Partnership HealthPlan of California
Health Risk Assessment Form
Seniors and Persons with Disabilities (SPD)

This form will help Partnership 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 mail 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 through Friday, between 8 a.m. – 5 p.m. TDD users should dial: (800) 735-2929

Please mail this completed form to:
Partnership HealthPlan of California
c/o Care Coordination
4665 Business Center Drive
Fairfield, CA 94534
Fax: (707) 863-4502

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

Name of PHC 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 ☐ Yes ☐ No
   Asthma/Lung problems ☐ Yes ☐ No
   Heart problems ☐ Yes ☐ No
   Diabetes ☐ Yes ☐ No
   HIV or AIDS ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Medical Therapy Program or Unit (MTP/MTU) condition ☐ Yes ☐ 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 ☐ Yes ☐ No ☐ 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 Signed: _____

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