MOLINA HEALTHCARE

Health Survey

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

Member Name:	**Member's Home Phone:**
Person Completing this Survey:	**Member's Cell Phone:**
Relationship to Member:	**Phone for Person Completing the Survey:**
Member Healthcare ID:	**Today's Date:**
Member's Date of Birth :	**Writing Number:**_____
State:	**Proposed Effective Date:**_____

QUESTION	RESPONSE
Do you have a language need other than English?	☐ Arabic ☐ Creole ☐ French ☐ Mandarin ☐ Russian ☐ Somali ☐ Spanish ☐ Vietnamese ☐ Other, please describe your preferred language:
Do you have any special preferences we should be aware of? Please check all boxes that apply.	Check all that apply: ☐ Cultural preference ☐ Hearing impairment ☐ Literacy ☐ Religion/Spiritual needs or preferences ☐ Visual impairment ☐ None ☐ If Other Please describe your preferences:

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

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

Living Will and Advance Directive	
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. 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. Do you have a living will or an advanced directive in place? If no, would you like to receive more information about advance directives?	Living will ☐ Yes ☐ No Advance directive ☐ Yes ☐ No ☐ Yes ☐ No
Behavioral Health	
Over the last 2 weeks, how often have you had little interest or pleasure in doing things?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Over the last 2 weeks, how often have you been feeling down, depressed or hopeless?	☐ Not at all ☐ Several days ☐ More than half the days ☐ 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 Molina Healthcare 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 (800) 665-3086, TTY: 711. The call is free.

Molina Healthcare 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 (800) 665-3086 (TTY: 711).