



L.A. Care
HEALTH PLAN®

lacare.org

Health Risk Assessment

Fold in half and place in the enclosed envelope. No postage is necessary.

Call **1.888.223.1150** if you have questions or want to complete the survey over the phone.

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 **1.888.223.1150**).*

☐ Member

☐ Legal Guardian

☐ Member, with help from a family member

☐ A Caregiver

☐ Member's Power of Attorney

☐ 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 1.888.223.1150.

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/quadruplegic/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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Going upstairs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Getting dressed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Brushing teeth, brushing hair, shaving	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Making meals or cooking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Getting out of bed or a chair	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shopping and getting food	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Using the toilet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Washing dishes or clothes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Writing checks or keeping track of money	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Getting a ride to see the doctor or to see your friends	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Doing house or yard work	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Going out to visit family or friend	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Using the phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Keeping track of appointments	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Good heating	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Good cooling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rails for any stairs/ramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hot water	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Indoor toilet	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A door to the outside that locks	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stairs to get into your home or stairs inside your home	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Elevator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Space to use a wheelchair	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clear ways to exit your home	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 **1.888.223.1150**.*

Mailing Instructions:

Fold in half and place in the enclosed envelope. No postage is necessary. Call **1.888.223.1150** if you have questions.

- Free language assistance services are available. You can request interpreting or translation services, information in your language or in another format, or auxiliary aids and services. Call L.A. Care at **1.888.839.9909 (TTY 711)**, 24 hours a day, 7 days a week, including holidays. The call is free.
- Los servicios de asistencia de idiomas están disponibles de forma gratuita. Puede solicitar servicios de traducción e interpretación, información en su idioma o en otro formato, o servicios o dispositivos auxiliares. Llame a L.A. Care al **1.888.839.9909 (TTY 711)**, las 24 horas del día, los 7 días de la semana, incluso los días festivos. La llamada es gratuita.
- 提供免費語言協助服務。您可申請口譯或翻譯服務，您使用之語言版本或其他格式的資訊，或輔助援助和服務。請致電 L.A. Care 電話 **1.888.839.9909 (TTY 711)**，服務時間為每週 7 天，每天 24 小時（包含假日）。上述電話均為免費。
- Có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Quý vị có thể yêu cầu dịch vụ biên dịch hoặc phiên dịch, thông tin bằng ngôn ngữ của quý vị hoặc bằng các định dạng khác, hay các dịch vụ và thiết bị hỗ trợ ngôn ngữ. Xin vui lòng gọi L.A. Care tại **1.888.839.9909 (TTY 711)**, 24 giờ một ngày, 7 ngày một tuần, kể cả ngày lễ. Cuộc gọi này miễn phí.
- Available ang mga libreng serbisyo ng tulong sa wika. Maaari kang humiling ng mga serbisyo ng pag-interpret o pagsasalang-wika, impormasyon na nasa iyong wika o nasa ibang format, o mga karagdagang tulong at serbisyo. Tawagan ang L.A. Care sa **1.888.839.9909 (TTY 711)**, 24 na oras sa isang araw, 7 araw sa isang linggo, kabilang ang mga holiday. Libre ang tawag.
- 무료 언어 지원 서비스를 이용하실 수 있습니다. 귀하는 통역 또는 번역 서비스, 귀하가 사용하는 언어 또는 기타 다른 형식으로 된 정보 또는 보조 지원 및 서비스 등을 요청하실 수 있습니다. 공휴일을 포함해 주 7일, 하루 24시간 동안 L.A. Care, **1.888.839.9909 (TTY 711)**번으로 문의하십시오. 이 전화는 무료로 이용하실 수 있습니다.
- Տրամադրելի են լեզվական օգնության անվճար ծառայություններ: Կարող եք խնդրել բանավոր թարգմանչական կամ թարգմանչական ծառայություններ, Ձեր լեզվով կամ տարբեր ձևաչափով տեղեկություն, կամ օժանդակ օգնություններ և ծառայություններ: Զանգահարեք L.A. Care **1.888.839.9909** համարով (TTY 711), օրը 24 ժամ, շաբաթը 7 օր, ներառյալ տոնական օրերը: Այս հեռախոսազանգն անվճար է:
- Мы предоставляем бесплатные услуги перевода. У Вас есть возможность подать запрос о предоставлении устных и письменных услуг перевода, информации на Вашем языке или в другом формате, а также вспомогательных средств и услуг. Звоните в L.A. Care по телефону **1.888.839.9909 (TTY 711)** 24 часа в сутки, 7 дней в неделю, включая праздничные дни. Этот звонок является бесплатным.
- 言語支援サービスを無料でご利用いただけます。通訳・翻訳サービス、日本語や他の形式での情報、補助具・サービスをリクエストすることができます。L.A. Careまでフリーダイヤル **1.888.839.9909 (TTY 711)** にてご連絡ください。祝休日を含め毎日24時間、年中無休で受け付けています。

