



Health Survey

Section 1: Member Information

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____

Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Cell ☐ Home

Section 2: Health Survey

Please answer the questions below as best as you can.

1. Who is completing this assessment?

- ☐ Member
- ☐ Community-based organization
- ☐ Authorized Representative (AOR)
- ☐ Other (specify): _____

1a. If you are completing this survey for a member, what is your relationship to the member?

- | | |
|---|---|
| ☐ Caregiver/Helper | ☐ Interpreter |
| ☐ Conservator/Durable Power of Attorney (DPOA) | ☐ Lawyer |
| ☐ Family Member | ☐ Medical Provider |
| ☐ Friend | ☐ Social Services Provider |
| ☐ Guardian | ☐ Other (specify): _____ |

2. What is your preferred **spoken** language:

- | | |
|------------------------------------|---|
| ☐ English | ☐ Vietnamese |
| ☐ Spanish | ☐ Farsi |
| ☐ Cantonese | ☐ Tagalog |
| ☐ Mandarin | ☐ Other (specify): _____ |

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3. What is your preferred **written** language:

☐ English

☐ Farsi

☐ Spanish

☐ Tagalog

☐ Chinese

☐ Other (specify):

☐ Vietnamese

4. Do you speak a language other than English at home?

☐ Yes

☐ No

☐ N/A

4a. If you answered **Yes** to the previous question, please specify:

5. What is your race/ethnicity (select all that apply)?

☐ American Indian or Alaskan Native

☐ Other Asian

☐ Black or African American

☐ Vietnamese

☐ Chinese

☐ White

☐ Hispanic or Latino

☐ Other (specify):

☐ Middle Eastern or North African

☐ Native Hawaiian or Other Pacific
Islander

6. What is your sexual orientation?

☐ Bisexual

☐ Lesbian or gay

☐ Heterosexual (straight)

☐ Not sure

☐ Prefer not to answer

☐ Sexual orientation not listed (specify):

7. What was your sex assigned at birth?

☐ Female

☐ Male

☐ Not sure

☐ Prefer not to answer

☐ Sex not listed (specify):

8. What pronouns do you use?

☐ He/him/his

☐ She/her/hers

☐ They/them/theirs

☐ Prefer not to answer

☐ Other (specify): _____

9. Where do you live (select all that apply):

☐ Assisted living

☐ Board and care home

☐ Group home

☐ Homeless

☐ I have a place to live today, but I am worried about losing it in the future

☐ I have a steady place to live

☐ Own home

☐ Rent

☐ Shelter

☐ Skilled nursing facility

☐ Staying with friends/family

☐ Temporary housing (e.g., recuperative care)

☐ Temporary housing – Unsheltered (e.g., tent)

☐ Temporary housing – Vehicle (e.g., car, van, RV)

☐ Prefer not to answer

☐ Other (specify): _____

10. Think about the place where you live. Do you have problems with any of the following (select all that apply):

☐ Access to indoor toilet

☐ Keeping cool/air conditioning

☐ Kitchen appliances not working (e.g., refrigerator, oven, stove, microwave)

☐ Lack of heat

☐ Lack of hot water

☐ Lead paint or pipes

☐ Mold

☐ Pests (e.g., bugs/cockroaches, ants, mice)

☐ Proper grab bars in the shower/bath

☐ Railings for ramps or stairs

☐ Smoke detectors missing or not working

☐ Water leaks

☐ None of the above

☐ Other (specify): _____

10a. If you have problems with any of the above, would you like help fixing the issue?

☐ Yes

☐ No

☐ N/A

11. In general, how would you describe your health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Prefer not to answer

12. Your primary care provider (PCP) is the main doctor/provider/nurse practitioner you see for check-ups and when you have a medical concern. When you have a medical problem, who do you call first?

- ☐ 911
- ☐ Provider/clinic
- ☐ No one
- ☐ Prefer not to answer

13. Do you have a hard time trying to see your provider/clinic or specialist?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

13a. If you answered **Yes** to the previous question, please specify:

14. Are you pregnant?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Prefer not to answer
- ☐ N/A

14a. If you are pregnant, are you currently seeing a doctor/provider/nurse practitioner for this pregnancy?

