CHAMPION HEALTH PLAN

Thank you for participating in the Health Risk Assessment (HRA) for end stage renal disease (ESRD). Your insights will enable our MAPD health plan case manager to customize your care plan. We assure confidentiality and urge you to be as precise as possible.

Today's date:_____

PERSONAL INFORMATION:

1. Full name:_____

2. Best phone number:_____

3. Date of birth:_____Gender: ☐ Female; ☐ Male; ☐ Other

4. Medicare ID:_____

5. Medicaid (Medi-CAL) ID:_____

6. Preferred language: ☐ English; ☐ Spanish; ☐ Vietnamese; ☐ Chinese; ☐ Korean

☐ Tagalog; ☐ Other:_____

7. Race or ethnicity: check all that apply ☐ White; ☐ Black; ☐ Asian; ☐ American Indian/Alaska Native; ☐ Hawaiian or other Pacific Islander; ☐ Hispanic;

☐ Other_____: ☐ I choose not to answer.

8. Height:_____(Feet)_____(Inches)

9. Weight:_____(Lbs.)

ESRD STATUS:

10. ESRD diagnosis date:_____

11. Have you had a transplant? ☐ Yes ☐ No If yes, date of transplant:_____

12. Are you on a waiting list for a kidney transplant? ☐ Yes ☐ No

13. Are you currently receiving dialysis treatments? ☐ Yes ☐ No

- If yes, what type of dialysis treatment are you receiving?

  o Hemodialysis

  ☐ In-center

  ☐ Home Hemodialysis

  o Peritoneal Dialysis

  ☐ CCPD (Continuous Cycling Peritoneal Dialysis)

  ☐ CAPD (Continuous Ambulatory Peritoneal Dialysis)

  o Other:_____

14. Dialysis center name and address:_____

_____

15. Dialysis treatment frequency: ☐ 3 times per week; ☐ Other:_____

_____

16. Access type

☐ Catheter ☐ Fistula ☐ Graft

17. Have you had any problems getting to your dialysis treatments? (e.g., transportation?)

☐ Yes ☐ No If yes, details:_____

18. Are you having trouble following your recommended kidney diet?

☐ Yes ☐ No If yes, detail:_____

OTHER MEDICAL HISTORY / INFORMATION:

19. How many times were you hospitalized in the past year?

☐ None ☐ One ☐ Two Times ☐ Three Times ☐ More

20. How many times did you visit the Emergency Room in the past year?

☐ None ☐ One ☐ Two Times ☐ Three Times ☐ More

21. List any other medical conditions you have (e.g., hypertension, diabetes):

_____

_____

22. Do you have any pain? ☐ Yes ☐ No

23. Where is your pain?_____

24. Is the pain:

☐ Sharp ☐ Dull ☐ Achy ☐ Tingling ☐ Burning

25. What is your pain score:

☐ Mild (1-3) ☐ Moderate (4-7) ☐ Severe (8-10)

26. How severe is the pain:

☐ Comes and goes ☐ Constant Low ☐ Constant Medium ☐ Constant High

☐ Very High ☐ Prevents sleep

27. How is your hearing?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

28. If you are deaf, do you have a personal sign-language interpreter? ☐ Yes ☐ No

Do you need Champion Insurance to schedule a sign-language interpreter to be present at your doctor appointments? ☐ Yes ☐ No ☐ Other:_____

29. If you drive yourself, or someone you know drives you, Champion will reimburse money for gas (per IRS standards).

30. How is your eyesight?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

31. Do you need information in large print? ☐ Yes ☐ No ☐ Other?_____

32. Are you getting injections for your eyes? ☐ Yes ☐ No

33. Have you been to the dentist in the past year? ☐ Yes ☐ No

FRAILTY INDICATORS:

Have you experienced or are experiencing any of the following in the past year?

34. Recent unintentional weight loss?	☐ Yes	☐ No
35. Regular feelings of exhaustion or fatigue?	☐ Yes	☐ No
36. Decline in grip strength?	☐ Yes	☐ No
37. Trouble in walking or ascending stairs?	☐ Yes	☐ No
38. Slower walking speed or reduced physical activity?	☐ Yes	☐ No
39. Any falls in the past year?	☐ Yes	☐ No

BEHAVIOR:

			Frequency
40. Physical activity	☐ Yes	☐ No	Times per week:
41. Smoke or use tobacco	☐ Yes	☐ No	Times per week:
42. Alcohol use	☐ Yes	☐ No	Times per week:
43. Unprotected sex	☐ Yes	☐ No	Times per month:
44. Use a seat belt in cars	☐ Yes	☐ No	☐ Always; ☐ Sometimes; ☐ Never
45. Home Safety Evaluation	☐ Yes	☐ No	We can provide one for you

EMOTIONAL / PSYCHOLOGICAL FEELINGS:

Indicate your response to each of the following. Have you had...

