

Member name \_\_\_\_\_

DOB \_\_\_\_\_ Member ID \_\_\_\_\_

# DSNP Health Risk Assessment Tool

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- 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	<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? <input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
Not been able to stop or control worrying? <input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
Had little interest or pleasure in doing things? <input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
Felt down, depressed or hopeless? <input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day

- 23 How often did you have a drink containing alcohol in the last year?  
 Never     Monthly or less     2-4 times/month  
 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the electric, gas, oil or water company threatened to shut off services in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already shut off
How many times have you moved where you were living? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> More
Were you homeless or living in a shelter? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has lack of transportation kept you from medical appointments or from getting medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has lack of transportation kept you from meetings, work, or from getting things needed for daily living? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you worried that your food would run out before you got the money to buy more? <input type="checkbox"/> Yes <input type="checkbox"/> 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 carepower 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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