



# Health Survey

ATTN: Member Assessment (B/S)  
 300 Oceangate Ste 100  
 Long Beach CA 90802-9894

<p><b>Member Name:</b></p> <p><b>Person Completing this Survey:</b></p> <p><b>Relationship to Member:</b></p> <p><b>Member Healthcare ID:</b></p> <p><b>Member's Date of Birth :</b></p> <p><b>State:</b></p>	<p><b>Member's Home Phone:</b></p> <p><b>Member's Cell Phone:</b></p> <p><b>Phone for Person Completing the Survey:</b></p> <p><b>Today's Date:</b></p> <p><b>Writing Number:</b> _____</p> <p><b>Proposed Effective Date:</b> _____</p>
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QUESTION	RESPONSE
<p>Do you have a language need other than English?</p>	<p> <input type="checkbox"/> Arabic                      <input type="checkbox"/> Creole  <input type="checkbox"/> French                        <input type="checkbox"/> Mandarin  <input type="checkbox"/> Russian                        <input type="checkbox"/> Somali  <input type="checkbox"/> Spanish                        <input type="checkbox"/> Vietnamese  <input type="checkbox"/> Other, please describe your preferred language:         </p>
<p>Do you have any special preferences we should be aware of? Please check all boxes that apply.</p>	<p>Check all that apply:</p> <p> <input type="checkbox"/> Cultural preference  <input type="checkbox"/> Hearing impairment  <input type="checkbox"/> Literacy  <input type="checkbox"/> Religion/Spiritual needs or preferences  <input type="checkbox"/> Visual impairment  <input type="checkbox"/> None  <input type="checkbox"/> If Other         </p> <p>Please describe your preferences:</p>

<p>What is your main health concern right now?</p>	
<p>Do you have any of these conditions? Please check the boxes that apply.</p>	<p> <input type="checkbox"/> Asthma  <input type="checkbox"/> Behavioral Health Conditions              <input type="checkbox"/> Bipolar Disorder              <input type="checkbox"/> Depression              <input type="checkbox"/> Psychotic Disorders (Schizophrenia)              <input type="checkbox"/> Substance Use Disorders  <input type="checkbox"/> Cancer (Presently being treated)  <input type="checkbox"/> Congestive Heart Failure (CHF)  <input type="checkbox"/> COPD with oxygen use  <input type="checkbox"/> Diabetes with complications  <input type="checkbox"/> ESRD on dialysis treatment  <input type="checkbox"/> HIV/AIDS  <input type="checkbox"/> Intellectual or Developmental Disabilities  <input type="checkbox"/> Pregnancy  <input type="checkbox"/> Other, please describe your health condition(s):       </p>
<p>How would you compare your health status compared to others your age? (Answer only if 18 years or older)</p>	<p> <input type="checkbox"/> Excellent    <input type="checkbox"/> Very Good    <input type="checkbox"/> Good  <input type="checkbox"/> Fair            <input type="checkbox"/> Poor       </p>
<p>Do you worry about your memory or have you been told by friends or family that they are worried about your memory? (Adult only question)</p>	<p> <input type="checkbox"/> Yes            <input type="checkbox"/> No       </p>
<p>Have you visited the Emergency Room (ER) in the past 6 months?</p>	<p> <input type="checkbox"/> Yes            <input type="checkbox"/> No          If yes, how many visits? _____          If yes, please describe the reason for the visit:       </p>

<p>Have you stayed overnight in the hospital in the past 6 months? If yes, please describe the reason for the hospital stay:</p>	<p><input type="checkbox"/> No  <input type="checkbox"/> Yes  If yes, how many visits? _____</p>
<p>Do you understand what your medication(s) are for and why you are taking them?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No  If No, we recommend:  • Putting your medication in a “Brown Bag” and taking them to your next doctor’s appointment.</p>
<p>What is your current living situation?</p>	<p><input type="checkbox"/> Live alone  <input type="checkbox"/> Live with spouse  <input type="checkbox"/> Live with other family  <input type="checkbox"/> Live with others unrelated  <input type="checkbox"/> Live in an assisted living facility  <input type="checkbox"/> Live in a group home  <input type="checkbox"/> Live in a nursing facility  <input type="checkbox"/> Live in a shelter  <input type="checkbox"/> Homeless  <input type="checkbox"/> Live in out of home placement  <input type="checkbox"/> Live in out of state medical facility  <input type="checkbox"/> None of the above, please describe:</p>
<p>Which activities <b>do you need help on</b>? Please check the boxes that you need help doing.</p> <p>Do you have someone helping you now?</p>	<p><input type="checkbox"/> Feeding self  <input type="checkbox"/> Bathing  <input type="checkbox"/> Dressing  <input type="checkbox"/> Using the toilet  <input type="checkbox"/> Continence/problems getting to the toilet on time  <input type="checkbox"/> Getting up from a chair or out of bed  <input type="checkbox"/> Grocery shopping or getting food  <input type="checkbox"/> Transportation  <input type="checkbox"/> None  <input type="checkbox"/> If Other, please list or describe</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>

<b>Living Will and Advance Directive</b>	
<p>An advanced directive is a form that lets your loved ones know your health care choice, if you are too sick to make them yourself.</p> <p>On the advance directive form, you can describe what type of treatment you want and how you wish to be cared for, so your family and caregivers know your wishes.</p> <p>Do you have a living will or an advanced directive in place?</p> <p>If no, would you like to receive more information about advance directives?</p>	<p>Living will      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>Advance directive      <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>

<b>Behavioral Health</b>	
Over the last 2 weeks, how often have you had little interest or pleasure in doing things?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
Over the last 2 weeks, how often have you been feeling down, depressed or hopeless?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
Please let us know of any other health concerns you have.	

Thank you for taking the time to complete this survey. Someone may reach out to you.

If you need more help to manage your health, you can ask for an Inter-discipline Care Team (ICT) meeting. A care team may include doctors, pharmacists, care providers, or other experts. You can choose who may join the team. The team can meet to discuss your concerns. The meeting may be in person or by phone. The team can give ideas to help manage your health.

If you have questions, please call Passport Health Plan at (866) 472-4582 TTY: 711, 7 days a week, 6 a.m. to 6 p.m., PST.

For health-related questions call our Nurse Advice Line at (800) 357-0163, TTY: 711, 7 days a week, 24 hours a day.

You can get this document for free in non-English language(s) or other formats, such as large print, braille, or audio. Call (844) 859-6152, TTY: 711. The call is free.

Passport Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of healthcare, claims experience, medical history, genetic information, evidence of insurability, geographic location.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (844) 859-6152, TTY: 711.