



## AmeriHealth Caritas Delaware

### Health Risk Assessment

Welcome to AmeriHealth Caritas Delaware. Now that you are a member, we ask that you please fill out this form. It will help us understand your needs and how to best support you with programs and services. If you need help completing this form, please call our Rapid Response and Outreach Team at **1-844-623-7090** and a health plan representative will help you.

If you are a parent or guardian completing this form for a child, please answer all questions on behalf of the name that you enter below.

Each enrolled member can also complete the Health Risk Assessment online through our member portal, available at [www.amerhealthcaritasde.com](http://www.amerhealthcaritasde.com).

**Please print in UPPERCASE letters.**

Member information			
First name:	Middle initial:	Last name:	
Member ID number:			
Address 1:			
Address 2:			
City:		State:	ZIP:
Date of birth:    /    /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Cell phone number:			
Email address:			



### Questions about your language

#### Which language do you prefer to speak?

- Arabic
- Chinese (Cantonese)
- Chinese (Mandarin)
- English
- French
- Hmong
- Korean
- Russian
- Spanish
- Vietnamese
- Other: \_\_\_\_\_

#### Which language do you prefer to read?

- Arabic
- Chinese (Cantonese)
- Chinese (Mandarin)
- English
- French
- Hmong
- Korean
- Russian
- Spanish
- Vietnamese
- Other: \_\_\_\_\_

#### How do you describe your race?

- American Indian or Alaska Native
- Asian
- Black/African American
- Middle Eastern/North African
- Native Hawaiian/Pacific Islander
- White
- Other: \_\_\_\_\_

#### What is your ethnicity?

- Hispanic
- Non-Hispanic
- I choose not to say
- Not provided or unknown
- Other: \_\_\_\_\_

**Get help.**

Fill out these questions to help us better serve you.

## Health Risk Assessment questions

At AmeriHealth Caritas Delaware, we know that health is more than what happens at your health care provider's office. We would like to ask you some questions about your everyday needs. Based on your answers, someone from AmeriHealth Caritas Delaware may contact you to discuss resources in your community. Your responses are private and protected like all of your health information, and all questions are optional.



**Housing**



**Transportation**



**Food**



**Interpersonal  
violence**

Questions about you

Fill out these questions to help us better serve you.

1. Can you tell me the last grade you finished in school?

- No high school
- Some high school
- High school graduate
- General Educational Development (GED) or high school equivalency
- Vocational or trade program
- Some college
- College graduate
- Graduate school or higher
- I choose not to answer this question

2. Do you ever get confused answering or asking questions about your health at your primary care provider (PCP) appointments?

- Yes (please check all that apply):
  - Understanding my PCP's instructions
  - Reading my PCP's instructions
  - Understanding how to take medicines
  - Understanding lab and test results
  - Understanding medical terms
  - Other \_\_\_\_\_
- No
- I choose not to answer this question

3. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living? This can be a ride to the PCP, a trip to get your medicine, going shopping for food, or going to work. (Select all that apply.)

- Yes, I have had trouble getting to the PCP or getting my medicine
- Yes, I have had trouble getting to other places I need to go
- No
- I choose not to answer this question

4. Have you had trouble getting child care when you need to go to a PCP appointment?

Yes

No

I choose not to answer this question

It can be stressful to have trouble paying bills and getting everyday things that you need.

5. Within the past 12 months, have you had trouble with any of the following items:

A. Did you worry that your food would run out before you got money to buy more?

Yes

No

I choose not to answer this question

B. Did the food you bought not last and you didn't have money to get more?

Yes

No

I choose not to answer this question

C. Have you been unable to get utilities (heat, electricity) when it was really needed?

Yes

No

I choose not to answer this question

D. Have you been paying your phone bill?

Yes

No

I choose not to answer this question

E. Have you been getting everyday items you need (such as diapers, shampoo, blankets, or mattresses)?

Yes

No

I choose not to answer this question

F. Have you been getting the clothing you and your family need?

Yes

No

I choose not to answer this question

G. Have you had trouble with something else?

---

---

Having shelter is an important part of your health.

6. Within the past 12 months, have you ever stayed outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else’s home (i.e., couch surfing)?

- Yes
- No
- I choose not to answer this question

A. Are you worried about losing your housing? Select all that apply.

- I have housing
- I don’t have housing
- I have housing, but I am worried about losing it
- I choose not to answer this question

7. Are any of your needs urgent? (For example, you don’t have food for tonight, you don’t have a place to stay tonight, or you are afraid you will get hurt if you go home today.) Select all that apply.

- Yes, I don’t have a place to stay tonight
- No, none of my needs are urgent
- Yes, I don’t have food today
- I choose not to answer this question
- Yes, I am afraid I will get hurt if I go home today

8. Would you like help with any of the needs you have identified?

- Yes
- No
- I choose not to answer this question

If yes: \_\_\_\_\_

At AmeriHealth Caritas Delaware, we understand that the well-being and safety of our members and caregivers are essential, so we ask everyone these questions:

9. Do you feel physically and emotionally safe where you currently live? (Examples are your neighborhood, your living arrangements, and feeling free from risk for falling.)

