L.A. Care
HEALTH PLAN®

lacare.org

Health Risk Assessment

Fold in half and place in the enclosed envelope. No postage is necessary.
Call **1.855.810.9724** if you have questions or want to complete the survey over the phone.

LAC_2017_0052_HRA

LA1609 CMC 11/17

Health Risk Assessment

Member Last Name: _____

Member First Name: _____

Member #: _____ DOB: ____/____/_____

Phone Number: (____) ____ - _____ Alternative Phone Number: (____) ____ - _____

Email Address: _____

Address (Street Number and Name): _____

City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female ☐ Other

Written Language Preference: _____

Spoken Language Preference: _____

Who is completing this survey? *(If you need help with this survey, please call L.A. Care's Member Services Department at **1.855.810.9724**).*

☐ Member

☐ Member, with help from a family member

☐ Member's Power of Attorney

☐ Legal Guardian

☐ A Caregiver

☐ Other

Relationship: _____ Name: _____

Contact Info: _____

FUTURE MEDICAL APPOINTMENTS AND SUPPLIES

The following questions help L.A. Care make sure you keep your scheduled appointments and that you continue to receive the supplies and services you have in place. It is important that there is no interruption in the care you are already receiving.

1. Do you have any health care visits scheduled within the next 30 days?

☐ No *(Go to question #2.)*

☐ Don't know *(Go to question #2.)*

☐ Yes Please fill in the box below.

Doctor/Provider Name	What kind of doctor/provider?	Location	Date	Time	Do you need help with transportation? Yes/No*
1.					
2.					
3.					
4.					
5.					

If you need a ride to your appointment, please call L.A. Care's Member Services Department at **1.855.810.9724.*

2. Do you use medical equipment or supplies?
(Check all that apply.)

☐ No supplies *(Go to question #3.)*

2a. Mobility Assistance—to help you get around

- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Scooter

2b. Bathing/toileting

- ☐ Grab bars
- ☐ Shower/tub chair
- ☐ Raised toilet seat/chair
- ☐ Incontinence supplies—diapers, pull ups, bed pads
- ☐ Urinary catheter

2c. Supplies

- ☐ Diabetes supplies
- ☐ Ostomy supplies
- ☐ Food supplements

2d. Bed

- ☐ Hospital Bed
- ☐ Hoyer lift
- ☐ Slide board

2e. Other

- ☐ Oxygen
- ☐ CPAP/BiPAP
- ☐ IV infusions for medication
- ☐ Feeding tube
- ☐ Trach/suction supplies
- ☐ Ventilator
- ☐ Other: _____

YOUR HEALTH

The following questions help L.A. Care learn more about your health status to make sure you get the care and support you need.

3. In general, would you say your health is:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

4. Compared to one (1) year ago, is your health:

- ☐ Much better than one (1) year ago
- ☐ Somewhat better now than one (1) year ago
- ☐ About the same
- ☐ Somewhat worse now than one (1) year ago
- ☐ Much worse now than one (1) year ago

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

☐ Yes ☐ No

6. Do you have a regular doctor/provider?

☐ Yes ☐ No

7. When was the last time you saw your primary care provider?

- ☐ Less than 3 months ago
- ☐ Less than 6 months ago
- ☐ 6-12 months ago
- ☐ More than 1 year ago
- ☐ Not sure
- ☐ No regular doctor

8. Do you have reliable transportation to appointments?

☐ Yes ☐ No

9. Do you have any of the following medical conditions? *(Check all that apply.)*

- ☐ Asthma *(difficulty breathing)*
- ☐ Alzheimer's/dementia/memory loss
- ☐ Arthritis/chronic pain
- ☐ Cancer
- ☐ COPD/emphysema/bronchitis *(breathing problems)*
- ☐ Diabetes *(sugar)*
- ☐ Heart problems *(heart attack, chest pain)*
- ☐ Hearing loss
- ☐ Hepatitis *(liver problems)*
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Hypertension *(high blood pressure)*
- ☐ Kidney disease
- ☐ Physical disability/para/quadriplegic/amputation
- ☐ Seizures
- ☐ Vision loss
- ☐ None
- ☐ Other: _____

10. Do you have any of the following mental health conditions? *(Check all that apply.)*

- ☐ Alcohol abuse
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Post-traumatic Stress Disorder (PTSD)
- ☐ Substance abuse
- ☐ Schizophrenia
- ☐ None
- ☐ Other: _____

