐ Other: _____

16. How many different medications are you currently taking?

☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11+

17. Do you understand how to take your medications?

☐ Yes ☐ No

18. Do you have trouble getting or picking up your medications?

☐ Yes ☐ No

19. How much does pain interfere with your normal activities?

☐ Not at All ☐ A Little Bit ☐ Moderately ☐ A Lot ☐ Extremely

20. What are you currently doing to manage your pain?
Please check all that apply:

☐ Medication ☐ Physical Therapy ☐ Pain Management Clinic
☐ Nothing Currently ☐ Other: _____

HEALTH INFORMATION

21. Are you using any of these supplies or equipment right now?
Please check all that apply:

☐ Blood pressure monitor ☐ Incontinence supplies ☐ Tube feeding supplies
☐ C-Pap or Bi-Pap ☐ Nebulizer ☐ Ventilator
☐ Cane ☐ Ostomy supplies ☐ Walker
☐ Diabetes supplies ☐ Oxygen ☐ Wheelchair
☐ Eyeglasses/Contacts ☐ Portable toilet ☐ Wound care supplies
☐ Hearing aids ☐ Prosthetics ☐ None
☐ Hospital Bed/Hoyer Lift ☐ Suction supplies
☐ Other (Please specify): _____

22. Do you need help with getting any supplies or equipment at this time?

☐ Yes ☐ No

If Yes, please specify: _____

23. Do you need help filling out paperwork or writing?

☐ Yes ☐ No

24. Do you need help to talk to your doctor about your health?

☐ Yes ☐ No

25. Do you smoke cigarettes, use a vape pen, or other nicotine/tobacco products on a regular basis?

☐ Yes ☐ No

If Yes, would you like help to reduce your tobacco usage?

☐ Yes ☐ No

26. Do you feel you drink too much alcohol?

☐ Yes ☐ No

If Yes, would you like to discuss ways to help you drink less?

☐ Yes ☐ No

27. Are you using any drugs or taking prescription medications in a way that's not prescribed for you?

☐ Yes ☐ No

If Yes, would you like to discuss ways to help you use these drugs and/or medications less?

☐ Yes ☐ No

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

☐ Yes ☐ No

29. On average, how often do you feel lonely?

☐ Almost every day

☐ Sometimes

☐ Rarely

☐ Never

30. In the last 30 days, how often have you felt the following:

a) Little interest or pleasure in doing things

☐ Not at all

☐ Several days

☐ More than half the days

☐ Nearly every day

b) Feeling down, depressed or hopeless

☐ Not at all

☐ Several days

☐ More than half the days

☐ Nearly every day

If you are having thoughts of hurting yourself or others, please call the Suicide Prevention and Crisis Line at 9-8-8.

ACTIVITIES OF DAILY LIVING

31. Do you need help with any of these actions?
Please check "YES" or "NO" for each item:

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

If you answered Yes to any of the actions listed above, are you getting all the help you need?

☐ Yes ☐ No

If No, please specify:

_____

32. Do you have family members, friends, and/or caregivers who are willing and able to help you when you need it?

☐ Yes ☐ No

If Yes, do you think they ever have a hard time giving you all the help you need?

☐ Yes ☐ No

33. Do you sometimes use the phone and/or internet for your medical appointments?

☐ Yes ☐ No

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

☐ Yes ☐ No

35. Have you fallen in the last six (6) months?

☐ Yes ☐ No

If Yes, please specify how many times: _____

36. Are you afraid of falling?

☐ Yes ☐ No

SERVICES AND SUPPORTS

37. Are you currently using or receiving any of these resources in your community?

Please check "YES" or "NO" for each item:

	YES	NO
a) Case Manager, Social Worker, and/or Care Coordinator	☐	☐
Case Manager Name: _____		
Agency: _____		
Contact Information: _____		
b) Community-Based Adult Services/Adult Day Health Center	☐	☐
c) Community or Senior Center	☐	☐
d) County alcohol or drug outpatient program	☐	☐
e) County mental health case management services	☐	☐
f) Food assistance programs (Examples: Meals on Wheels, CalFresh, food banks)	☐	☐
g) Help paying utility bills/rent	☐	☐
h) Hospice/palliative care program	☐	☐
i) In-Home Supportive Services (IHSS)	☐	☐
If Yes, what is the name of your provider or caregiver? _____		
j) Mental Health Services	☐	☐
Case Manager Name: _____		
Agency: _____		
Contact Information: _____		

k) Social Security ☐ ☐

l) Transportation Services ☐ ☐

m) Veterans Affairs ☐ ☐

n) Wellness Organizations (such as exercise or disease management classes) ☐ ☐

o) Other community resources ☐ ☐

If Yes, please specify:

_____

38. Are you interested in getting information about any of the following resources?
(Please check "YES" or "NO" for each item)

	YES	NO
a) Dental	☐	☐
b) Vision	☐	☐
c) Gym/Fitness	☐	☐

39. Do you ever run out of money to pay for any of the following?
Please check all that apply:

☐ Food ☐ Rent ☐ Utilities ☐ Bills ☐ Medicine

40. Is anyone using your money without your consent?

☐ Yes ☐ No

41. Are you afraid of someone close to you or is someone close to you hurting you?

☐ Yes ☐ No

If Yes, your Case Manager will follow up with you.

What is the best time and contact phone number to call you?
Telephone Number: _____ Date/Time: _____

<u>If you are in immediate danger, please call 9-1-1.</u>

LIVING ARRANGEMENTS

42. In the past six (6) months, have you been living in stable housing?

☐ Yes ☐ No

43. What type of residence are you currently living in?

☐ Assisted living facility ☐ Long Term Care ☐ Senior Community

☐ Homeless/Car/Outside ☐ Own my residence ☐ Shelter

☐ Living in a friend or family member's home ☐ Rent my residence ☐ Other: _____

_____

44. Who do you live with?

Please check all that apply:

☐ I live alone ☐ Significant other/Partner/Spouse ☐ Friend ☐ Roommate/s

☐ Family member. Relationship to member: _____

☐ Other: _____

45. Are you worried or concerned that in the next six (6) months you may NOT have stable housing?

☐ Yes ☐ No

If Yes, please specify why:

☐ Threatened with/Received Eviction Notice ☐ Unaffordable housing ☐ Housing is barely adequate for my needs

☐ Other: _____

ADDITIONAL INFORMATION

46. What are your main concerns right now?

1) _____

2) _____

3) _____

47. Would you like to work with a Case Manager to customize your care plan?

A care plan is a set of health goals created by you and your care coordinators to help you manage your health and reach your health care goals. Many members find it helpful to work with their care coordinators to customize their Care Plan.

☐ Yes ☐ No

48. Would you like your Case Manager to schedule a meeting with your Care Team?

In this meeting we will discuss your Care Plan with you and your Care Team to help you reach your health and wellness goals.

☐ Yes ☐ No

Would you like to include anybody else in your Care Team such as family members, friends, caregivers, and/or your doctors?

☐ Yes ☐ No

If Yes, who?

Name: _____

Relationship: _____

Telephone Number: _____

Name: _____

Relationship: _____

Telephone Number: _____

49. Over the past year (12 months), how would you rate your health care from 0 to 10?

0 is the worst and 10 is the best health care possible: _____

Please provide any additional details you would like us to know: _____

_____

_____

_____

_____