



# PLEASE ANSWER ALL QUESTIONS

## Contact Information

First Name:	Last Name
Phone number:	Date of birth
Gold Kidney ID number	

Type of assessment (*to be completed by case manager*)  Initial  Annual  TOC

## Language / Cultural

1. Do you have a language preference other than English?  
 Yes  No  Unable to assess  Declined to answer

If yes, which language?  
 Arabic  Chinese  French  German  Hindi  
 Korean  Navajo  Spanish  Tagalog  Vietnamese  
 Other \_\_\_\_\_

2. Are there any specific cultural or religious beliefs that may affect your health care?  
 Yes  No  Unable to assess  Declined to answer

If yes, which of the following?  
 Amish  Baha'i  Buddhism  Christianity  Hindu  
 Jehovah's Witness  Judaism  Muslim  Seventh-day Adventist  
 Sikh  Other \_\_\_\_\_

If any of the above boxes are marked, what are the specifics of those beliefs?  
 \_\_\_\_\_



3. What is your race?

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> White                  |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Guamanian or Chamorro            | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Prefer not to answer   |
| <input type="checkbox"/> Korean                           |   |

4. What is your ethnicity?

- |  |   |
|--|---|
| <input type="checkbox"/> Not of Hispanic, Latino/a or Spanish origin | <input type="checkbox"/> Another Hispanic, Latino or Spanish origin |
| <input type="checkbox"/> Puerto Rican                                | <input type="checkbox"/> Prefer not to answer                       |
| <input type="checkbox"/> Mexican, Mexican American, Chicano/a        |   |
| <input type="checkbox"/> Cuban                                       |   |

5. What is the highest level of education you have completed?

- |  |  |
|--|--|
| <input type="checkbox"/> 8 <sup>th</sup> grade or less | <input type="checkbox"/> College Degree  |
| <input type="checkbox"/> High School Graduate or GED   | <input type="checkbox"/> Advanced Degree |
| <input type="checkbox"/> Some College                  |  |

**General**

6. In general, how would you rate your current health?

- |   |   |                               |                               |                               |
|---|---|-------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent        | <input type="checkbox"/> Very good          | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Unable to assess | <input type="checkbox"/> Declined to answer |                               |                               |                               |

Are there specific reasons that made you answer the question the way you did?

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**Activity / Exercise**

7. How is your current activity level?

- Same as 3 months ago       Better than 3 months ago  
 Worse than 3 months ago       Unable to assess       Declined to answer

8. Do you use any of the following assistive devices in your home?

- Cane     Walker     Crutches     Manual Wheelchair     Scooter  
 Powered Wheelchair     None     Other \_\_\_\_\_

**Substance Use**

9. How often do you use alcohol?

- Never       Sometimes       Often       Very often  
 Unable to assess       Declined to answer

10. Do you use illegal substances or medications not prescribed to you?

- Yes     No       Unable to assess       Declined to answer

If yes, do you want to quit using illegal substances or medications not prescribed to you?

- Yes     No       Unable to assess       Declined to answer

11. Do you use tobacco / nicotine products such as e-cigarettes / vape or dip / chew?

- Yes     No       Unable to assess       Declined to answer

If yes, do you want to quit smoking or using tobacco / nicotine products?

- Yes     No       Unable to assess       Declined to answer

**Mental Health**

12. Over the past 2 weeks, how often have you had little interest or pleasure in doing things?

- Not at all (0)       Several days (1)       More than half the days (2)  
 Nearly every day (3)



13. Over the past 2 weeks, how often have you been feeling down, depressed, or hopeless?

- Not at all (0)       Several days (1)       More than half the days (2)
- Nearly every day (3)

*(Note: If the total score for these PHQ-2 questions is 3 or greater than 3, it should auto-trigger additional PHQ-9 questions with potential case management referral.)*

**Vaccination**

14. Have you had a flu shot / vaccine?

- Yes     No       Unable to assess       Declined to answer

If so, when was your last flu shot / vaccine? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

15. Have you had a Td/Tdap shot / vaccine in the last 9 years?

- Yes     No       Unable to assess       Declined to answer

16. If over the age of 50, have you had a shingle shot / vaccine any time after you turned 50?

- Yes     No       Unable to assess       Declined to answer

17. Have you had a pneumococcal shot / vaccine?

- Yes     No       Unable to assess     Declined to answer

If yes, how many?

- 1st dose     2nd dose     Booster     Unable to assess
- Declined to answer

18. Have you had a Hepatitis immunization shot?

If yes, how many?

