

HPSM Health Risk Assessment (HRA)

INTRODUCTION

Thank you for filling out the HRA survey. Answering this set of health related questions will help us understand your healthcare status and needs. This should take about 20 minutes to complete. Instructions on how to return the survey are enclosed.

After we receive your survey, the HPSM Integrated Care Management team will review your answers and work with you to develop a personalized care plan. This care plan includes your medicines, visits with providers, nutrition, exercise and more.

The answers you give are confidential and will not change your CareAdvantage coverage.

If you prefer to complete this survey by phone, call **650-616-5035** or **1-888-783-3035** (TTY: **1-800-735-2929** or dial **7-1-1**). Phone hours are Monday – Friday 8:00 a.m. to 5:00 p.m.

Please use blue or black pen and completely fill in the bubble.

Right	Wrong
	

Today's Date

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

2. How was the survey completed?		
Completed and submitted to HPSM by mail/email/Fax/in person	Completed by phone with HPSM staff	Completed in person with HPSM staff

Member Information

3. 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 (Please print)	

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

Health Care

5. How would you rate your overall health over the past 4 weeks?

Excellent	Very good	Good	Fair
Poor	Very poor	Don't know	Prefer not to answer

6. Have you been diagnosed with or are currently being treated for any of the following conditions? Please select all that apply:

<input type="checkbox"/>	A. Alzheimer's Disease or any related dementia
<input type="checkbox"/>	B. ADHD (attention deficit hyperactivity disorder)
<input type="checkbox"/>	C. Anxiety
<input type="checkbox"/>	D. Autism
<input type="checkbox"/>	E. Bipolar Disorder
<input type="checkbox"/>	F. Depression
<input type="checkbox"/>	G. Psychotic disorder (schizophrenia)
<input type="checkbox"/>	H. Substance use disorder
<input type="checkbox"/>	I. HIV/AIDS
<input type="checkbox"/>	J. Other
<input type="checkbox"/>	K. I have never been diagnosed for any of these conditions

7. In the past 6 months, how often have you visited the emergency room or stayed overnight in the hospital?

Not at all	1 time	2-5 times	More than 6 times
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Health Care *(continued)*
8. Do you have a primary care physician (PCP)? If yes, please give contact information.

Yes	No	Don't know	Prefer not to answer
Name of Primary Care Physician		Phone Number	

9. Do you have a specialist/clinic managing your medical care? If yes, please give contact information.

Yes	No	Don't know	Prefer not to answer
Name of Specialist/Clinic		Phone Number	

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

Yes	No	Don't know	Prefer not to answer
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11. Do you need help filling out health forms?

Yes	No	Don't know	Prefer not to answer
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12. Do you have any upcoming health care appointments that HPSM can assist with coordinating?

Yes	No	Don't know	Prefer not to answer
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**13. If this is applicable to you, are you currently pregnant, or have you given birth in the last 12 months?
If yes, answer item 13a. If no, skip to 14.**

Yes	No	Don't know	Prefer not to answer
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13a. If yes, are you currently seeing a doctor for this pregnancy/birth?

Yes	No	Don't know	Prefer not to answer
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Health Care *(continued)*

14. Are you currently affected by any of the following issues?	Yes	No	Don't know	Prefer not to answer
A. Seeing: Do you bump into things around your house?				
B. Hearing: Has anyone ever suggested you may need your hearing tested?				
C. Oral health: Do you have concerns regarding your teeth/mouth?				

15. Do you currently NEED HELP getting any of the following services or supplies?	Yes	No	Don't know	Prefer not to answer
A. Seeing/vision (glasses, contacts etc.)				
B. Hearing (hearing aids)				
C. Oral health/dental care (dentures, cavities, cleanings, pain, etc.)				
D. Specialist care (heart, lungs, pain, mental health, etc.)				
E. Medications (prescribed by your provider)				
F. Sexual healthcare (OB/GYN, family planning, urology, etc.)				
G. Incontinence supplies (adult diapers) and/or treatment				
H. Medical equipment and/or supplies (cane, walker, wheelchair, diabetes care, blood pressure, wound care, oxygen, etc.)				
I. Interpreter services				

16. Do you need help taking your medications?			
Yes	No	Don't know	Prefer not to answer

17. Do you have a plan for your health care if you cannot make decisions? <i>If Yes, skip to 17b. If No, answer 17a.</i>			
Yes	No	Don't know	Prefer not to answer

Health Care *(continued)*

17a. If No, do you have someone who makes choices for you, such as a representative?

