Your Health Risk Assessment Questionnaire

An important tool that helps us understand your healthcare needs.

Each year, Medicare asks HealthTeam Advantage to invite our members to complete a health survey. This short questionnaire helps us get to know you better so we can make sure you're using all the benefits and programs available in your plan. Your answers will not change your plan benefits or your premium.

Just answer each question as best you can — there are no right or wrong answers. If you're a member of our **HMO C-SNP** plan, completing this survey is required. For **PPO** plan members, it's optional — but we encourage you to fill it out. Your answers may be shared with your primary care provider and care management team to help them better support your health needs.

Do you need help completing this?
We're here for you!

Call your HealthCare Concierge at 1-888-965-1965 (TTY 711).

8am-8pm | April 1-September 30, Monday-Friday
October 1-March 31, 7 Days a Week

Contact Information

Name: _____

Your HealthTeam Advantage ID Number or Medicare Number: _____

Date of Birth: _____ **Phone:** _____

Email: _____

Preferred method of communication: _____ **Phone** _____ **Email**

Preferred time to contact: _____ **Morning** _____ **Afternoon** _____ **Evening**

Getting to Know You

Race/Ethnicity

____ White ____ Black/African American ____ Native American
____ Asian or Pacific Islander ____ Hispanic/Latino ____ Multi-ethnic

Other _____

Height _____ ft _____ in **Weight** _____ lbs

In the previous 12 months, how many times have you seen your primary care provider (PCP)?

_____ None
_____ One time
_____ 2-3 times
_____ 4 or more times
_____ I don't have a primary care provider.

I use the following locations for my medical care:

Primary Care Provider	_____ Yes	_____ No	Urgent Care	_____ Yes	_____ No
Specialist	_____ Yes	_____ No	Emergency Room	_____ Yes	_____ No

In the previous six months, have you been to the emergency room four or more times?

_____ Yes _____ No

In the previous six months, have you been admitted to the hospital more than twice?

_____ Yes _____ No

In the previous six months, have you fallen more than twice?

_____ Yes _____ No

Do you use any of the following to be safe moving and walking?

_____ Cane _____ Walker _____ Scooter _____ Wheelchair _____ Ramp

Have you designated someone to make medical decisions if you can't? (Medical Power of Attorney)

_____ Yes _____ No

Do you have a living will or advance directive?

_____ Yes _____ No

Would you like information on a living will or advance directive?

_____ Yes _____ No

Do you have any of the following conditions? Check all that apply.

Anxiety	_____ Yes	_____ No	Heart Attack	_____ Yes	_____ No
Atrial Fibrillation	_____ Yes	_____ No	Heart Disease	_____ Yes	_____ No
Chronic Heart Failure	_____ Yes	_____ No	High Blood Pressure	_____ Yes	_____ No
Dementia	_____ Yes	_____ No	Lung Problems	_____ Yes	_____ No
Depression	_____ Yes	_____ No	Memory Loss	_____ Yes	_____ No
Diabetes	_____ Yes	_____ No	Stroke	_____ Yes	_____ No

Does one of your medical conditions significantly overwhelm your ability to take care of yourself?

____ Yes ____ No

Do you have trouble obtaining food on a frequent basis?

____ Yes ____ No

Do you need assistance with the following? Check one response for each task.

Task	Able to do this without help.	I have some help with this.	I need help and I have no one to help me.
Bathing			
Dressing			
Eating			
Using the restroom			
Walking			
Taking medications			
Meal preparation			
Housekeeping chores			
Shopping and errands			
Transportation			
Money management			

If you smoke, are you thinking about quitting smoking? Would you be interested in receiving some information?

____ Yes ____ No ____ I don't know

Do you take more than 10 medications?

____ Yes ____ No

Do you sometimes go without your medications due to cost?

____ Yes ____ No

Do you have difficulty getting to the pharmacy to pick up your medications?