46. Reduced interest/pleasure in usual activities in the past two weeks? ☐ Yes ☐ No

47. Feelings of sadness or hopelessness in the past two weeks? ☐ Yes ☐ No

48. Feelings of significant anger or rage in the past two weeks? ☐ Yes ☐ No

49. Feelings of significant stress in the past two weeks? ☐ Yes ☐ No

50. Feelings of loneliness or social isolation in the past two weeks? ☐ Yes ☐ No

LIVING SITUATION AND COMMUNITY SUPPORT:

What is your housing situation today?

51. I have housing	☐ Yes	☐ No
52. I am staying with others in a hotel	☐ Yes	☐ No
53. I am staying in a shelter	☐ Yes	☐ No
54. I am living outside on the street, on a beach, in a car or in a park	☐ Yes	☐ No
55. Do you live in an independent house, apartment, condo, or mobile home? ☐ Alone; ☐ Friend; ☐ Spouse; ☐ Child ☐ Other	☐ Yes	☐ No
56. Do you live in an assisted living facility/apartment, or board and care home, or nursing home?	☐ Yes	☐ No
57. I choose not to answer these questions	☐ Yes	☐ No

58. List any community support or resources that help with your ESRD care or wellness:

_____

_____

ACTIVITIES OF DAILY LIVING (ADLS):

Tell us how much help you need with each of the following:

59. Bathing

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

60. Dressing

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

61. Eating

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

62. Toileting

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

63. Grooming

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

64. Walking

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

65. Transferring (from bed to chair for example)

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

66. Do you have someone to help you with the above if you need help? ☐ Yes ☐ No

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS):

Tell us how much help you need with each of the following:

67. Shopping

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

68. Food Preparation

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

69. Using the telephone

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

70. Housekeeping

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

71. Laundry

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

72. Taking medications

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

73. Handling my finances

☐ Can do this myself ☐ Need a little help ☐ Can't do this ☐ I need significant help

74. Do you have someone to help you with the above if you need help? ☐ Yes ☐ No

75. Do you have any difficulties in affording medical care or medications? ☐ Yes ☐ No

76. Do you sometimes run out of money to pay for food/rent/bills/medicine?

☐ Yes ☐ No

77. Who helps you at home with daily tasks, treatments, and appointments, and how do they help?_____

_____

78. Do you have someone who is paid to help take care of you at home, like a caregiver through In-Home Supportive Services (IHSS)? ☐ Yes ☐ No

79. Do you regularly exercise?

☐ Yes, how often:_____

☐ No, reason:_____

80. Do you use your doctor's patient portal? ☐ Yes ☐ No

Why not?_____

81. Do you have an advance care plan?

☐ Yes

- ☐ Living Will
- ☐ Durable Power of Attorney for Healthcare
- ☐ Do Not Resuscitate (DNR) Order
- ☐ Physician Orders for Life-Sustaining Treatment (POLST)
- ☐ Do Not Intubate (DNI)

☐ No

MEDICATION & DIETARY GUIDANCE

82. How many different prescription medicines do you take:

☐ 1 - 3; ☐ 4 – 6; ☐ 7 - 10; ☐ more than 10 different medications

83. Challenges with understanding or adhering to medications prescribed?

☐ Yes ☐ No If yes, detail:_____

84. Do you have difficulty picking up your medications?

☐ Yes ☐ No If yes, detail:_____

NECESSITIES:

In the past year, did you or anyone you live with have trouble getting any of the following when really needed? Check all that apply:

85. Food	☐ Yes	☐ No
86. Utilities	☐ Yes	☐ No
87. Clothing	☐ Yes	☐ No
88. Childcare	☐ Yes	☐ No
89. Medicine or any health care that you needed (medical, dental, mental health care, vision, hearing, etc.)?	☐ Yes	☐ No
90. Phone	☐ Yes	☐ No
91. Other	☐ Yes	☐ No
92. I choose not to answer these questions	☐ Yes	☐ No

In the past year, the lack of transportation has caused you to miss any of the following:

93. Medical appointments	☐ Yes	☐ No
94. Non-medical appointments, meetings, work, or getting things I need	☐ Yes	☐ No
95. I choose not to answer these questions	☐ Yes	☐ No

VACCINATIONS / IMMUNIZATIONS:

Have you had this in the past 12 months?

96. Flu Shot	☐ Yes	☐ No	☐ Not yet but want it
97. Pneumonia	☐ Yes	☐ No	☐ Not yet but want it
98. COVID	☐ Yes	☐ No	☐ Not yet but want it

GOALS & PREFERENCES:

99. What are your main personal goals for your kidney care and overall health?

100. Do you have any wishes for your treatment, how your care is managed, or end-of-life care:

101. As the caregiver, what is your main goal for your family member/client?

ADDITIONAL FEEDBACK:

102. Share any other vital information about your health or care necessities:

Thank you for your help. This information is crucial to deliver optimal care tailored to meet your requests and needs. **Kindly send this completed form to:**

Champion Health Plan
PO Box 15337
Long Beach, CA 90815-9995

If you have any questions or need assistance, please call and ask to have your personal Care Manager return a call to you. Please call **1-800-885-8000** or **711 for TTY**. Ask for the Care Management Team.