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### HEALTH RISK ASSESSMENT

<b>Member's First Name:</b>	<b>M.I.:</b>	<b>Member's Last Name:</b>	<b>Date of Birth:</b>
			<b>Enrollment Date:</b>
<b>Address:</b>			<b>Member ID:</b>
<b>Phone:</b>			<b>Plan Number:</b>

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? <input type="checkbox"/> Yes <input type="checkbox"/> Refuse a. Do you agree to be contacted by an Astiva Case Manager? <input type="checkbox"/> Yes <input type="checkbox"/> Refuse <input type="checkbox"/> DO NOT CALL	
General Health Survey	
2. Have you seen your primary care doctor (PCP) within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Compared to other people your age, how would you describe your health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	4. In the last 12 months, how many times have you been admitted to the hospital or the emergency room? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> ≥ 3
5. Do you use any of the following medical equipment or medical devices? (Mark all that apply) <input type="checkbox"/> No <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Electric Scooter <input type="checkbox"/> Oxygen <input type="checkbox"/> CPAP/BiPAP <input type="checkbox"/> Hospital Bed	
6. Which of the following health conditions do you currently have? (Mark all that apply)	
a. <input type="checkbox"/> Diabetes or high blood sugar b. <input type="checkbox"/> COPD, Asthma, or other breathing/lung conditions c. <input type="checkbox"/> Kidney disease or failure d. <input type="checkbox"/> High blood pressure e. <input type="checkbox"/> Malnutrition/unintended weight loss	f. <input type="checkbox"/> Heart failure g. <input type="checkbox"/> Other heart disease h. <input type="checkbox"/> Active cancer i. <input type="checkbox"/> History of stroke j. <input type="checkbox"/> Severe obesity k. <input type="checkbox"/> High cholesterol
l. <input type="checkbox"/> Behavioral health condition m. <input type="checkbox"/> Alzheimer's Disease/dementia n. <input type="checkbox"/> Parkinson's Disease o. <input type="checkbox"/> Other _____ p. <input type="checkbox"/> None	
7. Have you had Advance Care Planning? (Discussion about your health care wishes if you become unable to make your own medical decisions.) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	



8. Do you normally experience severe pain, i.e.  $\geq 8$  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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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	12. In the last 12 months, how many times did you sustain a fall? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> $\geq 3$
a. Using the toilet:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. In the last 30 days, how many times per week have you exercised for at least 30 minutes? <input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> $\geq 5$
b. Feeding yourself:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Walking:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Bathing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Dressing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**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

**Member's Signature:**

**Date:**