11. Do you take 8 or more prescription medicines?

☐ Yes ☐ No

12. How many times have you been to the emergency room in the past 6 months?

☐ None
☐ 1 time
☐ 2 times
☐ 3 times or more
☐ Don't remember/Not sure

13. How many times have you been a patient in the hospital in the past 6 months?

☐ None
☐ 1 time
☐ 2 times
☐ 3 times or more
☐ Don't remember/Not sure

14. In the last 12 months, how many times have you been in a nursing home and/or rehab?

☐ None
☐ 1 time
☐ 2 or more times

15. During the past 4 weeks, how much did pain interfere with your normal activities *(including work outside the home and/or housework)?*

☐ Not at all
☐ A little bit
☐ Moderately
☐ Quite a bit
☐ Extremely

16. Are you getting wound care now?

☐ Yes ☐ No

17. Do you have difficulty chewing and/or swallowing?

☐ Yes ☐ No

18. Have you lost 10 or more pounds in the last year without trying?

☐ Yes ☐ No

STAYING SAFE AND INDEPENDENT

The following questions help L.A. Care make sure you are safe at home and have the support you need to live independently and stay healthy.

19. Do you need help with any of these actions?
(Select answer "Yes" or "No" to each individual item.)

Taking a bath or shower	☐ Yes	☐ No
Going upstairs	☐ Yes	☐ No
Eating	☐ Yes	☐ No
Getting dressed	☐ Yes	☐ No
Brushing teeth, brushing hair, shaving	☐ Yes	☐ No
Making meals or cooking	☐ Yes	☐ No
Getting out of bed or a chair	☐ Yes	☐ No
Shopping and getting food	☐ Yes	☐ No
Using the toilet	☐ Yes	☐ No
Walking	☐ Yes	☐ No
Washing dishes or clothes	☐ Yes	☐ No
Writing checks or keeping track of money	☐ Yes	☐ No
Getting a ride to see the doctor or to see your friends	☐ Yes	☐ No
Doing house or yard work	☐ Yes	☐ No
Going out to visit family or friend	☐ Yes	☐ No
Using the phone	☐ Yes	☐ No
Keeping track of appointments	☐ Yes	☐ No

19a. If yes, are you getting all the help you need with these actions?

_____

20. Have you fallen in the last month?

☐ Yes ☐ No

21. Are you afraid of falling?

☐ Yes ☐ No

22. Can you live safely and move easily around your home? *If yes, go to question 23.*

☐ Yes ☐ No

If no, does the place where you live have?
(Select "Yes" or "No" to each individual item.)

Good lighting	☐ Yes	☐ No
Good heating	☐ Yes	☐ No
Good cooling	☐ Yes	☐ No
Rails for any stairs/ramps	☐ Yes	☐ No
Hot water	☐ Yes	☐ No
Indoor toilet	☐ Yes	☐ No
A door to the outside that locks	☐ Yes	☐ No
Stairs to get into your home or stairs inside your home	☐ Yes	☐ No
Elevator	☐ Yes	☐ No
Space to use a wheelchair	☐ Yes	☐ No
Clear ways to exit your home	☐ Yes	☐ No

23. Where do you live? *(Check all that apply.)*

☐ Live alone
☐ Live with spouse or significant other
☐ Live with children or other relatives or friends
☐ Live with caregiver
☐ Board and care facility
☐ Residential treatment center
☐ Assisted living
☐ Nursing home
☐ Homeless
☐ Other: _____

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

☐ Yes ☐ No

25. Do you ever think that your caregiver is having a hard time giving you all the help you need?

☐ Yes ☐ No

26. I would like to ask you about how you think you are managing your health conditions?

26a. Do you need help taking your medicines?

☐ Yes ☐ No

26b. Do you need help filling out health forms?

☐ Yes ☐ No

26c. Do you need help answering questions during a doctor's visit?

