Clover Health

Health Assessment Survey

We want to help you be as healthy as you can be with healthcare tailored to you. Please complete this survey and send it back in the enclosed postage-paid envelope. You can also complete the survey online at cloverhealth.com/hra or by calling 1-888-657-1207 (TTY 711) 8 am–8 pm local time, 7 days a week.*

First Name:	Last Name:
Clover Health Member ID#: **C** **P** ☐☐☐☐☐☐☐☐	
Date of Birth (mm/dd/yyyy): ☐☐/☐☐/☐☐☐☐	Today's Date (mm/dd/yyyy): ☐☐/☐☐/☐☐☐☐

1. Do you have a mobile phone number and/or email address? (Complete below if you do)

Mobile Phone: ☐☐☐-☐☐☐-☐☐☐☐

Email Address: _____ @_____ . _____

By providing your email address and phone number(s), you consent to receiving information related to your membership with Clover Health (e.g., benefit information), programs and services offered (e.g., health education materials, reminders), and marketing and other communications (e.g., newsletters, surveys) electronically.

Communications related to your membership with Clover or your healthcare may include email, auto-dialed calls, pre-recorded or electronic voice messages, or text messages. You may opt out of these means of communication at any time by clicking the "opt out" link within any email message, or contacting Clover, or responding STOP to a text message. You may also request a hard copy of any materials that Clover delivers electronically.

2. What is the best method to reach you? (Check all that apply)

☐ Email ☐ Phone ☐ Text ☐ Mail ☐ Other: _____

3. What is the best time of day to reach you? (Choose one)

☐ Morning (8 am–Noon) ☐ Afternoon (Noon–4 pm) ☐ Evening (4–8 pm)

4. Do you have an emergency contact—someone who helps with your medical care?

Name: _____ Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

How are they related to you? ☐ Family ☐ Friend ☐ Other: _____

We will not talk with this person about your health unless you give us permission to do so. If you would like to permanently give us permission to talk with this person, please complete an Authorization of Representative Form (found at: cloverhealth.com/aor), or you can call 1-888-657-1207 for assistance.

5. What motivates you to stay healthy? (Respond below)

6. What concerns do you have about staying healthy now? (Choose all that apply)

- ☐ Not having a good support system
- ☐ Not being able to access or obtain my medical care (prescriptions, copays, etc.)
- ☐ Not being able to afford my housing, or utility bills
- ☐ Not having transportation
- ☐ Not having the equipment I need to be safe (walker, commode chair, grab bars, etc.)
- ☐ Other: _____

_____

7. Which of the following best describes where you live? (Choose one)

- ☐ Private house
- ☐ Private apartment
- ☐ Assisted living facility
- ☐ Senior housing
- ☐ Other: _____
- ☐ No housing/homeless

8. Who do you live with? (Choose all that apply)

- ☐ I live alone
- ☐ Spouse or partner
- ☐ Other family
- ☐ Friend(s)
- ☐ Hired caregiver(s)

9. In general, would you say your health is: (Choose one)

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

10. Do you currently smoke or have you smoked in the past? (Choose one)

- ☐ Current smoker
- ☐ Former smoker
- ☐ Never smoked

11. Approximately how often do you exercise? (Choose one)

- ☐ Never
- ☐ Once a month
- ☐ Once a week
- ☐ More than once a week

12. How often do you have a drink containing alcohol? (Choose one)

- ☐ Never
- ☐ Monthly or less
- ☐ 2–4 times a month
- ☐ 2–3 times a week
- ☐ 4 or more times a week

13. Does your health limit moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? If so, how much? (Choose one)

☐ Yes, very limited ☐ Yes, somewhat limited ☐ No, not limited at all

14. Do you use any of the following to help you walk or get around? (Choose all that apply)

☐ Crutches ☐ Walker ☐ Cane ☐ Wheelchair ☐ Scooter

☐ Other (please describe): _____ ☐ None of the above

15. How many times in the last year have you fallen?
(Fill in one digit per box)

☐☐

16. Do you need help from another person to do any of the following activities? (Choose all that apply)

☐ Feed yourself
☐ Use the toilet
☐ Put on or take off your clothes
☐ Walk within your home
☐ None of the above
☐ Take your medications
☐ Take a bath or shower
☐ Get out of your bed and into a chair
☐ Pick up groceries, prescriptions, etc.

17. Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things in past 2 weeks?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless in past 2 weeks?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

18. How often in the past 4 weeks have you had trouble thinking or remembering? (Choose one)

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

19. During the past 4 weeks, how often was someone available to help you if you needed help?
For example, if you...
- were sick and had to stay in bed
- needed someone to talk to
- needed help with daily chores (Choose one below)

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

20. In the past year, have you been treated for any of the following conditions? (Choose all that apply)

- ☐ High blood pressure (hypertension)
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Heart disease (heart attack, congestive heart failure/CHF, angina)
- ☐ Irregular heart rhythm (atrial fibrillation)
- ☐ Lung disease (COPD, emphysema, asthma)
- ☐ Kidney disease
- ☐ Stroke
- ☐ Arthritis
- ☐ Chronic pain
- ☐ Cancer
- ☐ Dementia
- ☐ Depression or anxiety

21. How many different doctors have you seen in the past year?
(Fill in one digit per box) ☐☐

22. How many times have you been to the emergency room or hospital in the past year?
(Fill in one digit per box) ☐☐

23. How many different medications do you currently take on a daily basis?
(Fill in one digit per box) ☐☐

24. How often are you able to take your medications as prescribed by your doctor? (Choose one)

- ☐ I always take them as prescribed.
- ☐ I sometimes take them as prescribed.
- ☐ I rarely take them as prescribed.
- ☐ I do not have to take prescribed medications.

25. How confident are you that you can control and manage most of your health problems? (Choose one)

- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ I do not have any health problems.

26. Would you like help finding a primary care physician (a main doctor who coordinates your care)?

☐ Yes ☐ No

27. Did someone help you complete this form?

☐ No, completed by myself ☐ Yes, completed with help of friend, family, or caregiver

Thank you for completing this survey. Please send it back to us as soon as you can. If you have any questions, please call 1-888-657-1207 (TTY 711) 8 am–8 pm local time, 7 days a week.*

*Between April 1st and September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.