- Yes
- Unsure
- No
- I choose not to answer this question

10. Within the past 12 months, have you been:

A. Slapped, kicked, or otherwise physically hurt by anyone?

- Yes
- No
- I choose not to answer this question

B. Humiliated or emotionally abused by anyone?

- Yes
- No
- I choose not to answer this question



Questions about your health

1. In general, would you say your health is:

- Great
- Fair
- I choose not to answer this question
- Good
- Poor

2. Over the last two weeks:

A. How often have you experienced little interest or pleasure in doing things?

- Not at all
- More than half the days
- I choose not to answer this question
- Several days
- Nearly every day

B. How often have you felt sad, depressed, or hopeless, causing you to lose interest or pleasure in doing things?

- Not at all
- More than half the days
- I choose not to answer this question
- Several days
- Nearly every day

C. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

- Never or almost never
- Often
- I choose not to answer this question
- Sometimes
- All the time

3. Are you pregnant?

- Yes
- No
- I choose not to answer this question

4. What is your current height and weight?

- \_\_\_\_\_ Height
- \_\_\_\_\_ Weight
- I choose not to answer this question

5. Do you have any concerns about your weight?

- Yes
- No
- I choose not to answer this question

6. Do you have any problems with walking, bathing, dressing, or using the toilet?

- Yes
- No
- Unsure
- I choose not to answer this question

7. Has your PCP ever said that you have these health conditions?

Anxiety disorder:

- Yes
- No
- Unsure
- I choose not to answer this question

Asthma, wheezing, or trouble breathing:

- Yes
- No
- Unsure
- I choose not to answer this question



Attention deficit hyperactivity disorder (ADHD):

Yes  No  Unsure  I choose not to answer this question

Cancer (other than minor skin cancers):

Yes  No  Unsure  I choose not to answer this question

Chronic obstructive pulmonary disease (COPD) or emphysema (damage to the lungs that gets worse over time):

Yes  No  Unsure  I choose not to answer this question

Is your PCP currently treating you for chronic pain? (Chronic pain is defined as pain that typically lasts longer than three months or past the time of normal healing.)

Yes (PCP's name) \_\_\_\_\_  No  I choose not to answer this question

Depression:

Yes  No  Unsure  I choose not to answer this question

Diabetes or high blood sugar:

Yes  No  Unsure  I choose not to answer this question

Heart disease, chest pain, heart attack, or other heart problem:

Yes  No  Unsure  I choose not to answer this question

High blood pressure:

Yes  No  Unsure  I choose not to answer this question

Overweight:

Yes  No  Unsure  I choose not to answer this question

Stroke or reduced blood flow to the head or legs:

Yes  No  Unsure  I choose not to answer this question

Hearing problems (hearing loss that can't be improved with a hearing aid):

Yes  No  I am being treated now  I choose not to answer this question

Vision problems (poor eyesight that can't be improved with glasses or contacts):

Yes  No  I am being treated now  I choose not to answer this question

Do you have any condition(s) not already discussed?

Yes. Please list: \_\_\_\_\_  No  Unsure  I choose not to answer this question



**8. Do you use tobacco?**

Yes, I use (check all that apply):

Cigarettes

Pipes

Chewing/smokeless tobacco

Cigars

E-cigarettes

No

I choose not to answer this question

**9. If you smoke, do you want to smoke less or quit using tobacco?**

Yes, I am ready

Yes, but not right now

No

I choose not to answer this question

**10. Are you aware that your Medicaid benefits may cover medications to help you cut back or quit smoking?**

Yes

No

I choose not to answer this question

**11. If you have quit smoking, how many years has it been since you quit?**

Within 3 months

1 – 5 years

I choose not to

Less than a year

More than 5 years

answer this question

**12. Do you drink alcohol?**

Yes

No

I choose not to answer this question

**13. Do you want to drink less or quit drinking alcohol?**

Yes, I am ready

No

Yes, but not right now

I choose not to answer this question

**14. Do you use other substances?**

Yes, I use (check all that apply):

Prescription drugs

Street drugs

IV drugs

Other:

No

I choose not to answer this question

**15. Are you currently receiving any substance use or mental health services?**

Yes

No

I choose not to answer this question





**20. Do you know the name of your family PCP?**

- Yes (PCP's name) \_\_\_\_\_  I choose not to answer this question
- No

**21. Have you seen your PCP in the last 12 months?**

- Yes (list month) \_\_\_\_\_  No  Unsure
- I choose not to answer this question

**22. An advance directive, living will, and medical power of attorney are documents that will let your family know your wishes for medical decisions if you are unable to speak for yourself. Do you have one of these documents?**

- Yes
- No (More information can be found in your Member Handbook or by speaking to your PCP.)
- I choose not to answer this question

**23. Are you interested in learning more about your health care benefits, including medications, vision benefits for children, and the benefits provided at the wellness center?**

- Yes  No  I choose not to answer this question

**Thank you for completing our care needs screening! This information will help us provide you the best possible care. We will keep your information private.**

If you need help completing this form, please call our Rapid Response and Outreach Team at **1-844-623-7090** and a health plan representative will help you.

**Please return this form in the postage-paid return envelope or send to:**

AmeriHealth Caritas Delaware Rapid Response  
P.O. Box 80104  
London, KY 40742

You may also fax the completed form to **1-855-806-6242**.



**AmeriHealth** *Caritas*<sup>™</sup>

---

Delaware

[www.amerhealthcaritasde.com](http://www.amerhealthcaritasde.com)