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 may share your answers with your primary care provider (PCP) and those treating you or helping with your care. 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 the 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. **What ongoing health conditions do you have? (Mark an X in the box next to the conditions you have.)**
   ☐ Alzheimer's or dementia ☐ Hepatitis C

☐ Stroke

☐ Parkinson's disease

☐ Anxiety

☐ Bipolar disorder

☐ Depression

☐ Schizophrenia

☐ Diabetes

☐ Epilepsy or seizure disorder

☐ Heart failure

☐ High blood pressure

☐ HIV or AIDS

☐ Kidney disease

On dialysis? ☐ Yes ☐ No

☐ Liver problems

☐ Multiple sclerosis

☐ Cancer: Active treatment

_____

☐ Transplant

_____

☐ Other _____

6. **Have you had any changes in thinking, remembering or making decisions?**
   ☐ Yes ☐ No

7. **"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

8. **In the past 6 months, how many times did you go to the hospital emergency room?**
   ☐ None ☐ 1 time ☐ 2 times or more

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

☐ None ☐ 1 time ☐ 2 times or more

10. What is your main health concern? _____

Living Arrangement and Daily Functioning

11. 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):

_____

12. Think about the place you live. Do you have problems with any of the following?

☐ Pests such as bugs, ants or mice

☐ Mold

☐ Lead paint or pipes

☐ Lack of heat

☐ Oven or stove not working

☐ Smoke detectors missing or not working

☐ Water leaks

☐ None of the above

13. Can you live safely and move easily around in 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

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

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

15. 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

16. 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 _____

17. 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?

_____

Mental Well-Being

18. 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

19. 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

20. Over the past month (30 days), how many days have you felt lonely?

☐ None — I never feel lonely ☐ Less than 5 days

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

21. 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

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

☐ Yes ☐ No

a. If yes, please explain: _____

23. 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

24. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes ☐ No

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

☐ Transportation help

☐ County alcohol or drug outpatient services

☐ County mental health

☐ Food assistance programs (Meals on Wheels, CalFresh, food banks)

☐ Dental

☐ Help paying utility bills (CARE/FERA)

☐ In-Home Supportive Services (IHSS)

☐ Regional Center of Orange County (RCOC)

☐ Housing Services

☐ Other community resource:

_____

26. Are you interested in getting any information about the resources listed above?

☐ Yes ☐ No

Social History

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

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

28. 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

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

☐ 1–2 ☐ 3–4 ☐ 5 or more

Do you want to talk to someone about resources available for reducing or quitting your alcohol use? ☐ Yes ☐ No

Health Care Planning

30. 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

_____

31. 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

32. What are your goals for your health?

_____

Thank you for answering these questions. Your answers will help us serve you better.

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.

Enclosure:

- Notice of Nondiscrimination