____ No

____ Sometimes

____ Most of the time

____ Always

We believe everyone deserves the chance to live a healthy life. Not having enough food, reliable transportation, or a safe place to live can make that harder. Please take a moment to answer the next few questions so we can better understand your situation. We may not have resources for every need, but we'll do our best to connect you with help whenever possible.

	Yes	No
FOOD		
Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
HOUSING/UTILITIES		
Within the past 12 months, have you ever stayed outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
Are you worried about losing your housing?		
Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
TRANSPORTATION		
Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
INTERPERSONAL SAFETY		
Do you feel physically or emotionally unsafe where you currently live?		
Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by anyone?		
Within the past 12 months, have you been humiliated or emotionally abused by anyone?		

Would you like to share any personal health goals or concerns? If so, please list or describe below.

_____

_____

_____

_____

_____

_____

IF you have DIABETES MELLITUS, please complete SECTION 2.

IF you have CHRONIC HEART FAILURE OR CARDIOVASCULAR DISORDERS, please complete SECTION 3.

IF you have MORE THAN ONE OF THESE DIAGNOSES, please complete SECTIONS 2 AND 3.

SECTION 2: Diabetes Mellitus

1. Which type of medication do you take for your diabetes? (check one)

_____ None
_____ Pills only
_____ Insulin only
_____ Both pills and insulin
_____ Other medicine by shot
_____ Pills, insulin, and other medication by shot

2. How often do you have your blood HgbA1c checked? (check one)

_____ Never
_____ Once a year
_____ Two or more times a year
_____ I don't know what HgbA1c is.

3. What was your last HgbA1c result? (check one)

_____ 6.5 or less
_____ Between 6.6 and 7.5
_____ Between 7.6 to 9.0
_____ More than 9.0
_____ Don't know

4. Do you have a glucometer (blood sugar testing device)?

_____ Yes _____ No

5. How many times do you check your blood sugar each day? (check one)

_____ Once
_____ Twice
_____ Three times
_____ Four or more times
_____ Less than daily
_____ Never

6. During a week, how often does your blood sugar drop below 70? (check one)

_____ Never
_____ Once
_____ Two or three times a week
_____ More than three times a week
_____ Don't know

7. How often do you have your feet checked? (check one)

_____ Once a year
_____ Twice a year
_____ Never

8. How often do you have an eye exam? (check one)

_____ Once a year
_____ Never

9. How often do you have your urine checked? (check one)

_____ Once a year
_____ Twice a year
_____ Never

SECTION 3: Chronic Heart Failure or Cardiovascular Disorder (i.e. cardiac arrhythmias, coronary artery disease, peripheral vascular disease, or chronic venous thromboembolic disorder)

1. Do you ever have difficulty walking or climbing stairs due to breathing? (check one)

_____ No
_____ Rarely
_____ Usually
_____ Always

2. How many pillows do you use to sleep at night? (check one)

_____ 1
_____ 2
_____ 3
_____ I can't sleep in a bed due to my breathing.

3. In the past month, how often have you been short of breath? (check one)

_____ Several times a day
_____ Once daily
_____ A few times a week
_____ Not at all

4. Do you have a working weight scale at home? (check one)

_____ Yes
_____ No

5. How often do you weigh yourself at home? (check one)

_____ Daily
_____ Twice a week
_____ Never
_____ I don't have a scale.

6. Are you on fluid restriction? (check one)

_____ No
_____ Yes
_____ Yes, but I don't follow it.
_____ Why do I need to worry about fluid amounts?

7. Do you ever have swelling in your ankles or legs? (check one)

_____ No
_____ Rarely
_____ Usually
_____ Always

8. Do you watch the salt you use to cook or how much you eat? (check one)

_____ Yes
_____ Sometimes
_____ No
_____ Why do I have to worry about salt?

9. Do you have a blood pressure monitor at home? (check one)

_____ Yes
_____ No

Thank you for completing! Now that you have finished, please mail your completed questionnaire to: HealthTeam Advantage, Attn: Quality Team (HRA), 5815 Samet Dr., Suite 107, High Point, NC 27265

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