I have a person who helps me make choices	I do not have a person who helps me make choices	Don't know	Prefer not to answer
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17b. If you have a representative or someone who acts on your behalf, please provide their name and best contact number.

Name	
Phone Number	Relationship to member

Living Environment

18. In the past 12 months, were you in a correctional facility (example: prison, jail, youth correctional facility)?

Yes	No	Don't know	Prefer not to answer	Does not apply
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19. In the past 12 months, were you in a nursing home?

Yes	No	Don't know	Prefer not to answer	Does not apply
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20. Are you worried about your living situation?

Yes	No	Don't know	Prefer not to answer	Does not apply
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Living Environment *(continued)*

21. What is your living situation today? (Choose one that applies):

	A. House, apartment, or trailer
	B. Car or mobile home
	C. Hospital, treatment facility, or nursing home
	D. Hotel or motel
	E. Staying with others
	F. In a shelter
	G. Living outside on the street/beach/in a park
	H. Don't know
	I. Prefer not to answer

22. Think about the place where you live. Do you have any problems with the following? (Choose all that apply)

	A. Pests such as bugs, ants, or mice
	B. Lead paint or pipes
	C. Oven or stove not working
	D. Water leaks
	E. Mold
	F. Lack of heat
	G. Smoke detectors missing or not working
	H. None of the above
	I. Don't know
	J. Prefer not to answer

Living Environment *(continued)*

23. 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
A. Rails for any stairs or ramps					
B. Space to use a wheelchair					
C. Stairs to get into your home or stairs inside of your home					
D. Elevator					
E. A door to the outside that locks					
F. Clear ways to exit your home					
G. Good lighting					
H. Good heating					
I. Good cooling					
J. Hot water					
K. Indoor toilet					

Function

24. Do you need help with any of these actions?	Yes	No	Don't know	Prefer not to answer
A. Taking a bath or shower				
B. Using the toilet				
C. Getting dressed				
D. Brushing hair, brushing teeth, shaving				
E. Going up or down the stairs				
F. Getting out of a bed or a chair				
G. Walking				
H. Shopping and getting food				
I. Making meals or cooking				
J. Eating				
K. Washing dishes or clothes				
L. Doing house or yard work				
M. Getting a ride to the doctor or to visit family and friends				
N. Writing checks or keeping track of money				
O. Using the phone				
P. Keeping track of appointments				

25. 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
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Function *(continued)*

26. Do you have family members or others who are willing and able to help you when you need it?
If yes, answer 26a and 26b. If no, skip to 27.

(A caregiver provides personal care or home care services and helps with your daily needs. It is not necessarily a paid service and can be provided by a family member, friend, neighbor, etc.).

Yes	No	I do not have a caregiver	Don't know	Does not apply
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26a. 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
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26b. How satisfied have you been in the past month with the help you have received from your caregiver, family members, friends, or neighbors?

Very	A little	Moderately	Not at all	Don't know	Prefer not to answer
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27. Are you afraid of falling?

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

Yes	No	Don't know	Prefer not to answer
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Utilities/Finances

29. Is anyone using your money without your okay?

Yes	No	Don't know	Prefer not to answer
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30. How true is this statement: Do you sometimes run out of money to pay for food, rent, bills, and medicine?

Often true	Sometimes true	Never true	Don't know	Prefer not to answer
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31. How true is the following statement? 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
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32. How true is the following statement? 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
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Transportation

33. What is your primary mode of transportation? *Select the one you use the most.*

	A. Car
	B. Bus/Public transit
	C. Taxi/Ride-share service
	D. Non-Emergency Ambulance/Transport
	E. Bicycle
	F. Walking
	G. Don't know
	H. Prefer not to answer

Transportation *(continued)*

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

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

Wellness/Behavioral Health

36. Do you exercise 2 to 3 hours every week? (Such as brisk walking for 30 minutes a day, 5 days a week)									
Yes	No	Don't know	Prefer not to answer						

37. 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	

38. 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	

39. 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

Wellness/Behavioral Health (continued)
40. Over the past two weeks (14 days), how often have you had little interest or pleasure doing things?