- ☐ Yes
- ☐ No
- ☐ N/A

15. Have you been to the Emergency Room (ER) two (2) or more times in the last 12 months?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

16. Have you been admitted to the hospital in the past 12 months?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

17. Have you been in a Skilled Nursing Facility (SNF) in the past 12 months?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

18. Do you see a doctor/provider/nurse practitioner regularly for a chronic condition?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

18a. If you answered **Yes** to the previous question, select all that apply:

- | | | |
|--|---|--|
| ☐ Asthma | ☐ Developmental disability (autism, cerebral palsy, down syndrome) | ☐ Mild cognitive impairment |
| ☐ Attention Deficit/Hyperactivity Disorder (ADHD) | ☐ Diabetes | ☐ Parkinson's disease |
| ☐ Bipolar disorder | ☐ Eating disorders (e.g., anorexia, bulimia) | ☐ Psychotic disorder |
| ☐ Cancer | ☐ Heart problems | ☐ Seizures |
| ☐ Chronic obstructive pulmonary disease (COPD) | ☐ Hepatitis | ☐ Sickle cell anemia |
| ☐ Cystic fibrosis | ☐ High blood pressure | ☐ Substance use disorder |
| ☐ Dementia or Alzheimer's | ☐ HIV or AIDS | ☐ Thought disorder |
| ☐ Depression/anxiety | ☐ Kidney disease | ☐ Tuberculosis |
| | ☐ Multiple sclerosis (MS) | ☐ Other (specify): _____ |

18b. If you answered **Yes** to the previous question, are you receiving all the help you need?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

19. Have you been tested for sexually transmitted infections in the past year?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

19a. If you answered **Yes** to the previous question, do you have any concerns about your test results?

- ☐ Yes
☐ No
☐ Prefer not to answer

20. When was your last dental check-up?

- ☐ Within the past six (6) months
☐ 6-12 months ago
☐ One (1) – two (2) years ago
☐ More than two (2) years ago
☐ Never
☐ Prefer not to answer

21. Do you take three (3) or more prescription medicines each day?

- ☐ Yes
☐ No
☐ Prefer not to answer

22. Please tell us the name of medications, vitamins, or supplements you are taking at this time (if any):

Name of Medication	Dose (How Much)	How Often Taken

23. Do you need help picking up your medication?

- ☐ Yes
☐ No
☐ Prefer not to answer

24. Do you need help taking your medication?

- ☐ Yes
☐ No
☐ Prefer not to answer

25. Over the past month (30 days), how many days have you felt lonely?

- ☐ None – I never feel lonely
- ☐ Less than five (5) days
- ☐ More than half the days (more than 15 days)
- ☐ Most days – I always feel lonely
- ☐ Prefer not to answer

26. Over the last two (2) weeks, how often have you had little interest or pleasure in doing things?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly everyday
- ☐ Prefer not to answer

27. Have you had any changes in thinking, remembering, or making decisions?

- ☐ Yes
- ☐ Sometimes
- ☐ No
- ☐ Prefer not to answer

28. In the past 12 months, have you ever drank or used more alcohol or drugs than you meant to?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

29. Have you felt you wanted or needed to cut down on your drinking or drug use?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

29a. Do you feel you have a problem with tobacco use?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

29b. If you use tobacco or smoke, are you ready to try quitting within the next month?

