CalOptima Health
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OneCare Plan

Health Risk Assessment

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan wants to provide you with access to good health care that meets your health needs. Your answers to these survey questions will help us serve you better. We will keep your information private, and only share your answers with your primary care provider (PCP) and those treating you or helping you meet your health needs. Filling out this survey will **not** affect your access to health care services.

A OneCare team member can ask you these questions over the phone, through a video call or in person. To request help with filling out this survey, call OneCare Customer Service toll-free at **1-877-412-2734** (TTY **711**). We have staff who speak your language. **Please call this number if you need help completing this survey.**

If you do not need help with this survey, please fill it out and mail it to us as soon as you can using the enclosed postage paid envelope.

Last name:	First name:	Health network:
CalOptima ID # (CIN):	Phone (home):	Phone (cell):
Address:		Email:
Height:	Weight:	Today's date:
Date of birth:		Gender

Instructions:

a. Please read each question and mark the box like this: ☒ for your answer.
b. Some questions ask you to write an answer on the line. Please write your answers on the line next to the question.

Thank you!

1. **Did someone help you fill out this survey?**

☐ Yes, my caregiver ☐ Yes, my legal guardian ☐ Yes, family or friend

☐ No, I completed the survey by myself

☐ Other (please explain): _____

   a. **If yes, why do you need help?**

☐ Cannot see well ☐ Do not read well ☐ Do not understand some questions

☐ Other (please explain): _____

2. **What language do you prefer to speak?**

☐ English ☐ Spanish ☐ Vietnamese ☐Arabic ☐ Korean

☐ Farsi ☐ Cantonese ☐ Mandarin ☐ Other:_____

Past and Current Health

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

☐ Very good ☐ Good ☐ Fair ☐ Poor

4. **When was the last time you saw your primary care provider (PCP) or doctor?**

☐ Less than 6 months ☐ 6 to 12 months ago ☐ More than 1 year ago ☐ Never

5. **Have you had any of the following? (Mark an X in the box next to the ones you have had.)**

☐ Flu shot or flu mist in the past year

☐ Pneumonia shot in the past 5 years

☐ Shot for shingles (h-zoster) in the past 5 years

☐ Colorectal cancer screening in the past year

☐ Mammogram in the past 2 years (female only)

☐ PAP smear in the past 3 to 5 years (female only)

☐ Bone density test (osteoporosis test)

6. **In the past 3 months have you been told that you need to get a surgery but have not done it?**
   ☐ Yes ☐ No ☐ Recommended but I refused

   Name of recommended surgery: _____

7. **What ongoing health conditions do you have? (Mark an X in the box next to the conditions you have.)**

☐ Alzheimer's or Dementia	☐ High blood pressure
☐ Anxiety	☐ HIV or AIDS
☐ Asthma	☐ Kidney disease
☐ Bipolar disorder	☐ Liver problems
☐ Chronic obstructive pulmonary disease (COPD) or emphysema	☐ Multiple sclerosis
☐ Depression	☐ Parkinson's disease
☐ Diabetes	☐ Schizophrenia
☐ Epilepsy or seizure disorder	☐ Stroke
☐ Heart failure	☐ Thyroid problems
☐ Hepatitis C	☐ Other _____

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

   ☐ Yes ☐ No

9. **Do you have any health problems that you feel are getting worse?** ☐ Yes ☐ No

   If yes, list the problem(s): _____

10. **Do you have any wounds, sores or skin breakdown that you are <u>not</u> getting treatment for?**
    ☐ Yes ☐ No

    If yes, please describe: _____

11. **How many prescribed medicines do you take?** ☐ None ☐ 1 to 5 ☐ 6 or more

12. **"I would like to ask you about how you think you are managing your health conditions"**

    a. Do you need help taking your medicine? ☐ Yes ☐ No

    b. Do you need help filling out health forms? ☐ Yes ☐ No

    c. Do you need help answering questions during a doctor's visit? ☐ Yes ☐ No

13. **Are you having any problems filling your prescribed medicines right now?** ☐ Yes ☐ No

    If yes, which medicine(s)? _____

14. **In the past 6 months, how many times did you go to the hospital emergency room?**

    ☐ None ☐ 1 time ☐ 2 times or more

15. **In the past 12 months, how many times did you stay at a hospital overnight?**

    ☐ None ☐ 1 time ☐ 2 times or more

16. **What is your main health concern?** _____

Specialist Care

17. **Are you getting care from a specialist now?** Specialists are doctors such as surgeons, heart doctors, skin doctors, mental health professionals and other doctors who are experts in one area of health care.

    ☐ Yes ☐ No

    If yes, what is or are the name(s) of your specialist(s) and what is their specialty?

    *Example: John Smith, Oncology*_____

    _____

    _____

18. **When was the last time you saw a specialist?**

    ☐ Less than 6 months ago ☐ 6 to 12 months ago ☐ More than a year ago

19. **Do you have pain that impacts your daily activities?** ☐ Yes ☐ No

    If yes, where is the pain on your body? _____

    Rate from 1–10 (1 being the least to 10 the most pain): _____

    If 5 or more, what are you doing to help with the pain? _____

20. **Do you have cancer?** ☐ Yes ☐ No

If yes, what kind of cancer? _____

Are you getting cancer treatment now? ☐ Yes ☐ No

21. Did you receive a transplant in the past year? ☐ Yes ☐ No

a. If yes, what kind? _____

22. Are you on dialysis? ☐ Yes ☐ No

23. Are you pregnant? (female only) ☐ Yes ☐ No ☐ N/A

If yes, when is your due date? _____

Are you getting prenatal care? ☐ Yes ☐ No

Living Arrangement and Daily Functioning

24. What is your current living arrangement?

☐ Live alone

☐ Live with family, friend or partner

☐ Live with paid caregiver

☐ Board and care facility

☐ Experiencing homelessness

☐ Motel

☐ Other (list):

