DSNP HRA

HRA Questions:

1. Are you having any difficulty understanding me? Yes or No If Yes, explain how you compensated: _____
2. What is your primary language? English/Spanish/Other (specify)
3. What is your preferred language? _____
4. May I ask, do you still live on (street name), Mr./Mrs. (last name)? Yes or No
5. How many times have you moved in the past year?
6. May we continue to use this phone number or is there a better number to contact you? _____
7. What is your marital status? Married/Not Married/Separated/Divorced/Widowed/Other
8. What is your current living arrangement? Alone/with spouse/significant other/Live with other family member/live in caregiver/part time caregiver
9. What is your religion? Catholic/Protestant/Jewish/Islamic/Buddhist/Hindu/None/Other
10. Do you have a primary care physician or other doctor you see regularly?
    a. If Yes – What is the name of your primary care provider (doctor)? _____
    b. If No – Do you need to choose or change your primary care provider, I can transfer you at the end of this call to our member services team, who can help you with that.
11. In general would you say your health is: Excellent, Very good, Good, Fair, Poor
12. Compared to one year ago, how would you rate your health in general now? Much better, Somewhat better, About the same, much worse.
13. During the past 4 years have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
    a. Cut down the amount of time you spent on work or other activities? Yes or No
    b. Accomplished less than you would like? Yes or No
    c. Were limited in the kind of work or other activities? Yes or No
    d. Had difficulty performing the work or other activities? Example: it took extra time. Yes or No
    e. Bodily pain that has contributed to interference with work or other activities? Yes or No
14. What is your Height? _____ and Weight? _____
15. Do you currently use tobacco products? Yes or No, Have you ever used tobacco products? Yes or No and if Yes, when?
16. How often do you drink alcoholic beverages? Never, Daily/how many?, Weekly/how many?, Monthly/how many?, Less than monthly?
17. Do you drive? Yes or No, If No, did you ever drive? Yes or No, If Yes, when and why did you stop? How often do you drive? Daily, weekly, monthly, less than monthly
18. In the past 2 years, has your driver's license been suspended or revoked? Yes or No, If yes, when?
19. Have you been to the emergency room in the past year? Yes or No, If Yes how many times have you been to the emergency room in the past year?

20. In the previous 12 months, have you stayed overnight as a patient in a hospital? Yes or No, If Yes, How many times have you stayed overnight as a patient in a hospital?
21. In the previous 12 months, have you stayed overnight as a patient in a hospital due to mental health issues? Yes or No, If Yes, How many times?
22. In the previous 12 months, how many times did you visit a physician or clinic?
23. How many times in the past 6 months have you had an episode of fainting, lost your balance, slipped or tripped over something or had any sort of accident that resulted in falling or dropping to the ground? ____ If more then zero, Did you get hurt? Yes or No, If yes, What has been your most serious injury or problem due to a fall? Bruises, Discomfort, Head Injury, Back/Vertebrae Fracture, Wrist/Arm Fracture, Leg Fracture, Cuts, Other:_____
24. Do you ever limit your activities, what you do or where you go, because you are afraid of falling? Yes or No
25. Is there a friend, relative or neighbor who would take care of you for a few days if necessary? Yes or No, If Yes, what is the name and phone number of that person? _____
26. Do you receive any public assistance, public programs, or community resources? Yes or No, If Yes, what kind? Choose from list below:
    a. Meals on Wheels
    b. Food Stamps
    c. Social Services
    d. Food Pantry
    e. Transportation
    f. Other: _____
27. What is the highest level of education or degree you obtained? Elementary School, High School Diploma, GED, Associates, Bachelors, Post Graduate, Other: _____
28. Do you use any of the following medical equipment?
    a. Wheelchair
    b. Walker
    c. Power Operated Mobility Device ie. Scooter
    d. Oxygen Equipment
    e. Hospital Bed
    f. Kidney Dialysis
    g. Other: _____
29. Are you receiving Home Health Services? Yes or No
30. How many medications do you take on a daily basis? If greater then zero, list the medications.

Existing Conditions:

Have you ever been diagnosed with any of the following conditions?

- Insulin Dependent Diabetes
- Blood Disorders
- Heart Disease/Disorder
- Congestive Heart Failure
- Stroke/TIA
- Kidney Disorder
- Renal Insufficiency
- Asthma
- Organ Transplant
- HIV/AIDS
- Mental or Nervous System Disorder
- Depression
- Anxiety
- Alzheimer's Dementia
- Cancer
- COPD
- High Blood Pressure

Depression Screen:

31. Over the last two weeks how often have you been bothered by any of the following problems?
    a. Little Interest or pleasure in doing things? Not at all, Several Days, More than Seven Days, Nearly Every day
    b. Feeling down, depressed or hopeless? Not at all, Several Days, More than Seven Days, Nearly Every day
    c. Trouble falling asleep, staying asleep, or sleeping too much? Not at all, Several Days, More than Seven Days, Nearly Every day
    d. Feeling tired or having little energy? Not at all, Several Days, More than Seven Days, Nearly Every day
    e. Poor appetite or eating too much? Not at all, Several Days, More than Seven Days, Nearly Every day
    f. Feeling bad about yourself, that you are a failure, or that you have let yourself or your family/friends down? Not at all, Several Days, More than Seven Days, Nearly Every day
    g. Trouble concentrating? Not at all, Several Days, More than Seven Days, Nearly Every day
    h. Moving or speaking more slowly than normal? Not at all, Several Days, More than Seven Days, Nearly Every day

32. Are you receiving counseling for depression? Yes or No
33. Are you taking medication for depression? Yes or No

34. Can you tell me what best describes your performance with the following tasks?
    a. Taking your medications: Independent, Partially Dependent, Dependent
    b. Managing your day to day finances: Independent, Partially Dependent, Dependent
    c. Doing Housework: Independent, Partially Dependent, Dependent
    d. Doing your laundry: Independent, Partially Dependent, Dependent
    e. Shopping for Groceries: Independent, Partially Dependent, Dependent
    f. Preparing your meals: Independent, Partially Dependent, Dependent
    g. Getting around inside your home: Independent, Partially Dependent, Dependent
    h. Feeding yourself: Independent, Partially Dependent, Dependent
    i. Getting in or out of bed or a chair: Independent, Partially Dependent, Dependent
    j. Bathing/Caring for personal hygiene: Independent, Partially Dependent, Dependent
    k. Dressing yourself: Independent, Partially Dependent, Dependent
    l. Using the toilet: Independent, Partially Dependent, Dependent

Cognition:

35. What is the best action to take in any emergency? Response appropriate yes or no
36. Who is the president of the United States? Response appropriate yes or no
37. What is the current date/year? Response appropriate yes or no