- ☐ Yes
- ☐ No
- ☐ N/A

30. Are you using any of the following medical equipment or supplies (select all that apply)?

- | | |
|---|---|
| ☐ Continuous Positive Airway Pressure (CPAP) | ☐ Wheelchair |
| ☐ Hospital Bed | ☐ Walker |
| ☐ Ostomy Bags | ☐ None |
| ☐ Oxygen | ☐ Prefer not to answer |
| ☐ Scooter | ☐ Other (specify): _____ |

31. Do you need assistive devices that you do not have?

- ☐ Yes
☐ No
☐ Prefer not to answer

31a. If you answered **Yes** to the previous question, please specify:

32. Do you need help with any of these actions?

- | | | |
|---|------------------------------|-----------------------------|
| a. Taking a bath or shower..... | ☐ Yes | ☐ No |
| b. Going up stairs | ☐ Yes | ☐ No |
| c. Eating | ☐ Yes | ☐ No |
| d. Getting dressed..... | ☐ Yes | ☐ No |
| e. Brushing your teeth or hair, or shaving..... | ☐ Yes | ☐ No |
| f. Making meals or cooking | ☐ Yes | ☐ No |
| g. Getting out of bed or a chair | ☐ Yes | ☐ No |
| h. Shopping and getting food..... | ☐ Yes | ☐ No |
| i. Using the toilet..... | ☐ Yes | ☐ No |
| j. Walking | ☐ Yes | ☐ No |
| k. Washing dishes or clothes..... | ☐ Yes | ☐ No |
| l. Writing checks or keeping track of money | ☐ Yes | ☐ No |
| m. Getting a ride to the doctor or to see your friends | ☐ Yes | ☐ No |
| n. Doing house or yard work | ☐ Yes | ☐ No |
| o. Going out to visit family or friends..... | ☐ Yes | ☐ No |
| p. Using the phone..... | ☐ Yes | ☐ No |
| q. Keeping track of your appointments..... | ☐ Yes | ☐ No |
| r. If Yes , are you getting all the help you need with these actions?..... | ☐ Yes | ☐ No |

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s. If you get help with any of the previous actions, who is your helper? ☐ N/A

Name of Your Helper: _____

t. What is your relationship to your helper? _____

u. May we contact your helper? ☐ Yes ☐ No

Phone Number of Your Helper: _____

33. Do you ever think your caregiver has a hard time giving you all the help you need?

- ☐ Yes
☐ No
☐ Prefer not to answer

34. Is there a family member or friend who helps you make your health care decisions or who is involved in your plan of care?

- ☐ Yes
☐ No
☐ Prefer not to answer

34a. If you answered **Yes** to the previous question, please provide the name and relationship to you.

Name: _____

Relationship: _____

35. As of today, do you receive any of the following services (select all that apply):

- | | |
|---|---|
| ☐ Adult day care services | ☐ Legal assistance |
| ☐ Case management (help with arranging medical services) | ☐ Medication management |
| ☐ Chore services (e.g., yard work, maintenance) | ☐ Personal care services (help with eating, dressing, bathing, etc.) |
| ☐ Community meals | ☐ Transportation |
| ☐ Home delivered meals | ☐ None of the above |
| ☐ Homemaking/housekeeping | ☐ Prefer not to answer |
| ☐ Information and assistance | ☐ Other (specify): _____ |

36. Do you have family members or others who are willing and able to help you when you need it?

- ☐ Yes
☐ No
☐ Prefer not to answer

37. Do you need help with food?

- ☐ Yes
☐ No
☐ Prefer not to answer

38. Do you need help with transportation?

- ☐ Yes
☐ No
☐ Prefer not to answer

39. Do you need help with your heating or water bill?

- ☐ Yes
☐ No
☐ Prefer not to answer

40. Can you live safely and move around easily in your home?

- ☐ Yes
☐ No
☐ Prefer not to answer

40. If **No**, does the place where you live have:

- | | | |
|--|------------------------------|-----------------------------|
| a. Good lighting..... | ☐ Yes | ☐ No |
| b. Good heating | ☐ Yes | ☐ No |
| c. Good cooling | ☐ Yes | ☐ No |
| d. Rails or any stairs or ramps | ☐ Yes | ☐ No |
| e. Hot water | ☐ Yes | ☐ No |
| f. Indoor toilet | ☐ Yes | ☐ No |
| g. A door to the outside that locks..... | ☐ Yes | ☐ No |
| h. Stairs to get into your home or stairs inside your home | ☐ Yes | ☐ No |
| i. Elevator | ☐ Yes | ☐ No |
| j. Space to use a wheelchair | ☐ Yes | ☐ No |
| k. Clear ways to exit your home..... | ☐ Yes | ☐ No |
| l. Working smoke detectors and fire extinguishers? | ☐ Yes | ☐ No |

