HEALTH APPRAISAL

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

Please complete the following questions the best that you can. Your answers will not affect your Medicaid or Medicare benefits and the information will be treated with confidentiality. Information you provide may be reviewed by a care manager and may be shared with your primary care doctor and care team. Any questions that you are not comfortable answering, mark "Decline to answer." Completion of this form implies that you agree to have this used for this purpose.

Required:

Full Name: _____ Date of Birth: _____

Medicaid/Medicare ID Number: _____ Phone Number: _____

Address: _____

Primary Care Physician: _____ Date: ____/____/_____

Race or Ethnicity:

- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ Decline to answer

What is your preferred language?

- ☐ English
- ☐ Spanish
- ☐ Arabic
- ☐ Chinese (incl. Cantonese, Mandarin)
- ☐ Navajo
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Decline to answer
- ☐ Other: _____

We are interested in honoring your values and beliefs. Do you have any cultural preferences we should know about that may impact your healthcare?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

What are your preferences? _____

Do you participate in any of the following? Choose all that apply.

- ☐ Full-time employment
- ☐ Part-time employment
- ☐ Actively seeking employment
- ☐ Attending school
- ☐ Community service (volunteer hours)
- ☐ Employment readiness activities (job search and skills training)
- ☐ Caregiver for children
- ☐ Caregiver for other people (age 18+)
- ☐ Decline to answer

Are you a veteran?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

Do you have a documented disability?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

If yes, please describe: _____

Level of Education

What is the highest grade or level of school that you completed?

- ☐ 8th grade or less
- ☐ Some high school
- ☐ High school graduate or GED
- ☐ Some college
- ☐ College graduate
- ☐ More than a 4-year college graduate
- ☐ Decline to answer

Contact Information

How would you prefer to be contacted?

☐ Mail ☐ Phone ☐ Cell ☐ Text ☐ Email

List contact information: _____

General Health:

In general, would you say your physical health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Decline to answer

In general, would you say your mental health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Decline to answer

In general, would you say your dental health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Decline to answer

Are you currently pregnant?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

How much control do you feel you have in managing your health conditions?

- ☐ Not at all
- ☐ Some
- ☐ A great deal
- ☐ A little
- ☐ Quite a bit
- ☐ Decline to answer

Height and Weight

What is your height? _____ What is your weight? _____ ☐ Decline to answer

Physical Activity

Do you exercise?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

How often do you exercise each week?

- ☐ Every day
- ☐ Almost every day
- ☐ 1–2 times per week
- ☐ 3–4 times per week
- ☐ 5 or more times a week
- ☐ Other
- ☐ Decline to answer

How many falls have you had in the past 6 months?

- ☐ None
- ☐ 1–2
- ☐ 3–4
- ☐ 5 or more
- ☐ Decline to answer

Activities of Daily Living & Instrumental Activities of Daily Living (Select all that apply)

In the past 7 days, did you need help from others to perform everyday activities such as:

- ☐ Showering
- ☐ Eating / Preparing to eat
- ☐ Dressing
- ☐ Getting in / out of bed, chair, or wheelchair
- ☐ Grooming / Bathing
- ☐ Shopping
- ☐ Using the toilet
- ☐ Finances
- ☐ Walking
- ☐ Housekeeping, household chores
- ☐ None / Don't need assistance
- ☐ Continence
- ☐ Decline to answer

Who, if anyone, helps you with your healthcare or daily living needs?

Name: _____ Phone number: _____

What do they help you with?
(e.g., transportation, taking medication, emotional support, filling out forms, etc.)

_____

_____

Please select any health problems a doctor has told you that you have, or that you take medications for.

- ☐ Adrenal problems
- ☐ Angina (chest pain)
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bipolar disorder
- ☐ Bleeding
- ☐ Blood clot to lung
- ☐ Cancer—solid tumor (localized)
- ☐ Cancer—solid tumor (metastatic)
- ☐ Chronic bronchitis or COPD/emphysema
- ☐ Dementia/memory loss
- ☐ Depression
- ☐ Diabetes (Type I or II)
- ☐ Fractures (broken bones)
- ☐ Gastroesophageal reflux disease (GERD)/ Reflux esophagitis
- ☐ Hearing problems
- ☐ Heart attack/heart disease
- ☐ Heart failure
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Leukemia
- ☐ Liver disease
- ☐ Lymphoma
- ☐ Migraine
- ☐ Organ transplant
- ☐ Osteoporosis
- ☐ Peptic ulcer
- ☐ Peripheral neuropathy
- ☐ Prostate problems
- ☐ Post traumatic stress disorder (PTSD)
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Substance use disorder
- ☐ Suicidal thoughts
- ☐ Thyroid problems (high or low)
- ☐ Transient ischemic attack (TIA or mini-stroke)
- ☐ Urinary tract infection (UTI)
- ☐ Vision problems
- ☐ Other: _____
- ☐ None
- ☐ Decline to answer

Are there any other medical conditions that you have had in the past 5 years?

☐ Yes ☐ No ☐ Decline to answer

List past medical conditions you have had and when in the past 5 years:

_____

_____

Do you take your medications as prescribed?

- ☐ Yes
- ☐ No
- ☐ No medications prescribed
- ☐ Decline to answer

List the medications you have been prescribed along with their doses and frequency:

_____

_____

_____

If you don't take your medications as prescribed, what gets in the way?

_____

_____

_____

List any other medications that you took in the past 5 years, what they were for, and the outcome:

_____

_____

_____

What Type Of Equipment Or Services Do You Use? Select All That Apply.

Equipment

- ☐ Wheelchair / Walker / Cane / Scooter
- ☐ Glucose monitor
- ☐ Bath chair
- ☐ C-PAP
- ☐ Oxygen
- ☐ Hoyer lift
- ☐ Raised toilet
- ☐ Hospital bed
- ☐ Hearing aid/s
- ☐ Blood pressure cuff
- ☐ Glasses / Contact lenses
- ☐ Scale
- ☐ Other: _____
- ☐ None
- ☐ Decline to answer

Your Healthcare In the Last 6 Months

What other providers do you see besides your primary care provider? Select all that apply.

- ☐ Behavioral health
- ☐ Cardiologist
- ☐ Dentist
- ☐ Dermatologist
- ☐ Digestive doctor (GI)
- ☐ Ear, nose, and throat doctor
- ☐ Endocrinologist
- ☐ Eye doctor
- ☐ Foot doctor
- ☐ General surgeon
- ☐ Gynecologist
- ☐ Neurologist
- ☐ Oncologist
- ☐ Orthopedic
- ☐ Pain management
- ☐ Renal
- ☐ Rheumatologist
- ☐ Urologist
- ☐ Other: _____
- ☐ None
- ☐ Decline to answer

In the past 6 months, how many times have you been in the:

☐ Emergency Room _____ times ☐ Hospital or facility overnight _____ times ☐ Decline to answer

Have you had any past hospitalizations or major procedures in the past 5 years?

☐ Yes ☐ No ☐ Decline to answer

If yes, list:

_____

_____

Interpersonal Safety

Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No ☐ Decline to answer

Health Screenings and Vaccines in the Last 5 Years

If applicable, when was the last time you had any of the following screenings and who was your provider? (Month/Year)

☐ Breast cancer screening (mammogram): Provider:

_____ _____

☐ Cervical cancer screening (PAP smear): Provider:

_____ _____

☐ Colorectal cancer screening (colonoscopy, sigmoidoscopy, FIT test): Provider:

_____ _____

☐ Prostate: Provider:

_____ _____

How confident are you filling out medical forms by yourself?

☐ Extremely ☐ Quite a bit ☐ Somewhat
☐ A little bit ☐ Not at all ☐ Decline to answer

When was the last time you had any of the following vaccines?

☐ Pneumonia: _____ ☐ Decline to answer

☐ Flu: _____ ☐ Decline to answer

☐ COVID: _____ ☐ Decline to answer

☐ Shingles _____ ☐ Decline to answer

Do you have an Advance Directive? (A document that says how you want your healthcare delivered)

☐ Yes ☐ No ☐ Decline to answer

List type of Advance Directive(s) you have:

_____

_____

Do you have any specific health concerns your health plan team can assist with?

☐ Yes ☐ No ☐ Decline to answer

If yes, please list your specific health concerns:

_____

_____

The Interdisciplinary Care Team (ICT) is an important component of your integrated care program. The ICT can consist of you, your provider, other specialist, care manager, family members, medical director, and behavioral health professionals as needed to develop your care plan. If you choose to participate, our care management team will contact you to schedule an ICT. Would you like to participate in the ICT?