☐ Yes ☐ No

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

☐ Yes ☐ No

28. In the last 3 months, were you ever hungry but didn't eat?

☐ Yes ☐ No

28a. If yes, why? *(Check all that apply.)*

☐ Financial issues
☐ Unable to shop for food
☐ Unable to prepare food
☐ Other: _____

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

☐ Yes ☐ No

30. Is anyone using your money without your ok?

☐ Yes ☐ No

31. Over the past month (30 days), how many days have you felt lonely? *(Check one.)*

- ☐ None—I never feel lonely
- ☐ Less than 5 days
- ☐ More than half the days (more than 15 days)
- ☐ Most days—I always feel lonely

32. Over the last 2 weeks (14 days), have you had little interest or pleasure in doing things?

- ☐ Not at all
- ☐ More than half the days
- ☐ Several days
- ☐ Nearly every day

33. Over the last 2 weeks (14 days), have you felt down, depressed or hopeless?

- ☐ Not at all
- ☐ More than half the days
- ☐ Several days
- ☐ Nearly every day

STAYING HEALTHY

The following questions help L.A. Care make sure you are doing things to keep yourself healthy and if you would like help getting services to assist you.

34. Do you smoke or use tobacco?

☐ Yes ☐ No

35. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

☐ Yes ☐ No

36. Have you had the following health screenings?

36a. Flu shot or flu mist in the last year

- ☐ No
- ☐ Yes
- ☐ Don't know
- ☐ Not applicable

36b. Pneumonia shot in last 5 years

- ☐ No
- ☐ Yes
- ☐ Don't know
- ☐ Not applicable

36c. Shot for shingles *(h-zoster)*

- ☐ No
- ☐ Yes
- ☐ Don't know
- ☐ Not applicable

36d. Colorectal screening *(colonoscopy, sigmoidoscopy, stool testing, other)*

- ☐ No
- ☐ Yes
- ☐ Don't know
- ☐ Not applicable

36e. Mammogram *(Female)* in the last 2 years

- ☐ No
- ☐ Yes
- ☐ Don't know
- ☐ Not applicable

36f. Pap smear *(Female)* in the last 3-5 years

- ☐ No
- ☐ Yes
- ☐ Don't know
- ☐ Not applicable

36g. Bone density test

- ☐ No
- ☐ Yes
- ☐ Don't know
- ☐ Not applicable

36h. Do you have diabetes (sugar)?

- ☐ No *(Go to question #37.)*
- ☐ Don't know *(Go to question #37.)*
- ☐ Yes, have you had the following tests/exams?

36i. HbA1c *(blood sugar test)* in the last 12 months?

- ☐ No
- ☐ Yes
- ☐ Don't know
- ☐ Not applicable

36j. Kidney function test?

- ☐ No
- ☐ Yes
- ☐ Don't know

36k. Retinal eye exam?

- ☐ No
- ☐ Yes
- ☐ Don't know

37. What concerns you most about your health?

_____

_____

_____

Thank you for taking the time to complete this important survey. Our Care Management Program at L.A. Care has nurses or other health professionals that can answer your questions and help you get the needed services. Our Care Management Team works with your doctor and other health care providers to ensure that you get the care you need. If you would like more information about the Care Management Program, please call L.A. Care's Member Services Department at ***1.855.810.9724****.*

Mailing Instructions:
Fold in half and place in the enclosed envelope. No postage is necessary. Call **1.855.810.9724** if you have questions.

