765 The City Drive South, #200 | Orange, CA 92868
www.astivahealth.com

Phone: (866) 688-9021

HEALTH RISK ASSESSMENT

Enrollee's First Name:	M.I.:	Enrollee's Last Name:	Date of Birth:
			Enrollment Date:
Address:			Enrollee's Medicare ID:
Phone:			Plan Number:

Dear Member:
A Health Risk assessment is a short survey that helps Astiva know more about your health status. The information you provide will be used to develop an Individualized Care Plan (ICP). Your responses will not impact your benefits and will only be shared with your primary care provider. We appreciate you taking the time to answer these questions honestly, so that we can better address your needs. Please return this form to us using the attached envelope. We value your trust and take every measure to protect your privacy.

Individual's Rights

1. Do you agree to participate in the completion of this health survey? ☐ Yes ☐ Refuse
   a. Do you agree to be contacted by an Astiva Case Manager? ☐ Yes ☐ Refuse ☐ DO NOT CALL

General Health Survey

2. Have you seen your primary care doctor (PCP) within the last 12 months? ☐ Yes ☐ No

3. Compared to other people your age, how would you describe your health?
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

4. In the last 12 months, how many times have you been admitted to the hospital or the emergency room?
   ☐0 ☐1 ☐ 2 ☐ ≥ 3

5. Do you use any of the following medical equipment or medical devices? (Mark all that apply)
   ☐No ☐Cane ☐Walker ☐Wheelchair ☐Electric Scooter ☐Oxygen ☐CPAP/BiPAP ☐Hospital Bed

6. Which of the following health conditions do you currently have? (Mark all that apply)

   a. ☐ Diabetes or high blood sugar
   b. ☐ COPD, Asthma, or other breathing/lung conditions
   c. ☐ Kidney disease or failure
   d. ☐ High blood pressure
   e. ☐ Malnutrition/unintended weight loss
   f. ☐ Heart failure
   g. ☐ Other heart disease
   h. ☐ Active cancer
   i. ☐ History of stroke
   j. ☐ Severe obesity
   k. ☐ High cholesterol
   l. ☐ Behavioral health condition
   m. ☐ Alzheimer's Disease/dementia
   n. ☐ Parkinson's Disease
   o. ☐ Other _____
   p. ☐ None

7. Have you had Advance Care Planning? (Discussion about your health care wishes if you become unable to make your own medical decisions.) ☐ Yes ☐ No ☐ Unsure

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8. Do you normally experience severe pain, i.e. ≥8 out of 10 in intensity? ☐ Yes ☐ No

a. If Yes, how do you manage your pain? (Mark all that apply) ☐Prescription ☐Over the Counter ☐Exercise ☐Physical Therapy ☐Alternative Therapy ☐Rest ☐No Treatment ☐Other _____

9. Is there anything that prevents you from taking medications as prescribed? (Mark the primary reason)

☐Difficult medication schedule	☐Picking up medications	☐Forgetting to take medications
☐Cost	☐I don't believe in medications	☐Nothing, I take them as prescribed
☐Side Effects	☐Not sure how to take them	☐I do not take any medications
☐Problems with vision	☐Difficulty filling prescriptions	☐Other _____

Emotional and Mental Health

10. Over the past month, how often have you been bothered by the following:	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐

Functional Assessment

11. How often do you need help for these tasks:	Unable to do this activity	Yes, I need assistance	No, I do this myself
a. Using the toilet:	☐	☐	☐
b. Feeding yourself:	☐	☐	☐
c. Walking:	☐	☐	☐
d. Bathing:	☐	☐	☐
e. Dressing:	☐	☐	☐

12. In the last 12 months, how many times did you sustain a fall?
☐0 ☐1 ☐2 ☐≥3

13. In the last 30 days, how many times per week have you exercised for at least 30 minutes?
☐0 ☐1-2 ☐3-4 ☐≥5

Social Health History

14. Within the past 12 months, did you worry that your food would run out before you got money to buy more?
☐ Yes ☐ No

15. Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicine, non-medical meetings, appointments, work, or from getting things you need?
☐ Yes ☐ No

16. Are you worried about losing your housing?
☐ Yes ☐ No

17. What best describes your current living arrangement?
☐Live alone ☐Live with family or significant other
☐Live with others, not family ☐Live with caregiver
☐Live in an assisted living or nursing facility
☐Lack stable housing

18. Are you afraid of anyone or is anyone hurting you?
☐ Yes ☐ No ☐ Decline

19. How many times in the past 12 months have you had more than 4-5 alcoholic drinks in a day?
☐ Never ☐ Once a month
☐ Once a week ☐ Daily or almost daily

Authorized Representative:
(Agent's signature)

Date: