Member name_____

DOB _____ Member ID_____

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SANFORD HEALTH PLAN

DSNP Health Risk Assessment Tool

1. How would you rate your overall health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. How would you rate your physical health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

3. How would you rate your mental health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

4. What conditions have you had in the past or are currently receiving treatment for?

☐ ADHD/ADD	☐ Alcohol use disorder	☐ Anxiety
☐ Asthma	☐ Bipolar disorder	☐ Cancer
☐ Chronic pain	☐ COPD/emphysema	☐ Dementia
☐ Depression	☐ Diabetes	☐ Hearing problems
☐ Heart disease	☐ Heart failure	☐ High blood pressure
☐ Transplant	☐ Renal/kidney failure	☐ Schizophrenia
☐ Stroke	☐ Substance use disorder	☐ Vision problems

☐ Other mental health diagnosis _____
☐ Other medical diagnosis _____
☐ None

5. How would you rate your pain on average? _____
0-10 scale with 0=No pain and 10=Worst pain imaginable

6. Have you stayed in the hospital more than three times in the last year?
☐ Yes ☐ No

7. In the past six months, how many times did you visit the emergency room?
☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

8. Do you take six or more medications? ☐ Yes ☐ No

9 How is your vision?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Wear glasses
☐ Blind/legally blind

10 How is your hearing?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Have Hearing Aids

11 How would you describe your dental health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Have Dentures

12 What is your primary language? ☐ English ☐ Spanish ☐ Other

13 During the past year, have you experienced changes in thinking, remembering or decision making?
☐ Never ☐ Sometimes ☐ Most of the time ☐ All of the time

14 Do you need help with any of the following?

Bathing	☐ No	☐ Yes, need help or equipment
Dressing	☐ No	☐ Yes, need help or equipment
Using the bathroom	☐ No	☐ Yes, need help or equipment
Getting in and out of a chair or bed	☐ No	☐ Yes, need help or equipment
Eating	☐ No	☐ Yes, need help or equipment
Taking your medicine	☐ No	☐ Yes, need help or equipment
Transportation	☐ No	☐ Yes, need help or equipment
Walking	☐ No	☐ Yes, need help or equipment
Using the telephone	☐ No	☐ Yes, need help or equipment
Household tasks *(cooking, laundry, chores)*	☐ No	☐ Yes, need help or equipment
Running errands or grocery shopping	☐ No	☐ Yes, need help or equipment
Managing your money *(paying bills, bank accounts)*	☐ No	☐ Yes, need help or equipment

15 For the activities above, do you get the help you need?
☐ I get all the help I need ☐ I could use more help ☐ I need more help
☐ I don't need any help

16 Are you a current participant of home and/or community-based services?

☐ No ☐ Yes If yes, which programs?

☐ Adult day care	☐ Adult foster care	☐ Adult residential
☐ Chore and ERS	☐ Community support	☐ Community transition
☐ Companionship	☐ Environmental modification	☐ Extended personal care
☐ Family home care	☐ Family personal care	☐ HCBS case management
☐ Home delivered meals	☐ Homemaker	☐ Non-medical transportation
☐ Nurse education	☐ Personal care services	☐ Residential habilitation
☐ Respite	☐ Special equipment/supplies	☐ Supervision
☐ Supported employment	☐ Transitional living	

17 Do you regularly receive/use any of the following?

☐ Oxygen therapy	☐ Medical equipment
☐ Infusions in home	☐ Infusions in the office
☐ Radiation	☐ Chemotherapy
☐ Other cancer treatments	☐ Physical therapy (home or office)
☐ Occupational therapy (home or office)	☐ Speech therapy (home or office)
☐ Counseling services	☐ Other behavioral health services

18 Do you have another case manager within the community? ☐ Yes ☐ No

If yes, who? _____

19 What best describes your current living situation?

☐ Live alone ☐ Live with family/spouse ☐ Live with a non-relative

☐ Live in an assisted living facility

20 What is your current marital status?

☐ Married ☐ In serious or committed relationship, not married

☐ Divorced ☐ Separated ☐ Widowed ☐ Single

21 How often do you get as much sleep as you want?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

22 In the last two weeks, how often have you:

Felt nervous, anxious or on edge? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day
Not been able to stop or control worrying? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day
Had little interest or pleasure in doing things? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day
Felt down, depressed or hopeless? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day

23 How often did you have a drink containing alcohol in the last year?
☐ Never ☐ 2-4 times/month ☐ Monthly or less ☐ 2-3 times/week
☐ 4 or more times/week

24 If you do drink alcohol, how many drinks containing alcohol did you have on a typical day when you were drinking in the past year?
☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+

25 Do you ever think about quitting or changing how much you drink? ☐ Yes ☐ No

26 Do you currently smoke or use tobacco products *(cigarettes, cigars, chew, vaping)*?
☐ Yes ☐ No

27 Any recreational or illicit drug use? ☐ No ☐ Yes If yes, which ones?
☐ Marijuana ☐ Meth ☐ Cocaine
☐ Unprescribed stimulants ☐ Unprescribed pain medications
☐ Unprescribed anxiety medications ☐ Inhalants
☐ Other _____

28 How hard is it for you to pay for the very basics like food, housing, medical care and heating?
☐ Very hard ☐ Hard ☐ Somewhat hard ☐ Not very hard ☐ Not hard at all

29 In the past 12 months:

Was there a time when you were not able to pay the mortgage or rent on time? ☐ Yes ☐ No
Has the electric, gas, oil or water company threatened to shut off services in your home? ☐ Yes ☐ No ☐ Already shut off
How many times have you moved where you were living? ☐ 1 ☐ 2 ☐ 3 ☐ More
Were you homeless or living in a shelter? ☐ Yes ☐ No
Has lack of transportation kept you from medical appointments or from getting medications? ☐ Yes ☐ No
Has lack of transportation kept you from meetings, work, or from getting things needed for daily living? ☐ Yes ☐ No
Have you worried that your food would run out before you got the money to buy more? ☐ Yes ☐ No

30 How satisfied are you with your social activities and relationships?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

31 How often do you feel alone or isolated from others?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

32 Do you have Advance Care Planning in place?

☐ Yes

- ☐ Health care Power of Attorney
- ☐ Comfort One
- ☐ Living Will
- ☐ Medical Orders for Scope of Treatment (MOST)
- ☐ Physician Orders for Life Sustaining Treatment (POLST)

☐ No

- ☐ If no, would you like information sent to you? ☐ Yes ☐ No

Please return to:
Sanford Health Plan
Attn: Care Management
PO Box 8000
Marshfield, WI 54449-8000