- قيسنتب وأكتغلب تامولعم وأتيريرحتلا ةمجرتلا وأتيروفلا ةمجرتلا تامدخ بلط كنكمي. أناجم ةحاتم ةتيوغللا ةدعاسملا تامدخ ةعاسلا رادمي لء 1.888.839.9909 (711 TTY) مقررلا لء L.A. Care بل صتا. ةيفاضل تامدخو تادعاسم وأ رخا. ةيناجم ةملاكملا. تاطعلا مايأ كلذ في فامب، عوبسلأ مايأ ل اوطو.

- ਪੰਜਾਬੀ: ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ, ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਜਾਂ ਕਿਸੇ ਹੋਰ ਫੋਰਮੈਟ ਵਿੱਚ, ਜਾਂ ਸਹਾਇਕ ਉਪਕਰਣਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। L.A. Care ਨੂੰ 1.888.839.9909 (TTY 711) ਨੰਬਰ ਉੱਤੇ ਕਾਲ ਕਰੋ, ਇੱਕ ਦਿਨ ਵਿੱਚ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਵਿੱਚ 7 ਦਿਨ, ਛੁੱਟੀਆਂ ਸਮੇਤ। ਕਾਲ ਮੁਫਤ ਹੈ।
- សេវាជំនួយខាងភាសា គឺមានជាយុត្តិធម៌។ អ្នកអាចស្នើសុំសេវាបំប្លែងផ្ទាល់មាត់ ឬការបំប្លែងស្នើសុំព័ត៌មាន ជាភាសាខ្មែរ ឬជាទំរង់មួយទៀត ឬជំនួយជ្រាបជ្រួត និងសេវា។ ទូរស័ព្ទទៅ L.A. Care តាមលេខ 1.888.839.9909 (TTY 711) បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃ មួយអាទិត្យ រួមទាំងថ្ងៃបុណ្យផង។ ការហៅនេះគឺឥតគិតថ្លៃឡើយ។
- Muaj kev pab txhais lus pub dawb rau koj. Koj tuaj yeem thov kom muab cov ntaub ntawv txhais ua lus lossis txhais ua ntawv rau koj lossis muab txhais ua lwm yam lossis muab khoom pab thiab lwm yam kev pab cuam. Hu rau L.A. Care ntawm tus xov tooj 1.888.839.9909 (TTY 711), tuaj yeem hu tau txhua txhua 24 teev hauv ib hnub, 7 hnub hauv ib vij thiab suab nrog cov hnub so tib si, tus xov tooj no hu dawb xwb.
- मुफ्त भाषा सहायता सेवाएं उपलब्ध हैं। आप दुभाषिया या अनुवाद सेवाओं, आपकी भाषा या किसी अन्य प्रारूप में जानकारी, या सहायक उपकरणों और सेवाओं के लिए अनुरोध कर सकते हैं। आप L.A. Care को 1.888.839.9909 (TTY 711) नंबर पर फ़ोन करें, दिन में 24 घंटे, सप्ताह में 7 दिन, छुट्टियों सहित। कॉल मुफ्त है।
- มีบริการช่วยเหลือภาษาฟรี คุณสามารถขอรับบริการการแปลหรือล่าม ข้อมูลในภาษาของคุณหรือในรูปแบบอื่น หรือความช่วยเหลือและบริการเสริมต่าง ๆ ได้ โทร L.A. Care ที่ 1.888.839.9909 (TTY 711) ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์รวมทั้งวันหยุด โทรฟรี

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 1-888-839-9909 (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 – 1-888-839-9909 (TTY 711)

Or you may send in a written grievance/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: civilrightscordinator@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, 1-800-537-7697 (TDD).

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