- If you speak English, language assistance services, free of charge, are available to you. Call **1.888.522.1298** (TTY: **711**), 24 hours a day, 7 days a week, including holidays. The call is free.
- Si usted habla español, los servicios de asistencia con el idioma estarán disponibles para usted sin costo. Llame al **1.888.522.1298** (TTY: **711**), las 24 horas del día, los 7 días de la semana, incluso los días festivos. La llamada es gratuita.
- 如果您說中文，您可免費獲得語言協助服務。請致電 **1.888.522.1298**（TTY：**711**），服務時間為每週 7 天，每天 24 小時（包含假日）。這是免費電話 。
- Nếu quý vị nói Tiếng Việt, hiện có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi **1.888.522.1298** (TTY: **711**), 24 giờ một ngày, 7 ngày một tuần, kể cả các ngày lễ. Cuộc gọi là miễn phí.
- 한국어를 사용하실 경우 언어지원서비스를 무료로 이용하실 수 있습니다. 연중무휴로 이용할 수 있는 **1.888.522.1298** (TTY: **711**) 번으로 전화하십시오. 통화료는 무료입니다.
- Եթե խոսում եք հայերեն, լեզվական աջակցության ծառայությունները հասանելի են Ձեզ անվճար: Զանգահարեք **1.888.522.1298** հեռախոսահամարով (TTY՝ **711**), օրը 24 ժամ, շաբաթը 7 օր, ներառյալ տոն օրերը: Հեռախոսազանգն անվճար է:
- إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجانًا. اتصل على **1.888.522.1298** (TTY: **711**) 24 ساعة في اليوم و 7 أيام في الأسبوع، بما في ذلك أيام العطلات. هذه المكالمة مجانية.
- Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами переводчика. Звоните по телефону **1.888.522.1298** (TTY: **711**), круглосуточно, без выходных, включая праздничные дни. Звонок бесплатный.
- 日本語のサービスを無料でご利用いただけます。**1.888.522.1298**（TTY: **711**）までお電話ください。このサービスは年中無休(祝祭日を含む)でご利用いただけます。通話料は無料です。
- اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان بطور رایگان در اختیار شما قرار دارد. می توانید در تمام 24 ساعت شبانه روز و 7 روز هفته، حتی روزهای تعطیل با **1.888.522.1298** (TTY: **711**) تماس بگیرید. تماس رایگان می باشد.
- अगर आप हिंदी बोलते हैं, तो मुफ्त में भाषा सहायता सेवाएं, आपके लिए उपलब्ध हैं। अवकाश के दिनों समेत, दिन के 24 घंटे, सप्ताह के 7 दिन **1.888.522.1298** (TTY: **711**) पर कॉल करें। कॉल नि:शुल्क है।
- បើអ្នកនិយាយភាសា ខ្មែរ, សេវាជំនួយផ្នែកភាសា គ្មានបង់ថ្លៃ គឺមានស្រាប់ជួយអ្នក។ សូមទូរស័ព្ទទៅ **1.888.522.1298** (TTY: **711**), 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍រួមទាំងថ្ងៃឈប់សម្រាក។ ការហៅទូរស័ព្ទនេះគឺមិនគិតថ្លៃទេ។
- Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1.888.522.1298** (TTY: **711**), 24 na oras sa isang araw, 7 araw sa isang linggo, kabilang ang mga piyesta opisyal. Libre ang pagtawag.
- หากท่านพูดภาษาไทย เรามีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่เสียค่าใช้จ่าย โปรดโทรฟรีที่หมายเลข **1.888.522.1298** (TTY: **711**) ได้ตลอด 24 ชั่วโมง ทุกวัน ไม่เว้นวันหยุด

- ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສັຽຄ່າ. ໂທຣ **1.888.522.1298** (TTY: **711**), ໄດ້ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ, ລວມເຖິງ ວັນພັກຕ່າງໆ. ເບີໂທຣນີ້ແມ່ນບໍ່ເສັຽຄ່າ.
- Yog koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj, hu rau **1.888.522.1298** (TTY: **711**), 24 teev hauv ib hnub, 7 hnub hauv ib asthiv, suav nrog cov hnub so tib si. Qhov hu no yog hu dawb xwb.
- ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਛੁੱਟੀ ਵਾਲੇ ਦਿਨਾਂ ਸਮੇਤ 24 ਘੰਟੇ, 7 ਦਿਨ **1.888.522.1298** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।ਕਾਲ ਮੁਫਤ ਹੈ।
- You can get this *Annual Notice of Changes* for free in other formats, such as large print, braille, or audio. Call **1.888.522.1298** (TTY: **711**), 24 hours a day, 7 days a week, including holidays. The call is free.
- If you want to receive materials, now and in the future, in a language other than English or in an alternate format, call Member Services at **1.888.522.1298** (TTY: **711**), 24 hours a day, 7 days a week, including holidays. The call is free.

L.A. Care Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. L.A. Care Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

L.A. Care Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Member Services Department at **1-888-522-1298** (TTY: **711**).

If you believe that L.A. Care Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance/complaint with the Civil Rights Coordinator of L.A. Care Health Plan. You have two options in which you may file a grievance/complaint:

You may call in a grievance/complaint at:

Member Services Department – **1-888-522-1298** (TTY: **711**)

Or you may send in a written complaint to:

Civil Rights Coordinator
c/o Compliance Department
L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
Email: **civilrightscoordinator@lacare.org**

You can file a grievance/complaint in person, by mail, by telephone, or by email. If you need help filing a grievance/complaint, the Civil Rights Coordinator via the Member Services Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1-800-868-1019, **800-537-7697** (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.