

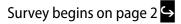
#### **HPSM Health Risk Assessment (HRA)**

#### INTRODUCTION

Thank you for taking HPSM's Health Risk Assessment (HRA). The assessment takes about 20 minutes to complete. Your answers to these questions will help us understand your health care status and needs. Then we can ensure you get any health care services or supplies you may need. After you take the HRA, HPSM will create a care plan just for you. You can participate in the meeting in which we start creating this plan. That will ensure your plan has everything you need. It can include your medications, doctor's visits, diet, exercise and more. You can review the care plan with your primary care doctor and also reach out to HPSM for anything you need. Your HRA and care plan are completely confidential. If you have questions, call **650-616-5035** or **1-888-783-3035** (toll free). We are open Monday – Friday 8:00 am to 5:00 pm.

Please completely fill in the bubble like this example:

Right	Wrong		
	$\bullet \ \textcircled{\ } \ \textcircled{\ } \ \bigtriangledown \ \textcircled{\ } \ O$		

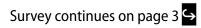




#### Today's Date

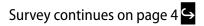
#### **Personal Information**

1. Please provide your personal information.				
Member name			Date of b	irth
Home phone number	Home phone number HPSM member ID number			
Cell phone number	r Alternate phone number			
Email address				
2. Who completed this surve	y?			
Self (Member)	Representative	Family member/r	elative	Caregiver
Friend	Friend Other			
3. How was the survey completed?				
Mailed by Member/Caregiver/Representative Completed by phone Completed in person				Completed in person



#### **Health Care**

4. Do you need help answering questions during a doctor's visit?					
Yes	No	Don't know Prefer not to answer			
5. Do you need help filling out health forms?					
Yes	No	Don't know	Prefer not to answer		
6. How would you rate your overall health over the past 4 weeks?					
Very poor	Poor	Good	Very Good		
Excellent		Don't know	Prefer not to answer		
7. What provider/doctor/clin	nic do you visit the most?				
Name of provider/doctor/d	clinic				
		Don't know	Prefer not to answer		
8. Is the provider listed abov	ve a PCP, Specialist or Clinic?				
РСР	Specialist	Clinic			
		Don't know	Prefer not to answer		
9. Do you have any upcoming health care appointments that HPSM can assist with coordinating?					
Yes	No	Don't know	Prefer not to answer		



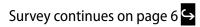
#### Health Care Continued

10. Do you currently NEED HELP getting any of the following services or supplies?			Yes	No	Don't know	Prefer not to answer
Oral/Dental Care (dentur	es, cavities, cleanings, pain, etc.)					
Specialist Care (heart, lur	ngs, pain, mental health, etc.)					
<b>Vision</b> (glasses, contacts e	etc.)					
Hearing (hearing aids)						
Medications (prescribed l	by your provider)					
Sexual Health Care (OB/0	Sexual Health Care (OB/GYN, family planning, urology, etc.)					
Incontinence Supplies (a	dult diapers) and/or Treatment					
	/ <b>or Supplies</b> (cane, walker, whee ure, wound care, oxygen, etc.)	elchair,				
Interpreter Services						
11. Do you need help taking	11. Do you need help taking your medications?					
Yes	No Don't know			Prefer no	t to answer	
12. Do you know what to do in the event of an emergency (fire, earthquake, public health event, etc.)?						
Yes	No	Don't kr	now		Prefer no	t to answer



### Health Care Continued

13. Do you have a plan for your health care if you cannot make decisions?							
Yes	Yes No Don't know Prefer not to answer						
13a. If no, do you have someone who makes choices for you, such as a representative, or are you able to make your own choices?							
l can make my own choices							
13b. If you have a representative or someone who acts on your behalf, can you give their name and best contact number?							
Name							
Phone Number Relationship to member							





# **Living Environment**

14. What is your living situation today?				
I have a steady place to live	e: (Choose one that applies)			
Car or Mobile home	Hospital, treatme	nt facility or nursing home	Hotel or motel	
House, apartment, or t	railer Rooming house o	or shared/individual room in an ass	istance type facility	
I have a steady place to live	e today but I am worried abou	t losing it in the future		
l do not have a steady plac in a car, in park)	e to live (staying with others, i	n a hotel, in a shelter, living outside	e on the street, on the beach,	
Don't know	Prefer not to answ	wer		
15. Think about the place <u>wh</u>	<u>iere</u> you live. Do you have p	roblems with any of the followin	g? (Choose all that apply)	
Pests such as bugs, ants, or mice	Lead paint or pipes	Oven or stove not working	Water leaks	
Mold	Lack of heat	Smoke detectors missing or not working	None of the above	
		Don't know	Prefer not to answer	



# Living Environment Continued

16. 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
Rails for any stairs or ramps					
Space to use a wheelchair					
Stairs to get into your home or stairs inside of your home					
Elevator					
A door to the outside that locks					
Clear ways to exit your home					
Good lighting					
Good heating					
Good cooling					
Hot water					
Indoor toilet					

