Health Risk Screening

_		e getting the best care, we'd like to ask you some . All your answers will be private and won't affect
Member name		
Member address		
Member phone		Member cell phone
Member email		
Do you agree to receive e educational materials)? ((nications from Humana (e.g., reminders, letters and Text Email
Member date of birth		Age
Member ID number		
Emergency contact name	e	Phone
Date completed		
Now we would like to ask help us personalize your h		nographic and preference questions, which will support experience.
a vall i .		
<u> </u>	d/or ethnicity? (One o	or more may be selected)
American Indian or Al	d/or ethnicity? (One o	or more may be selected) Native Hawaiian or Other Pacific Islander
American Indian or Ale Asian	d/or ethnicity? (One o	or more may be selected) Native Hawaiian or Other Pacific Islander White
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Health Risk Screening — continued

3. Do you or your caregiver have any of the following communication barriers?

(Select all that apply)

Hearing Impairment Developmental Delays None

Visual Impairment Non-verbal I choose not to answer this question

Other. Describe:

4. What was your sex at birth?

Female Unavailable

Male I choose not to answer this question

5. What gender do you currently identify with? (Select all that apply)

Female Female-to-male/transgender male/trans man

Male Male-to-female/transgender female/trans woman

Other Gendergueer/non-binary, neither exclusively male nor female

I choose not to answer this question

6. What are your pronouns? (Select all that apply)

He/him/his They/them/theirs I choose not to answer this question

She/her/hers Other

7. What is your sexual orientation? (Select all that apply)

Straight or heterosexual Bisexual Do not know

Lesbian, gay, or homosexual Something else I choose not to answer this question

8. What is your housing situation today?

I have housing

I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)

I choose not to answer this question

9. Are you worried about losing your housing?

Yes No I choose not to answer this question

10. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?

the following when it was really needed:		
Food	Yes	No
Clothing	Yes	No
Utilities	Yes	No
Child care	Yes	No
Medicine or any health care (Medical, Dental, Mental Health, Vision)	Yes	No
Phone	Yes	No
Other	Yes	No
describe:		
I choose not to answer this question		

11. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Select all that all that apply)

Yes, it has kept me from medical appointments

Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need

No

I choose not to answer this question

12. Over the last 2 weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things

Not at all More than half the days

Several days Nearly every day

Feeling down, depressed, or hopeless

Not at all More than half the days

Several days Nearly every day

Feeling nervous, anxious or on edge

Not at all More than half the days

Several days Nearly every day

Not being able to stop or control worrying

Not at all More than half the days

Several days Nearly every day

13. How do you describe your health?

Excellent Good Poor

Very good Fair

14. (Females) Are you Pregnant?					
Yes	No				
15. What health conditions do you o	urrently have? (Select all that app	ly)			
Attention deficit hyperactivity	Diabetes	Kidney failure			
disorder (ADHD)	Heart failure	Schizophrenia			
Asthma	Hepatitis	Other:			
Bipolar disorder	High blood pressure				
Cancer	Human immunodeficiency				
Chronic obstructive	virus (HIV) or acquired				
pulmonary disease (COPD)	immune deficiency				
Depression/anxiety	syndrome (AIDS)				
16. Do you currently take prescripti	on medicine?				
Yes	No	N/A			
16a. Are you able to obtain all med	cations when needed?				
Yes	No	N/A			
16b. Are you taking them as prescri	bed?				
Yes	No	N/A			
17. What type of health care appointments have you attended in the last 12 months? (Select all that apply)					
Physical health/medical — Appoi	ntment date(s)				
Mental or behavioral health — Appointment date(s)					
Dental — Appointment date(s)					
18. Do you have any pending appointments or procedures?					
Physical health/medical — Appoi	ntment date(s)				
Mental or behavioral health — Appointment date(s)					
Dental — Appointment date(s)	Dental — Appointment date(s)				
19. Do you or your caregiver need help arranging your health services?					
Yes. Describe the help you need:		No No			

20. Have you visited the Emergency Room (ER) in the past 6 months? How many times and why?						
1 time	3 times	5 times				
2 times	4 times	More than 5 times				
Describe why you went to the ER:						
I haven't been to the ER in the po	ast six months.					
24 11	- L					
21. Have you stayed overnight in the past 6 months? If yes, how man	· · · · · · · · · · · · · · · · · · ·	rgency Department) in the				
1 time	3 times	5 times				
2 times	4 times	More than 5 times				
Describe the reason for your hospital	Describe the reason for your hospital stay(s):					
I haven't stayed overnight in the	hospital.					
22. Do you need assistance with ar	ny of the following? (Select all tha	t apply)				
Dressing	Mobility	Daily medications				
Bathing/grooming	Cooking/preparing meals	Using the restrooms				
Eating	Transfer	Other. Describe:				
,						
22 Do you have a care siver?						
23. Do you have a caregiver?						
	Yes. What is your relationship to your caregiver? No					
23a. Do you and/or your caregiver fo	eel physically and emotionally safe	e where you currently live?				
Yes	Unsure					
No	I choose not to answer this question					
24. In the past year, have you beer your household?	afraid of your partner, ex-partne	er, caregiver, or anyone in				
Yes	Unsure					
No	I choose not to answer this question					
25. How often do you see or talk to	people that you care about and	feel close to? (For example:				
	visiting friends or family, going to	· · · · · · · · · · · · · · · · · · ·				
Less than once a week	6 or more times a week					
1 or 2 times a week	I choose not to answer this question					
3 to 5 times a week						
25a. Would you like to talk with sor	neone about this?					
Yes	No					

26. Over the last year, have you wished you could stop or cut back on any of the following items? (Select all that apply)

Drinking alcohol

Using tobacco or nicotine products (like cigarettes, cigars, snuff, chew, electronic cigarettes, or vaping) Gambling

Taking illegal drugs or prescription drugs for non-medical reasons

Other:

None of the above

Auxiliary aids and services, free of charge, are available to you. **855-223-9868 (TTY: 711)**, Monday through Friday, from 8:00 a.m. to 5:00 p.m., Central time.

Humana Inc. and its subsidiaries comply with Section 1557 by providing free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English Call the number above to receive free language assistance services.

Español (Spanish) Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

Tiếng Việt (Vietnamese) Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

繁體中文 (Chinese) 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

한국어 (Korean) 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Deutsch (German) Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

မြန်မာနိုင်ငံ (Burmese) အခမဲ့ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ ရယူရန် အထက်ပါ ဖုန်းနံပါတ်ကို ခေါ်ဆိုပါ။

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

Tagalog (Tagalog – Filipino) Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Français (French) Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

ພາສາລາວ (Lao): ໂທຫາເບີໂທລະສັບຂ້າງເທິງ ເພື່ອຮັບບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ.

ภาษาไทย (Thai): โทรไปที่หมายเลขด้านบนเพื่อรับบริการช่วยเหลือด้านภาษาฟรี

وُدرُا (Urdu) مفت لسانی اعانت کی خدمات موصول کرنے کے لیے درج بالا نمبر پر کال کریں۔

tsalagi gawonihisdi (Cherokee) രBLb ക്കെഴ് SJWJC J4കിL ക് D4ൾ SOhAക് J നല്ലെട്ടി TG്ക്രോപ്

فارسی (Farsi) دیریگه سامت قوفه ر امشاب ناگیار ت ر وصد ی نابز تالایهست تفایردی ارب

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