☐ Yes ☐ No ☐ Decline to answer

Substance Use

In the past 12 months, how often have you used tobacco or any other nicotine delivery product (i.e., e-cigarette, vaping, or chewing tobacco)?

☐ Daily or almost daily ☐ Weekly ☐ Monthly
☐ Less than monthly ☐ Never ☐ Decline to answer

Would you be interested in quitting tobacco use within the next month?

☐ Yes ☐ Unsure ☐ Not applicable
☐ No ☐ Decline to answer

How many times in the past year have you had 4 or more (for women) or 5 or more (for men) alcoholic drinks in a day? _____ times

In the last twelve months, did you use pot (marijuana), use a street drug, or use a prescription medication 'recreationally' (just for the feeling, or using more than prescribed)?

☐ Yes ☐ No ☐ Decline to answer

Emotional Health

Suicide Prevention Hotline Information 24/7: Call or Text 988

Over the last 2 weeks, how often have you been bothered by feeling little interest or pleasure in doing things?

☐ Not at all ☐ More than half the days ☐ Decline to answer
☐ Several days ☐ Nearly every day

Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?

☐ Not at all ☐ More than half the days ☐ Decline to answer
☐ Several days ☐ Nearly every day

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?

☐ Not at all ☐ More than half the days ☐ Decline to answer
☐ Several days ☐ Nearly every day

Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?

☐ Not at all ☐ More than half the days ☐ Decline to answer
☐ Several days ☐ Nearly every day

Pain

In the past 7 days, how much pain have you felt? (Scale of 0-10)

☐ None (0) ☐ Mild (1—3) ☐ Decline to answer
☐ Moderate (4—6) ☐ Severe (7—10)

Describe the pain and where it's located:

_____

_____

SOCIAL NEEDS: The next few questions are about basic things people need that can affect health. Your answers help us know if you need extra help. If you have needs, someone from our care management team may reach out to you.

Please indicate how often this describes you:		
I don't have enough money to pay my bills:		
☐ Never	☐ Rarely	☐ Sometimes
☐ Often	☐ Always	☐ Decline to answer

Housing/Utilities		
Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as a part of a household?		
☐ Yes	☐ No	☐ Decline to answer
In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?		
☐ Yes	☐ No	☐ Decline to answer

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

Transportation		
In the last 6 months, have you ever had to go without healthcare because you didn't have a way to get there?		
☐ Yes	☐ No	☐ Decline to answer

Health Choice Pathway (HMO D-SNP) is a subsidiary of Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross Blue Shield Association.

Evidence-Based Sources for HRA Development: American College of Cardiology; American Diabetes Association: Standards of Care in Diabetes; Centers for Disease Control and Prevention (CDC); Centers for Medicare & Medicaid Services (CMS); Institute of Medicine (IOM). Dietary Reference Intakes (DRIs); National Heart, Lung, and Blood Institute (NHLBI) guidelines for heart health (Adult Treatment Panel III (ATP III) Guidelines); U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans; U.S. Department of Agriculture (USDA). Dietary Guidelines for Americans; National Institutes of Health (NIH). Prevention, Detection, Evaluation, and Treatment of High Blood Pressure; American College of Preventive Medicine (ACPM); ASAM Criteria; SAMHSA; Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE); Health Leads Screening Toolkit; American Hospital Association (AHA): NCQA; Health Leads Screening. Effective 2023.

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OPTIONAL: The following questions are optional. We ask these questions to understand your needs. All information will remain confidential.

Sex Assigned at Birth:

- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Decline to answer

Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Transgender male/trans man/female-to-male (FTM)
- ☐ Transgender female/trans woman/ male-to-female (MTF)
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional gender category or other: _____
- ☐ Two-Spirit
- ☐ Don't know
- ☐ Decline to answer

Pronouns:

- ☐ He / Him
- ☐ She / Her
- ☐ They / Them
- ☐ Other: _____
- ☐ Don't know
- ☐ Decline to answer

Sexual Orientation:

- ☐ Lesbian, gay, or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Don't know
- ☐ Decline to answer
- ☐ Something else, describe: _____ _____