Medicare Health Survey

Please complete and return in the envelope provided.

Name: _____

Address: _____

City, State, ZIP Code: _____

Date of Birth: _____ Member ID # (located on ID card): _____

Mobile Phone #: _____ Home or Landline #: _____

I would like to receive text messages from CDPHP: ☐ Yes ☐ No

Email address: _____

By providing your email address here, you are consenting to receive emails from CDPHP.

General and Preventive Care:

- In general, would you say your health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
- Have you had a flu shot this year or are you planning to receive one this year? . . . . . ☐ Yes ☐ No
- Have you had a pneumonia shot once in the last five years? . . . . . ☐ Yes ☐ No
- Have you received the COVID-19 vaccine? . . . . . ☐ Yes ☐ No

Health Conditions:

- Do you have a primary care doctor? . . . . . ☐ Yes ☐ No
- Have you been seen by your doctor in the last year? . . . . . ☐ Yes ☐ No
- Are you behind on regularly scheduled preventive health care such as cancer screenings or immunizations? . . . ☐ Yes ☐ No
- In the past three months, have you received care from...
  A telemedicine provider (through a phone call or video)? . . . . . ☐ Yes ☐ No
  An urgent care facility? . . . . . ☐ Yes ☐ No
  An emergency room? . . . . . ☐ Yes ☐ No
  A hospital? . . . . . ☐ Yes ☐ No
- Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, who specialize in one area of health care. Is your personal doctor a specialist? . . . . . ☐ Yes ☐ No
  If you need help finding a doctor or other provider, please call Member Services at 1-888-248-6522.
- What health or medical conditions do you have now or have had in the past? (check all that apply):

☐ anxiety	☐ asthma	☐ bi-polar disorder	☐ cancer
☐ COPD/emphysema	☐ dialysis	☐ dementia	☐ depression
☐ diabetes	☐ hearing problems	☐ heart disease	☐ hypertension (high blood pressure)
☐ kidney disease	☐ organ transplant	☐ schizophrenia	☐ stroke
☐ vision problems	☐ not applicable	☐ Other: _____	

- Do you have a history of falls or problems with balance? . . . . . ☐ Yes ☐ No
- Do you currently use any assistive device(s) such as a walker, cane, wheelchair, commode, oxygen? . . . . . ☐ Yes ☐ No
- If you take prescription medications, do you have problems with any of the following? CHOOSE ALL THAT APPLY
  ☐ Cost (medication copays and/or deductibles)
  ☐ Coverage (medication coverage, medication approval process)
  ☐ Doctor (wait times, refill request process, office staff)
  ☐ Pharmacy (hold/wait times, pharmacy hours, pharmacy staff)
  ☐ Transportation (rides to and from the pharmacy or doctor's office)
  ☐ Not applicable/I do not take prescription medications

(*Continued on other side*)

- Do you need any assistance with scheduling a medical appointment or understanding your health insurance benefits? ☐ Yes ☐ No
- Do you live in:
  ☐ Your own home, apartment, condominium, or mobile home?
  ☐ An assisted living apartment, nursing home, or adult care facility?
- 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)
- Think about the place 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 ☐ Water leaks ☐ Smoke detectors missing or not working
  ☐ None of the above
- 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
- In the past four weeks, have you experienced a feeling of depression,hopelessness, or loss of interest in pleasurable activities? ☐ Yes ☐ No
- Do you have difficulty remembering events that have happened in the recent past? ☐ Yes ☐ No
- During the last 12 months, have you used alcohol or drugs in ways that cause problems for you or those around you? ☐ Yes ☐ No
- Do you smoke tobacco or use nicotine products? ☐ Yes ☐ No

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:

- 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
- 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

About You:

- Have you signed any of the following legal documents:
  Power of Attorney ☐ Yes ☐ No
  Do Not Resuscitate Order (DNR) ☐ Yes ☐ No
  Health Care Proxy ☐ Yes ☐ No
  Living Will ☐ Yes ☐ No
  MOLST (Medical Order for Life-Sustaining Training) ☐ Yes ☐ No

I, _____, hereby authorize CDPHP® to make all of the information in this questionnaire available to my physician for case management purposes. This authorization shall remain in effect until revoked by me in writing, and may be revoked at any time except to the extent that CDPHP has already acted in reliance upon it. (References to "CDPHP" refer to both Capital District Physicians' Health Plan, Inc and CDPHP Universal Benefits,® Inc)

Enrolled Plan Name: _____ Dated:_____

Signature _____ Print Name_____

Agent Name (optional) _____ Agent ID (optional)_____