Not at all	Less than 5 days	More than 7 days	Nearly every day
		Don't know	Prefer not to answer

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

Not at all	Less than 5 days	More than 7 days	Nearly every day
		Don't know	Prefer not to answer

42. Do you need help getting connected to any mental health or behavioral health services?

Yes	No	Don't know	Prefer not to answer
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43. Have you had any changes in thinking, remembering, or making decisions?

Yes	No	Don't know	Prefer not to answer
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44. Are you afraid of anyone or is anyone hurting you?

Yes	No	Don't know	Prefer not to answer
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45. Are you currently receiving any specialized medical care for serious illness (*hospice or palliative care services*)?

(Hospice provides comprehensive comfort care and focuses on the quality of life for a member with serious illness who is approaching end of life. Palliative care is focused on improving the quality of life for a person with serious illness and managing their symptoms.)

Yes	No	Don't know	Prefer not to answer
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Wellness/Behavioral Health (continued)

46. Do you currently use any tobacco products (smoke, vape, chew, etc.)? If yes go to #46a. If no, skip to #47.

Yes	No	Don't know	Prefer not to answer
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46a. Yes, I use the following tobacco products. (Choose all that apply):

Cigarettes	Cigar	Vape	Chew	Other
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47. How often do you have a drink containing alcohol?

A. Never
B. Monthly or less
C. 2 to 4 times a month
D. 2 to 3 times a week
E. 4 or more times a week
F. Don't know
G. Prefer not to answer

48. In the past year, have you used a recreational drug or prescription medication for non-medical reasons? If yes, please answer #49. If no, skip to #50.

Yes	No	Don't know	Prefer not to answer
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49. Has anyone ever expressed concern about your drinking, smoking, and/or drug use?

Yes	No	Don't know	Prefer not to answer
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50. Do you need help getting connected to any services for alcohol or drug use?

Yes	No	Don't know	Prefer not to answer
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Community, County or State Services/Resources

51. Are you currently enrolled or receiving any services or resources through the Community, the County or the State? If yes, answer #51a.

Yes	No	Don't know	Prefer not to answer
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51a. If yes, please check all that apply from the list below:

<input type="checkbox"/>	A. Disability Services – Golden Gate Regional Services, Center for Deafness, etc.
<input type="checkbox"/>	B. Energy or Utility Assistance – PG&E C.A.R.E. Program
<input type="checkbox"/>	C. Financial Assistance
<input type="checkbox"/>	D. Food Programs – Meals on Wheels, Food Banks, CalFresh
<input type="checkbox"/>	E. Homeless Services - Shelters
<input type="checkbox"/>	F. Housing Assistance – Deposit and Rental Assistance, Home Modification, Section 8 Voucher
<input type="checkbox"/>	G. Job Training, Placement and Development
<input type="checkbox"/>	H. Legal Services – Legal Aid Society
<input type="checkbox"/>	I. Services for Older Adults – Personal Care or In Home Supportive Services (IHSS)
<input type="checkbox"/>	J. Senior Centers and Senior Dining Centers – Community Based Adult Services (CBAS) or Adult Day Care
<input type="checkbox"/>	K. Socialization Programs – Wider Circle
<input type="checkbox"/>	L. Transportation Services – Redi-Wheels
<input type="checkbox"/>	M. Other:

If you need help completing this survey, please contact the **Member Assessment Unit** at 650-616-5035 or 1-888-783-3035.

If you need to contact your assigned care manager, please contact the **Integrated Care Management Department** at 650-616-2060. We are open Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY: 1-800-735-2929 or dial 7-1-1.

Thank you for your input and partnering with CareAdvantage by Health Plan of San Mateo to support your health journey.