Yes	No	Don't know	Prefer not to answer

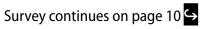


## Function

18. Are you currently affected by any of the following issues?	Yes	No	Don't know	Prefer not to answer
Seeing: Do you bump into things around your house?				
Hearing: Has anyone ever suggested you may need your hearing tested?				
<b>Oral health:</b> Do you have concerns regarding your teeth/mouth?				
19. Do you need help with any of these actions?	Yes	No	Don't know	Prefer not to answer
Taking a bath or shower				
Going up or down the stairs				
Making meals or cooking				
Shopping and getting food				
Eating				
Getting dressed				
Brushing hair, brushing teeth, shaving				
Getting out of a bed or a chair				
Using the toilet				
Walking				
Washing dishes or clothes				
Writing checks or keeping track of money				
Getting a ride to the doctor or to see your friends				
Doing house or yard work				
Going out to visit family or friends				
Using the phone				
Keeping track of appointments				

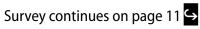
# Function Continued

20. 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	
21. Do you have family mem	bers or others willing and abl	e to help you when you need	it?	
Yes	No	Don't know	Prefer not to answer	
22. Do you ever think your ca	aregiver has a hard time givin	g you all the help you need?		
Yes	No	Don't know	Prefer not to answer	
23. Are you afraid of falling?				
Yes	No	Don't know	Prefer not to answer	
24. Have you fallen in the last month?				
Yes	No	Don't know	Prefer not to answer	



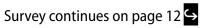
#### **Utilities/Finances**

25. Is anyone using your money without your okay?					
Yes	No	Don't know	Prefer not to answer		
26. Do you sometimes run out of money to pay for food, rent, bills and medicine?					
Yes	No	Don't know	Prefer not to answer		
27. 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		
28. Within the past 12 mo	onths, the food you bought ju	st didn't last and you didn't ha	ive money to get more.		
Often True	Sometimes True	Never True			
		Don't know	Prefer not to answer		



# Transportation

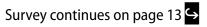
29. What is your primary mode of transportation?					
Car	Bus/Public transit	Taxi/Ride-share	Bicycle		
Walking		Don't know	Prefer not to answer		
30. Do you put off or neglect going to the doctor because of distance or transportation?					
Yes	No	Don't know	Prefer not to answer		
31. Has lack of transportation kept you from getting to medical appointments, meetings, work or getting things needed for daily living?					
Yes	No	Does not apply to me			
		Don't know	Prefer not to answer		



# OF SAN MATEO

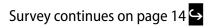
#### Wellness

32. Do you exercise f	or 2 to 3	hours eve	ery week	(brisk wall	king for 30	0 minutes	a day, 5 da	ays a week	<) <b>?</b>	
Yes		No			Don't know			Pr	Prefer not to answer	
33. 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			Prefe	Prefer not to answer	
34. 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		Prefe	Prefer not to answer			
35. Over the past mo	onth (30	days), hov	v many d	ays have	you felt le	onely?				
None Less than 5 days			More than 15 days			N	Nearly every day			
			Dor	Don't know		Pr	Prefer not to answer			
36. Over the past two	o weeks	(14 days),	how ofte	en have ye	ou had lit	tle intere	st or plea	sure doir	ng things?	
None		Less than 5 days			More than 7 days			N	Nearly every day	
			Don't know		Pr	Prefer not to answer				
37. Over the past two	o weeks	(14 days),	how ofte	en have ye	ou felt do	wn, depr	essed or l	nopeless?	,	
None Less than 5 days		More than 7 days		N	Nearly every day					
					Don't know		Pr	Prefer not to answer		



#### **Wellness** Continued

38. Have you had any changes in thinking, remembering or making decisions?							
Yes	No	Don't know	Prefer not to answer				
39. Do you currently use any tobacco products (smoke, vape, chew)?							
Yes	No	Don't know	Prefer not to answer				
If yes, I use the following tobacco product(s): (Choose all that apply)							
Smoke Vape Chew							
40. Does anyone in your household currently use any tobacco products (smoke, vape, chew)?							
Yes	No	Don't know	Prefer not to answer				
If yes, someone in my household uses the following tobacco product(s): (Choose all that apply)							
Smoke	Vape	Chew					
41. How often do you have a drink containing alcohol?							
Never	Monthly or less	2 to 4 times a month	2 to 3 times a week				
4 or more times a week		Don't know	Prefer not to answer				
42. Has anyone ever commented on your drinking, smoking, and/or drug use?							
Yes	Yes No		Prefer not to answer				



# OF SAN MATEO

#### **About You**

43. Are you a U.S. Armed Forces veteran?							
Yes	No	Don't know	Prefer not to answer				
44. Are there any immediate needs that you would like us to follow up on?							
Yes	No	Don't know	Prefer not to answer				
44a. If yes, provide your preferred contact information:							
Phone							

Thank you for taking the survey.