



# Partnership HealthPlan of California

## Health Risk Assessment Form

### Seniors and Persons with Disabilities (SPD)

This form will help Partnership HealthPlan of California learn about your health and wellness needs and find ways we can help you. Please take a few minutes to fill out this form and send it back as soon as possible.

If you think you need to see a doctor before Partnership calls you, you should go to the doctor or hospital at that time.

If you have questions, please call Partnership at **(800) 809-1350**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call **(800) 735-2929**.

**Please return your completed form in the green envelope.**

Partnership HealthPlan of California  
4665 Business Center Drive  
Fairfield, CA 94534

*Filling out this form is voluntary. We will not deny your care because of how you respond.*

**Name of Partnership Member:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Medi-Cal ID Number:** \_\_\_\_\_

1. What is your preferred language?  
 English    Spanish    Russian    Mandarin    Tagalog    Other
2. What was your gender at birth?  
 Male    Female    Other
3. What do you like to be called?  
 He/Him/His    She/Her/Hers    They/Them/Their    Other
4. Do you have trouble communicating due to hearing, vision, or speech problems?  
 Yes    No  
If yes, do you need special materials/equipment?    Yes    No
5. Do you have a regular doctor?    Yes    No
6. Do you see a specialist(a doctor who specializes in health problems, like heart, kidney, cancer or other health problems)?    Yes    No
7. Do you feel your doctor(s) understand your medical needs?    Yes    No
8. Do you need to see a doctor in the next 60 days?    Yes    No  
If yes, do you have the appointment scheduled?    Yes    No
9. Do you get services or care from a regional center that cares for people with developmental disabilities?    Yes    No

10. Are you pregnant?  Yes  No
11. Have you been to the emergency room 2 or more times in the last 12 months?  Yes  No
12. Have you been admitted to the hospital in the last 12 months?  Yes  No
13. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, or ostomy bags?  Yes  No  
*If yes, do you need help getting more supplies?*  Yes  No
14. Do you smoke or use tobacco products?  Yes  No  
*If yes, would you like help quitting?*  Yes  No
15. Do you use home oxygen?  Yes  No
16. How many prescription medicines do you take each day?  
 1  2  3  4  5  6  7  8 or more
17. Have you ever been told you have any of these health problems?  
(check yes or no for each of the problems below)
- |   |                              |                             |
|---|------------------------------|-----------------------------|
| California Children's Services (CCS) condition      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma/Lung problems                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart problems                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV or AIDS   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Disease                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seizures  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Medical Therapy Program or Unit (MTP/MTU) condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- If yes to any, do you see a doctor or specialist for any of these problems?*  Yes  No
- If yes to any, have you ever had any surgeries for these problems?*  Yes  No
- Do you need help finding a doctor to help you with these problems?  Yes  No
18. Have you ever been told you have a mental or behavioral health problem such as depression, bipolar disorder, or schizophrenia?  Yes  No  
*If yes, do you need help finding a doctor to help you with a mental or behavioral health problem?*  Yes  No
19. Would like more information about how to improve your health or stay healthy?  Yes  No
20. Do you need help with any of these actions? (**Yes** or **No** to each individual action, choose **N/A** if this is something you have never done)
- |                         |                              |                             |                              |
|-------------------------|------------------------------|-----------------------------|------------------------------|
| Taking a bath or shower | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
|-------------------------|------------------------------|-----------------------------|------------------------------|

- Going up stairs  Yes  No  N/A
- Eating  Yes  No  N/A
- Getting dressed  Yes  No  N/A
- Brushing teeth, brushing hair, shaving  Yes  No  N/A
- Making meals or cooking  Yes  No  N/A
- Getting out of a bed or a chair  Yes  No  N/A
- Shopping and getting food  Yes  No  N/A
- Using the toilet  Yes  No  N/A
- Making it to the toilet on time/without an “accident”  Yes  No  N/A
- Walking  Yes  No  N/A
- Washing dishes or clothes  Yes  No  N/A
- Writing checks or keeping track of money  Yes  No  N/A
- Getting a ride to the doctor or to see your friends  Yes  No  N/A
- Doing house or yard work  Yes  No  N/A
- Going out to visit family or friends  Yes  No  N/A
- Using the phone  Yes  No  N/A
- Keeping track of appointments  Yes  No  N/A

**If yes, are you getting all the help you need with these actions?**

- Yes  No  N/A

21. Can you live safely and move easily around your home?

- Yes  No  N/A

*If no*, does the place where you live have:  
(Yes, No, or N/A to each individual item)

- Good lighting  Yes  No  N/A
- Good heating  Yes  No  N/A
- Good cooling  Yes  No  N/A
- Rails for any stairs or ramps  Yes  No  N/A
- Hot water  Yes  No  N/A
- Indoor toilet  Yes  No  N/A
- A door to the outside that locks  Yes  No  N/A
- Stairs to get into your home or stairs inside your home  Yes  No  N/A
- Elevator  Yes  No  N/A
- Space to use a wheelchair  Yes  No  N/A
- Clear ways to exit your home  Yes  No  N/A

22. I would like to ask you about how you think you are managing your health conditions

- Do you need help taking your medications?  Yes  No  N/A
- Do you need help filling out health forms?  Yes  No  N/A
- Do you need help answering questions during a doctor’s visit?  Yes  No  N/A

23. Which of the following answers best describes how you feel with your medical needs? (check all that apply)

- I sometimes forget what I am supposed to do for my health
- I can’t afford all of things I need to take care of myself
- It’s hard to read or understand directions at times
- I’m confused about what I really need to do for my health

- I don't think it is necessary to do what my doctor says all of the time
- I don't understand my medical needs
- I feel confident that I know how to take care of what I need

24. Do you have family members or others willing and able to help you when you need it?  Yes  No  N/A
25. Do you ever think your caregiver has a hard time giving you all the help you need?  Yes  No  N/A
26. Are you afraid of anyone or is anyone hurting you?  Yes  No  N/A
27. Is anyone using your money without your ok?  Yes  No  N/A
28. Have you had any changes in thinking, remembering, or making decisions?  Yes  No  N/A
29. Have you fallen in the last month?  Yes  No  N/A  
Are you afraid of falling?  Yes  No  N/A
30. Do you sometimes run out of money to pay for food, rent, bills, and medicine?  Yes  No  N/A
31. Over the past month (30 days), how many days have you felt lonely?  
 None – I never feel lonely  
 Less than 5 days  
 More than half the days (more than 15)  
 Most days – I always feel lonely
32. In general, would you say that your health is  
 Excellent  Very Good  Good  Fair  Poor

Signature of person filling out the form: \_\_\_\_\_

Date: \_\_\_\_\_

*If not signed by member, what is your relationship to the member:*  
Parent/ Guardian/ Other Representative

***Thank you for your time filling out this form.***  
**CONFIDENTIAL**