PLEASE ANSWER ALL QUESTIONS

Contact Information	
First Name	Last Name
Phone number	Date of birth
MBI	Gold Kidney ID number
INTERNAL USE ONLY 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?

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Prefer not to answer

4. What is your ethnicity?

- ☐ Not of Hispanic, Latino/a or Spanish origin
- ☐ Puerto Rican
- ☐ Mexican, Mexican American, Chicano/a
- ☐ Cuban
- ☐ Another Hispanic, Latino or Spanish origin
- ☐ Prefer not to answer

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

- ☐ 8th grade or less
- ☐ High Schol Graduate or GED
- ☐ Some College
- ☐ College Degree
- ☐ Advanced Degree

General

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

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

☐ Unable to assess ☐ Declined to answer

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

_____

_____

_____

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?

_____

_____

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?

_____

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?

_____

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

☐ Pests such as bugs, ants, or mice

☐ Mold

☐ Lead paint or pipes

☐ Lack of heat

☐ Oven or stove not working

☐ Smoke detectors missing or not working

☐ Water leaks

☐ None of the above

☐ Other

_____

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