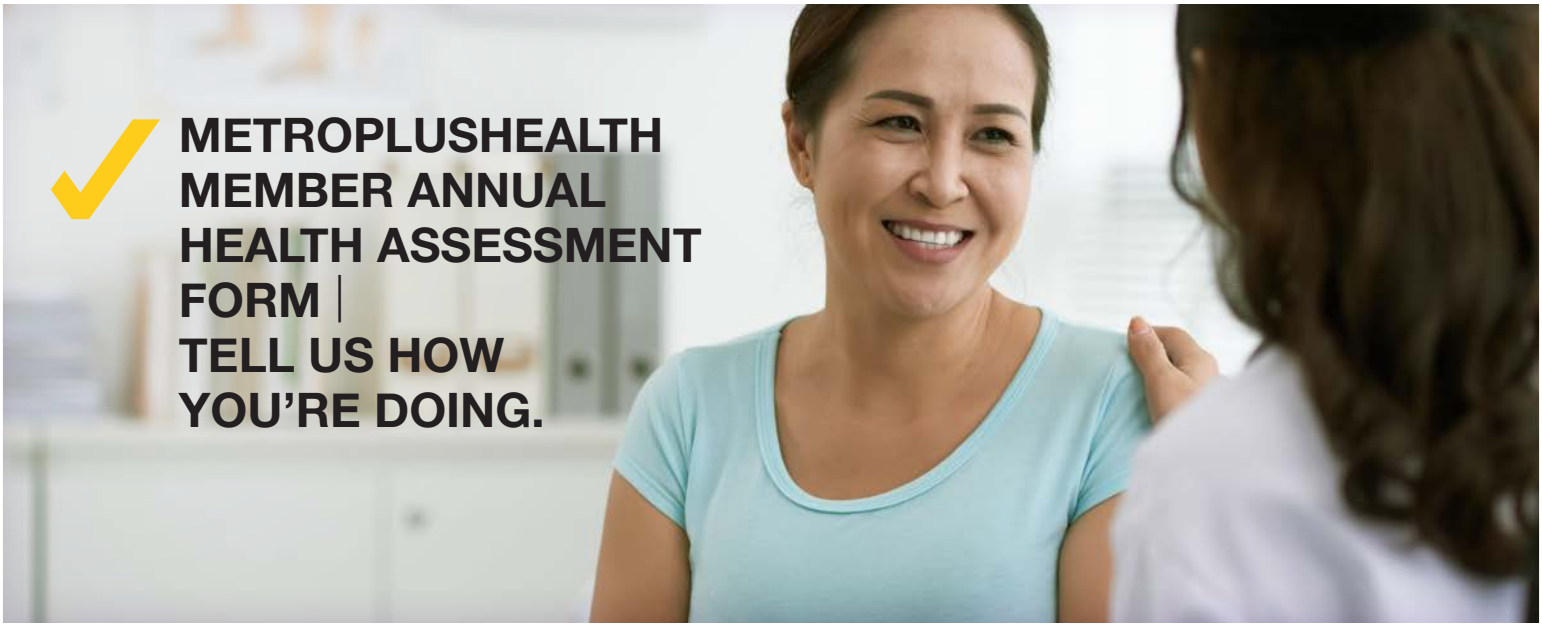

METROPLUSHEALTH MEMBER ANNUAL HEALTH ASSESSMENT FORM | TELL US HOW YOU'RE DOING.

PLEASE COMPLETE IN FULL AND MAIL BACK TO US AT:

MetroPlus Health Plan • 50 Water Street, 7th Floor • New York, NY 10004

First, Last Name: _____ **Member ID#:** _____

Mailing Address: _____

Phone: _____ Date of Birth: _____ Height: _____ft. _____ in. Weight: _____lbs.

Preferred Language: ❑ English ❑ Spanish ❑ Chinese ❑ Creole ❑ Urdu ❑ Bengali ❑ Other: _____

Race: ❑ White American Indian ❑ Alaskan Native ❑ Asian ❑ Black / African American
❑ Native Hawaiian / Pacific Islander ❑ Two or More Races ❑ Other: _____ ❑ Decline to answer

Ethnicity: ❑ Hispanic or Latino ❑ Non Hispanic or Latino ❑ Decline to answer

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In general, would you say that your health is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Would you like us to call you to help you with any urgent health problem? ❑ Yes ❑ No

Do you have a doctor you see regularly? ❑ Yes ❑ No

If Yes, has your doctor advised you to start, increase, or maintain some level of exercise or physical activity? (for example, start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program)? ❑ Yes ❑ No

