Health Assessment Survey—For broker agent use only

Member name: _____

Medicare beneficiary ID (MBI#): _____

Broker agent name: _____

Broker agent number: _____

1. **What is your primary language?**

   ___ English ___ Spanish ___ Russian ___ Nepali ___ Mandarin

   ___ Cantonese ___ Vietnamese ___ Other, please write-in answer on Page 1.

2. **Compared to other people your age, would you say that your health is?**

   ___ Excellent ___ Good ___ Fair ___ Poor

3. **How would you describe the health of your mouth and teeth?**

   ___ Excellent ___ Good ___ Fair ___ Poor

4. **Have you had a flu shot in the last year?**

   ___ Yes ___ No ___ I don't know or I don't remember

5. **How many different prescription medications do you take on an average day?**

   ___ 0 ___ 1-4 ___ 5-8 ___ 9 or more ___ I don't know

6. **Do you take all your medications as prescribed? Please mark all that apply.**
   ___ I do take all my medications as prescribed
   ___ I don't take all my medications as prescribed
   ___ I have trouble paying for my medications
   ___ I have trouble getting my medications
   ___ I have trouble remembering to take my medications
   ___ I have trouble understanding how and/or why to take my medications the correct way
   ___ I don't know if I am taking my medications as prescribed

7. **In the past year, how many times were you admitted to the hospital?**

   ___ None ___ One time ___ 2-3 times ___ More than 3 times ___ I don't know

8. In the past year, how many times did you visit the emergency room for your own needs?

___ None ___ One time ___ 2-3 times ___ More than 3 times ___ I don't know

9. Have you ever been told that you have any of the following? Please mark all that apply.

___ High blood pressure
___ Asthma
___ Diabetes
___ Sickle cell
___ Memory problems
___ Depression
___ High cholesterol
___ COPD/Emphysema
___ Kidney failure
___ Cancer
___ ADHD
___ Anxiety
___ Heart failure/Heart disease or CHF
___ Stroke
___ Dialysis
___ Back pain
___ Intellectual disability
___ Substance use disorder
___ Other
___ None of these

10. Over the past two weeks, have you been bothered by little interest or pleasure in doing things several days or more?

___ Yes ___ No

11. Over the past two weeks, have you been bothered by feeling down, depressed, or hopeless several days or more?

___ Yes ___ No

12. How often do you feel lonely?

___ Hardly ever or never ___ Some of the time ___ Often

13. Do any of the following apply to you? Please mark all that apply.

___ I feel my weight is too high
___ I don't eat a healthy diet
___ I smoke or use tobacco
___ I drink too much alcohol
___ I use drugs or medications not ordered for me
___ I feel my weight is too low
___ I don't get enough physical activity
___ I have trouble handling my stress
___ None of these

14. Do any of the following make it hard to communicate? Please mark all that apply.

___ I have trouble hearing
___ I have trouble reading
___ I have trouble seeing
___ I have trouble speaking
___ None of these

15. Do you experience any of the following? Please mark all that apply.

___ I forget information recently learned
___ I ask for the same information multiple times or need reminder notes
___ I have trouble following instructions
___ I become confused or distracted in the middle of a conversation
___ I struggle to remember words, dates, or events
___ I lose or misplace things
___ My family/friends say I am forgetful
___ None of these

16. What is your living situation today?

___ I have a stable place to live
___ I have a place to live, but I am worried about losing it in the future
___ I don't have a stable place to live

17. Who do you live with?

___ I live alone
___ I live with other family member(s)
___ I live in a nursing home
___ I live in a group home
___ I live with my spouse
___ I live with friends or nonrelative(s)
___ I live in personal care/assisted living
___ Other

18. Are you the primary caregiver for someone else?

___ Yes, I have no issues or concerns caregiving for someone else
___ Yes, caregiving for someone else impacts my own health and wellness
___ No, I am not the primary caregiver for someone else

19. Do you receive or do you need assistance from another person for tasks like taking medications, meal preparation, housekeeping, laundry, telephone, shopping, or managing finances?

___ Yes, every day
___ Yes, 1 or 2 times per week
___ Yes, 1 or 2 times per month
___ No, I don't need help

20. Do you receive or do you need assistance from another person for bathing, dressing, toileting, bowel and bladder function, or eating?

___ Yes, every day
___ Yes, 1 or 2 times per week
___ Yes, 1 or 2 times per month
___ No, I don't need help

21. Who helps and supports you with completing daily tasks? Please mark all that apply.

___ Spouse
___ Caregivers from an agency
___ Other family member(s)
___ Staff in facility
___ Friends or nonrelative(s)
___ I don't need help and support

22. If you are receiving help from others, is the help and support reliable?

___ Yes, I have enough help and it is reliable
___ Yes, I have help, but sometimes it is not available
___ No, I need more help than I currently have
___ N/A, I don't receive help and support from others

23. Do you have assistive devices or other equipment to manage daily living? Please mark all that apply.

___ Cane
___ Prosthetic
___ Nebulizer
___ Walker
___ Hospital bed
___ Oxygen
___ Wheelchair
___ Hoyer lift
___ CPAP or BiPAP
___ Motorized scooter
___ Glucometer
___ Ventilator
___ Other(s)
___ None of these

24. Have you fallen 2 or more times in the last 3 months?

___ Yes ___ No ___ I don't know

25. Do you utilize any of these resources? Please mark all that apply.

___ MATP—Medical Assistance Transportation Program
___ SNAP—Supplemental Nutrition Assistance Program
___ LiHEAP—Low Income Home Energy Assistance Program
___ LTSS—Long-Term Services and Supports: Personal Care at Home or Nursing Facility Care
___ None of these

26. Do you need help with getting any of the following? Please mark all that apply.

___ Transportation
___ Food
___ Utilities
___ Clothing
___ Household supplies
___ None of these

27. Have you or a spouse ever served in the military?

___ Yes
___ No
___ I don't know

28. An advance directive (also called a living will) tells others how you want to be cared for if you are unable to make your own choices about health care in the future. Do you have an advance directive?

___ Yes, I have an advance directive
___ No, I don't have an advance directive, and I am not interested at this time
___ No, I don't have an advance directive. Please send me information by mail.
___ I don't know

29. A personal representative can speak on your behalf with the Health Plan about your private health information and benefit coverage. Have you provided us with a personal representative?

___ Yes, I have identified my personal representative
___ No, I am not interested in identifying a personal representative at this time
___ No, I have not identified a personal representative. Please send me information by mail.
___ I don't know

2022_BRKHAS_22SNP2815397 (MS) 4/4/22