- One dose     Two doses       Three doses       Unable to assess
- Declined to answer

If yes, when was your last Hepatitis immunization shot? Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



**Chronic Conditions**

19. Has a doctor ever told you that you have the following?

- Diabetes or Prediabetes       High blood pressure       Kidney disease
- Heart disease                       Asthma                               COPD
- HIV / AIDS                               Stroke                               Cancer
- Bipolar disorder                       Depression                       Schizophrenia
- Dementia                               Hearing problems               Vision problems
- None                                       Other \_\_\_\_\_

*(Note: Specific assessments should auto-trigger for diabetes, kidney disease, heart disease, and lung disease if they are marked in the above question.)*

**Current Care**

20. Do you have a primary care doctor (regular doctor) that you can easily see on a routine basis?

- Yes                       No                       Unable to assess                       Declined to answer

If yes, what is the name and contact information of your primary care doctor?

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21. Do you have other doctors / specialists that you see?

- Yes                       No                       Unable to assess                       Declined to answer

If yes, what is the name and contact information of your specialist as well as what type of doctor are they?

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22. In the past 3 months, have you visited the emergency room and / or stayed overnight in the hospital?

- Yes                       No                       Unable to assess                       Declined to answer

If yes, how many times and for what reasons?

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23. Do you use any of the following medical devices in your home?

- Oxygen    CPAP/BiPAP    Wound vac    Insulin pump    Hospital bed  
 None    Other \_\_\_\_\_

**Activities of Daily Living (ADLs)**

24. Do you need help from others to perform everyday activities such as eating, getting dressed, grooming, getting in and out of chairs, bathing, walking, or using the toilet?

- Yes    No

If yes, do you get the help you need?

- Yes    No

**Instrumental Activities of Daily Living (IADLs)**

25. Do you need help from others to take care of things such as laundry and housekeeping, shopping for groceries, using the telephone, cooking or meal preparation, driving or using public transportation, home repair, or taking your own medications?

- Yes    No

If yes, do you get the help you need?

- Yes    No

**Fall**

26. Have you fallen more than once in the past 6 months? (A fall is when your body goes to the ground without being pushed.)

- Yes    No    Unable to assess    Declined to answer



**Living Situation**

If someone chooses the underlined answers, they might have an unmet health-related social need.

27. What is your living situation today?

- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus, or train station, or in a park)
- Other \_\_\_\_\_

28. Think about the place where you live. Do you have problems with any of the following?  
CHOOSE ALL THAT APPLY

- |   |  |
|---|--|
| <input type="checkbox"/> <u>Pests such as bugs, ants, or mice</u> | <input type="checkbox"/> <u>Smoke detectors missing or not working</u> |
| <input type="checkbox"/> <u>Mold</u>                              | <input type="checkbox"/> <u>Water leaks</u>                            |
| <input type="checkbox"/> <u>Lead paint or pipes</u>               | <input type="checkbox"/> None of the above                             |
| <input type="checkbox"/> <u>Lack of heat</u>                      | <input type="checkbox"/> Other _____                                   |
| <input type="checkbox"/> <u>Oven or stove not working</u>         |  |

**Food**

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

29. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often True                       Sometimes True                       Never True

30. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- Often True                       Sometimes True                       Never True



**Transportation**

31. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?  
 Yes     No

**Medication**

32. Do you have any difficulty getting your medications?  
 Yes     No  
If yes, what is your difficulty in getting your medications?  
\_\_\_\_\_

33. Do you understand your medications and how to take them?  
 Yes     No     Unable to assess     Declined to answer  
If no, what is it that you do not understand?  
\_\_\_\_\_

**Pain**

**(If a member scores positive, please immediately refer to Case Management)**

34. In the past 7 days, how much pain have you felt?  
 None     Some     A lot  
If you have been in pain, specify the location or the cause of the pain.  
\_\_\_\_\_

35. Do you have an advance directive? *(An advance directive is a written document expressing your medical care wishes should you be unable to speak for yourself.)*  
 Yes     No     Unable to assess     Declined to answer  
If no, can we provide you with information regarding advance directives?  
 Yes     No     Unable to assess     Declined to answer





**Reporting**

36. Assessment Status:    Pending    Completed    Refused

Completion Date: \_\_\_\_\_

Who completed the form?    Member    Spouse    Family Member or Friend

Please mail the completed form to:

Gold Kidney Health Plan  
Attention: Enrollment Department  
P. O. Box 285  
Portsmouth, NH 03802