Do you have any of the following? ❑ Diabetes ❑ Heart problems ❑ High blood pressure ❑ Cancer
❑ Breathing problems (asthma or COPD) ❑ Memory problems ❑ Hearing problems ❑ Vision problems
❑ Mental / emotional problems ❑ Urinary Incontinence ❑ HIV ❑ Drug or alcohol problems
❑ Other medical problems: _____

How many different medicines do you take a day? ❑ None ❑ 1-3 ❑ 4-7 ❑ 8 or more

Do you need help with your basic activities (such as getting dressed, taking a bath, eating, getting in / out of a chair)? ❑ I'm able to do this without help ❑ I need help, and get the help I need
❑ I need help, and do not get the help I need

Do you need help with housekeeping, taking medication, shopping, money management, preparing meals, or transportation? ❑ I'm able to do this without help

❑ **I** need help, and get the help I need ❑ **I** need help, and do not get the help I need

In the past 6 months, have you ever had to go without healthcare because you didn't have a way to get there? ❑ Yes ❑ No

Did you fall in the past 6 months? ❑ Yes ❑ No

Does anyone in your life hurt, threaten, frighten you, or make you feel unsafe?

❑ Yes ❑ No ❑ Prefer not to answer

Do you use any of the following:

❑ Cane ❑ Walker ❑ Wheelchair ❑ Hospital bed ❑ Oxygen ❑ Protective Briefs / Pads (Adult diapers)

❑ Other _____

Do you have repeated or ongoing pain?

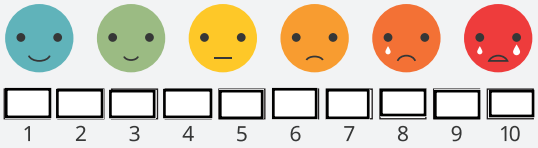
❑ Yes ❑ No **If yes,** start date: _____

If yes, where is the pain? _____

_____

_____

If yes, mark off your level of pain here:



What is your living situation?

❑ 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 (temporarily staying with others, in a hotel, shelter, living outside on street, on a beach, in a car, abandoned building, bus or train station, park, other)

Are you worried that the place you are living now is making you sick? (i.e. mold, bugs / rodents, water leaks, not enough heat, other) ❑ Yes ❑ No ❑ Other: _____

Do you currently receive public assistance (Food Stamps, Meals on Wheels, HEAP, EPIC, public or cash assistance, etc.)? ❑ Yes ❑ No ❑ I do not know

In the past year, did you worry that your food could run out before you got money to buy more?

❑ Yes ❑ No ❑ Prefer not to answer

In the past year, has the electric, gas, oil, or water company threatened to shut off services to your home?

❑ Yes ❑ No ❑ I do not know

Do you smoke cigarettes, vape (e-cigarettes), or use tobacco? ❑ Current ❑ Former ❑ Never

Did you get the Influenza Vaccine (Flu Shot) this year? ❑ Yes ❑ No ❑ I do not know

Please list your medications (list additional medications of an extra sheet, if applicable):

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication List (continued - list additional medications of an extra sheet, if applicable):

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

Medication Name: _____ **Dose:** _____ **Frequency:** _____

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

❑ Not at all ❑ Several Days

❑ More than half of those days ❑ Almost every day

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

❑ Not at all ❑ Several Days

❑ More than half of those days ❑ Almost every day

ONLY WOMEN 50 YEARS OLD AND UNDER: Are you pregnant? ❑ Yes ❑ No ❑ I do not know

ONLY WOMEN 50-74 YEARS OLD: Did you have a mammogram (to check for breast cancer) this year or last? ❑ Yes ❑ No ❑ I do not know

ONLY THOSE 45-75 YEARS OLD: Did you have the following tests to check for colon cancer?

❑ Colonoscopy (in the past 10 yrs.) ❑ Sigmoidoscopy (in the past 5 yrs.)

❑ Stool Test for blood (within the last yr.)

Do you have any of the following?

❑ **Advance Directive / Living Will (a document that says what medical treatment you would like if you are unable to speak for yourself)**

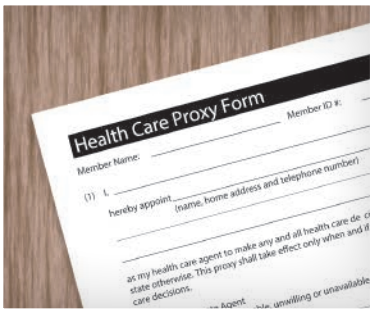
❑ **Health Care Proxy (a person who can make health care decisions for you, if you are not able to)**

❑ **No, but advanced care planning was discussed with me**

❑ **No, and advanced care planning was not discussed with me**

❑ **No, but I am interested to learn more:** ❑ Yes* ❑ No

* We will send you an Advance Directive and Health Care Proxy Form



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Date Completed: _____

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