Member name_______________________________

DOB ________ Member ID____________________

Medicare Advantage Health Assessment

1. How would you rate your overall health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. How would you rate your physical health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

3. What conditions have you had in the past or are currently receiving treatment for?
☐ Anxiety ☐ Asthma ☐ Bipolar disorder
☐ Cancer ☐ COPD/Emphysema ☐ Dementia
☐ Depression ☐ Diabetes ☐ Hearing problems
☐ Heart Disease ☐ Heart Failure ☐ High Blood Pressure
☐ Transplant ☐ Renal/Kidney failure ☐ Schizophrenia
☐ Stroke ☐ Vision problems ☐ None

4. Have you stayed in the hospital more than three times in the last year?
☐ Yes ☐ No

5. In the past six months, how many times did you visit the emergency room?
☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

6. Do you take six or more medications?
☐ Yes ☐ No

7. How would you rate your pain on average? ____________________
0-10 scale with 0=No pain and 10=Worst pain imaginable

8. How would you describe your dental health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Have Dentures

9. How is your hearing?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Have Hearing Aids

10. How is your vision?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Wear glasses
☐ Blind/Legally blind

11. How often do you get as much sleep as you want?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

12. In the past month, how would you rate your sleep?
☐ Very Good ☐ Good ☐ Poor ☐ Very Bad

13. In the past six months, have you experienced leaking of urine? ☐ Yes ☐ No
If yes, have you spoken with your health care provider about leaking of urine?
☐ Yes ☐ No

14. Do you need help with any of the following?

Activity	No	Yes
Bathing	☐ No	☐ Yes, need help or equipment
Dressing	☐ No	☐ Yes, need help or equipment
Using the bathroom	☐ No	☐ Yes, need help or equipment
Getting in and out of a chair or bed	☐ No	☐ Yes, need help or equipment
Eating	☐ No	☐ Yes, need help or equipment
Taking your medicine	☐ No	☐ Yes, need help or equipment
Transportation	☐ No	☐ Yes, need help or equipment
Walking	☐ No	☐ Yes, need help or equipment
Using the telephone	☐ No	☐ Yes, need help or equipment
Household tasks *(cooking, laundry, chores)*	☐ No	☐ Yes, need help or equipment
Running errands or grocery shopping	☐ No	☐ Yes, need help or equipment
Managing your money *(paying bills, bank accounts)*	☐ No	☐ Yes, need help or equipment

15. For the activities above, do you get the help you need?
☐ I get all the help I need ☐ I could use more help
☐ I need more help ☐ I don't need any help

16. Do you have stairs or steps in your home? ☐ Yes ☐ No

17. In the past six months, have you fallen to the ground without being pushed?
☐ Yes ☐ No

18. How often do you feel unsteady when walking or have concerns with balance?
☐ Never ☐ Occasionally ☐ Daily ☐ All the time

19. How often do you feel fatigued?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

20. Have you lost weight without trying in the last three months? ☐ Yes ☐ No

21. Have you eaten less than normal over the past three months? ☐ Yes ☐ No
    If yes, is this because of no appetite or chewing/swallowing difficulties? ☐ Yes ☐ No

22. How often did you exercise for at least 20–30 mins at least five days a week?
    ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

23. How often do you eat at least five servings of fruits and vegetables per day *(one serving is one-half cup)?*
    ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

24. How often do you eat foods high in fat such as whole milk, fried food, fatty meats?
    ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

25. How often do you eat foods high in fiber *(i.e., whole grain bread and cereal, beans)*?
    ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

26. Do you currently smoke or use tobacco products *(cigarettes, cigars, chew, vaping)*?
    ☐ Yes ☐ No

27. How often did you have a drink containing alcohol in the last year?
    ☐ Never ☐ 2-4 times/month ☐ Monthly or less
    ☐ 2-3 times/week ☐ 4 or more times/week

28. If you do drink alcohol, how many drinks containing alcohol did you have on a typical day when you were drinking in the past year?
    ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10+

29. Do you ever think about quitting or changing how much you drink? ☐ Yes ☐ No

30. In the last two weeks, how often have you:

Felt nervous, anxious or on edge? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day
Not been able to stop or control worrying? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day
Had little interest or pleasure in doing things? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day
Felt down, depressed or hopeless? ☐ Not at all ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every day

31. What best describes your current living situation?
    ☐ Live alone ☐ Live with Family/Spouse
    ☐ Live with a non-relative ☐ Live in an assisted living facility

32. How often do you feel alone or isolated from others?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

33. How satisfied are you with your social activities and relationships?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

34. How often do you feel angry?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

35. How often do you feel stressed?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

36. Do you find you have to choose between buying groceries, medicine or paying bills? ☐ Yes ☐ No

37. What was the highest grade or level of school you completed?
☐ Eighth grade or less
☐ Some high school, did not graduate
☐ High school graduate/GED
☐ Some college or two-year degree
☐ Four-year college graduate (B.A., B.S.)
☐ More than Four-year degree

38. What is your current marital status?
☐ Married
☐ In serious or committed relationship, not married
☐ Divorced
☐ Separated
☐ Widowed
☐ Single

39. What is your primary language?
☐ English ☐ Spanish
☐ Other ______________________________

Please return to:
Sanford Health Plan, Attn: Care Management, P.O. Box 91110, Sioux Falls, SD 57109-1110

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