41. Have you fallen in the last month?

- ☐ Yes
☐ No
☐ Prefer not to answer

42. Are you afraid of falling?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

43. Do you need help filling out health forms?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

44. Do you need help answering questions during a doctor's visit?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

45. Are you afraid of anyone or is anyone hurting you?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

46. Is anyone using your money without your okay?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

47. Do you sometimes run out of money to pay for food, rent, bills, and medicine?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

48. Are there any additional resources or assistance that you would like more information on/for?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

48a. If you answered **Yes** to the previous question, please explain:

Caregiver Questions

The following questions are about you, the caregiver, as they relate to providing care to the care recipient. The following items refer to how a caregiver feels and behaves as a result of providing care. There are no right or wrong answers.

1. During the past four (4) weeks, because of helping the care recipient, would you say that you were:
 - a. Unsure whether the member was getting proper care?
☐ Strongly agree
☐ Agree
☐ Disagree
☐ Strongly disagree
 - b. Uncertain about how to best care for the member?
☐ Strongly agree
☐ Agree
☐ Disagree
☐ Strongly disagree
 - c. That you should be doing more for the member?
☐ Strongly agree
☐ Agree
☐ Disagree
☐ Strongly disagree
 - d. That you could do a better job of caring for the member?
☐ Strongly agree
☐ Agree
☐ Disagree
☐ Strongly disagree
2. During the past four (4) weeks, because of helping the care recipient, would you say:
 - a. That the member tried to manipulate you?
☐ Strongly agree
☐ Agree
☐ Disagree
☐ Strongly disagree

- b. That your relationship with the member was strained?
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Disagree
 - ☐ Strongly disagree
- c. That the member made requests over and above what they needed?
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Disagree
 - ☐ Strongly disagree
- d. That you were resentful toward the member?
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Disagree
 - ☐ Strongly disagree
- e. That you were angry toward the member?
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Disagree
 - ☐ Strongly disagree
3. During the past four (4) weeks, because of helping the care recipient, would you say:
- a. Your physical health was worse than before?
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Disagree
 - ☐ Strongly disagree
- b. You felt downhearted, blue, or sad more often?
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Disagree
 - ☐ Strongly disagree

- c. You were more nervous or bothered by nerves than before?
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Disagree
 - ☐ Strongly disagree
- d. You had less pep or energy?
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Disagree
 - ☐ Strongly disagree
- e. You were bothered more by aches and pains?
- ☐ Strongly agree
 - ☐ Agree
 - ☐ Disagree
 - ☐ Strongly disagree
4. During the past four (4) weeks, because of helping the care recipient, would you say that you:
- a. Participated in church or religious activities?
- ☐ Less often
 - ☐ The same
 - ☐ More often
- b. Visiting with friends or family?
- ☐ Less often
 - ☐ The same
 - ☐ More often
- c. Participated in group or organized activities?
- ☐ Less often
 - ☐ The same
 - ☐ More often
- d. Engaged in volunteer activities?
- ☐ Less often
 - ☐ The same
 - ☐ More often
- e. Went out to dinner, the theater, or a show?
- ☐ Less often
 - ☐ The same
 - ☐ More often

This Health Survey is complete. Thank you!

Please return the completed survey to:

Attn: Case and Disease Management Department
Alameda Alliance for Health
1240 S. Loop Road
Alameda, CA 94501

If you are an **Alliance Medi-Cal** member and have any questions, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-free at **1.877.932.4567**
If you cannot hear or speak well (CRS/TTY): **711/1.800.735.2929**

If you are an **Alameda Alliance Wellness** member and have any questions, please call:

Alameda Alliance Wellness Member Services Department
Monday – Sunday (seven (7) days a week), 8 am – 8 pm
Toll-Free: **1.888.88A.DSNP (1.888.882.3767)**
If you cannot hear or speak well, use TTY or call **1.800.735.2929**

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