_____

25. Can you live safely in and move easily around your home? ☐ Yes ☐ No

If no, does the place where you live have:

a.	Good lighting	☐ Yes	☐ No
b.	Good heating	☐ Yes	☐ No
c.	Good cooling	☐ Yes	☐ No
d.	Rails for any stairs or ramps	☐ Yes	☐ No
e.	Hot water	☐ Yes	☐ No
f.	Indoor toilet	☐ Yes	☐ No
g.	A door to the outside that locks	☐ Yes	☐ No
h.	Stairs to get into your home or stairs inside your home	☐ Yes	☐ No
i.	Elevator	☐ Yes	☐ No
j.	Space to use a wheelchair	☐ Yes	☐ No
k.	Clear ways to exit your home	☐ Yes	☐ No

26. Have you fallen in the last month? ☐ Yes ☐ No

a. Are you afraid of falling? ☐Yes ☐ No

27. Do you need help with any of these actions?

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

If yes, are you getting all the help you need with these actions? ☐ Yes ☐ No

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

☐ Yes ☐ No

If yes, name and relationship of caregiver _____

29. Do you ever think your caregiver has a hard time giving you all the help you need?

☐ Yes ☐ No

a. If yes, what support do you think your caregiver needs? _____

30. Do you have problems with your teeth that keep you from eating a healthy diet?

☐ Yes ☐ No

a. If yes, explain: _____

31. Is it often hard for you to swallow food or liquids without choking? ☐ Yes ☐ No

Mental Well-Being

32. In the past 2 weeks, have you had little interest or pleasure in doing things?

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

33. In the past 2 weeks, have you felt down, sad or hopeless?

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

34. Over the past 30 days, how many days have you felt lonely?

☐ None — I never feel lonely ☐ Less 5 days

☐ More than half the days (more than 15) ☐ Most days — I always feel lonely

35. Are you afraid of anyone or is anyone hurting you? ☐ Yes ☐ No

a. Is anyone using your money without your OK? ☐ Yes ☐ No

Services Received

36. Do you use any of these aids? (Mark an X in the box next to the aids you use.)

☐ Braces or artificial limbs ☐ Infusions (intravenous [IV] medication)

☐ Catheter (urinary) ☐ Ostomy bags or supplies

☐ CPAP or BiPAP (a machine to help you sleep) ☐ Oxygen

☐ Diabetes supplies (glucose meter, etc.) ☐ Tracheostomy (trach) or suction supplies

☐ Diapers or incontinence supplies ☐ Tube feeding supplies

☐ Hearing aids ☐ Walker or cane

☐ Hospital bed ☐ Wheelchair

If you are not using any of these, do you need any aids? ☐ Yes ☐ No

If yes, please list: _____

37. Do you sometimes run out of money to pay for food, rent, bills, and medicine? ☐ Yes ☐ No

a. If yes please explain, _____

38. Do you currently access any Medi-Cal services?

☐ Transportation help
☐ Help paying utility bills (CARE/FERA)
☐ County alcohol or drug outpatient services
☐ In-Home Supportive Services (IHSS)
☐ County mental health
☐ Regional Center of Orange County (RCOC)
☐ Food assistance programs (Meals on Wheels, CalFresh, food banks)
☐ Housing Services
☐ Dental
☐ Other community resource: _____

39. Are you interested in getting any information about the resources listed above? ☐ Yes ☐ No

Social History

40. Do you smoke, vape or use tobacco? ☐ Yes ☐ No

If yes, do you want help to quit? ☐ Yes ☐ No

41. How often do you have a drink that has alcohol in it?

☐ Never ☐ 1 time or less per month ☐ 2-4 times per month
☐ 2-3 times per week ☐ 4 or more times per week

42. How many drinks (that have alcohol) do you have on a typical day when you drink?

☐ 1-2 ☐ 3-4 ☐ 5 or more

Health Care Planning

43. Do you have someone who makes health care and other choices for you?

☐ No, I can make my own choices

☐ Yes, I have a friend or family member Name and relationship

_____

☐ Yes, I have a legal guardian Name and relationship

_____

44. Do you have an advance directive for health care? (This is a document that tells doctors and hospitals what to do in case you are not able to speak for yourself.) ☐ Yes ☐ No

If yes, what kind?

☐ Living will ☐ Durable power of attorney for health care

☐ Healthcare proxy ☐ Physician orders for life-sustaining treatment (POLST)

If no, would you like to talk to someone about getting an advance directive? ☐ Yes ☐ No

45. Do you have any cultural and religious beliefs that affect your treatment choices?

☐ Yes ☐ No

If yes, please explain? _____

46. In what language do you prefer to get written health information?

☐ English ☐ Spanish ☐ Vietnamese ☐ Arabic

☐ Korean ☐ Farsi ☐ Traditional Chinese

☐ Other: _____

47. In what format do you prefer to get health information?

☐ Written (print)

☐ Written (large print)

☐ Braille

☐ Audio or CD

48. What are your care goals? _____

OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, is a Medicare Advantage organization with a Medicare contract. Enrollment in OneCare depends on contract renewal. OneCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Call OneCare Customer Service toll-free at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. Visit us at www.caloptima.org/OneCare.

Enclosures:

- Notice of Nondiscrimination Insert