

Member name _____

DOB _____ Member ID _____

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?

<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Alcohol use disorder	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Cancer
<input type="checkbox"/> Chronic pain	<input type="checkbox"/> COPD/emphysema	<input type="checkbox"/> Dementia
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Heart failure	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Transplant	<input type="checkbox"/> Renal/kidney failure	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Stroke	<input type="checkbox"/> Substance use disorder	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Other mental health diagnosis _____		
<input type="checkbox"/> Other medical diagnosis _____		
<input type="checkbox"/> 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	<input type="checkbox"/> No	<input type="checkbox"/> Yes, need help or equipment
Dressing	<input type="checkbox"/> No	<input type="checkbox"/> Yes, need help or equipment
Using the bathroom	<input type="checkbox"/> No	<input type="checkbox"/> Yes, need help or equipment
Getting in and out of a chair or bed	<input type="checkbox"/> No	<input type="checkbox"/> Yes, need help or equipment
Eating	<input type="checkbox"/> No	<input type="checkbox"/> Yes, need help or equipment
Taking your medicine	<input type="checkbox"/> No	<input type="checkbox"/> Yes, need help or equipment
Transportation	<input type="checkbox"/> No	<input type="checkbox"/> Yes, need help or equipment
Walking	<input type="checkbox"/> No	<input type="checkbox"/> Yes, need help or equipment
Using the telephone	<input type="checkbox"/> No	<input type="checkbox"/> Yes, need help or equipment
Household tasks (cooking, laundry, chores)	<input type="checkbox"/> No	<input type="checkbox"/> Yes, need help or equipment
Running errands or grocery shopping	<input type="checkbox"/> No	<input type="checkbox"/> Yes, need help or equipment
Managing your money (paying bills, bank accounts)	<input type="checkbox"/> No	<input type="checkbox"/> 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?

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

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

- | | |
|--|--|
| <input type="checkbox"/> Oxygen therapy | <input type="checkbox"/> Medical equipment |
| <input type="checkbox"/> Infusions in home | <input type="checkbox"/> Infusions in the office |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Other cancer treatments | <input type="checkbox"/> Physical therapy (home or office) |
| <input type="checkbox"/> Occupational therapy (home or office) | <input type="checkbox"/> Speech therapy (home or office) |
| <input type="checkbox"/> Counseling services | <input type="checkbox"/> 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

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