UMPQUA HEALTH ALLIANCE

Health Risk Assessment Screening

Member Information		
First and Last Name	**Member ID**	**DOB**
Mailing Address	**Phone Number**	**Email Address**

Personal Characteristics

1. **Would you like to receive email or text communication from us?** ☐ Yes ☐ No ☐ Don't know
2. **Do you need an interpreter to communicate with us do you need notices in another format?**
   ☐ Yes ☐ No ☐ Don't know
3. **Do you need a sign language interpreter to communicate with us?**
   Yes (type needed) _____ ☐ No ☐ Don't know
4. **What is your preferred spoken language?** ☐ English ☐ Spanish ☐ Other: _____
5. **What is your preferred written language?** ☐ English ☐ Spanish ☐ Other: _____
6. **What is your sexual orientation?**
   ☐ Straight ☐ Bisexual ☐ Transgender ☐ Asexual ☐ Gay or Lesbian
   Other: _____
7. **Which of the following describes your ethnic identity?**
   ☐ Hispanic ☐ Not Hispanic ☐ Don't know ☐ Decline
8. **Which of the following describes your racial identity?**

American Indian or Alaska Native ☐
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Mexican Native or Indio
- ☐ Central American, or South American

Asian ☐
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Laotian
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian or Pacific Islander ☐
- ☐ Guamanian or Chamorro
- ☐ Micronesian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Hispanic or Latino/a ☐
- ☐ Hispanic or Latino/a Central American
- ☐ Hispanic or Latino/a Mexican
- ☐ Hispanic or Latino/a South American
- ☐ Other Hispanic or Latino/a

Black or African American ☐
- ☐ African American
- ☐ African (Black)
- ☐ Caribbean (Black)
- ☐ Other Black

Middle Eastern/ North African ☐
- ☐ North African
- ☐ Middle Eastern

White ☐
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other

Other Categories
- ☐ Other (please list) _____
- ☐ Don't know
- ☐ Decline

Family and Home

9. **Are you currently pregnant? If yes, when are you due?** ☐ Yes ☐ No Due Date: _____
10. **Have you been discharged from the armed forces of the United States?** ☐ Yes ☐ No ☐ Don't know
11. **Are you or is your close family a veteran?** ☐ Yes ☐ No ☐ Don't know
12. **Are you a refugee?** ☐ Yes ☐ No ☐ Don't know

UMPQUA HEALTH ALLIANCE

13. **In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.**
☐ Food ☐ Clothing ☐ Utilities ☐ Phone ☐ Medicine ☐ Child Care
☐ Vision ☐ Housing ☐ Medical care ☐ Dental care ☐ Mental Health care
☐ Other: _____

14. **Do you need help or have troubles with any of these daily activities?**
☐ Eating ☐ Getting dressed ☐ Grooming
☐ Bathing ☐ Preparing food ☐ Using the toilet
☐ Walking or falling often ☐ Climbing stairs ☐ Remembering tasks or events
☐ Concentrating ☐ Making decisions ☐ Running errands alone
☐ Learning new things ☐ Communicating ☐ Controlling your behavior
☐ Mood troubles or intense feelings ☐ Experiencing delusions ☐ Have hallucinations
☐ Taking/organizing medications

15. **Do you live in one of the following locations?**
☐ Nursing home ☐ Assisted living home ☐ Behavioral health home ☐ No

16. **What is your housing situation?**
☐ I have housing
☐ I do not have housing (staying with others, hotel, shelter, living outside, in a car, or in a park)

17. **Are you worried about losing your housing?** ☐ Yes ☐ No

18. **How many family members, including yourself, do you currently live with?** (write number):_____

19. **YOUTH ONLY: What is the child's living arrangement?** ☐ Parent(s)/guardian ☐ DHS ☐ Foster home
Other (please explain): _____

20. **YOUTH ONLY: Does your child show signs of social, emotional or behavioral problems?** ☐ Yes ☐ No

21. **YOUTH ONLY: Is your child currently attending school?** ☐ Yes ☐ No

Money and Resources

22. **Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.**
☐ Yes, it has kept me from medical appointments or from getting my medications
☐ Yes, it has kept me from non-medical needs, work, or appointments
☐ No

23. **What is the highest level of school that you have finished?**
☐ Less than high school ☐ High school diploma/GED ☐ More than high school

24. **What is your current work situation?**
☐ Part-time or temporary work ☐ Full-time work ☐ Unemployed
☐ Unemployed but not seeking work (student, retired, disabled, unpaid care giver)
☐ Other (please explain):

25. **At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?** ☐ Yes ☐ No

26. **During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.** (write amount):_____

27. **What is your main health insurance?**
☐ None/Uninsured ☐ Medicaid ☐ Other Public Insurance (CHIP)
☐ Private Insurance ☐ Medicare ☐ Other Public Insurance (not CHIP)

28. **In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?** ☐ Yes ☐ No

Social and Emotional Health

29. **Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?** ☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

UMPQUA HEALTH ALLIANCE

30. **How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)**
☐ Less than once a week 1 or 2 times a week ☐ 3 to 5 times a week ☐ 5+ times a week

31. **. Do you feel physically and emotionally safe where you currently live?** ☐ Yes ☐ No ☐ Don't know

32. **In the past year, have you been afraid of your partner or ex-partner?** ☐ Yes ☐ No ☐ Don't know

33. **Are there any cultural, religious, or spiritual beliefs or practices that may influence your care?**
☐ No ☐ Yes (please explain): _____

_____

Medical and Dental Services

34. **Do you have one of these disabilities?** ☐ Hard of hearing ☐ Deaf ☐ Blind ☐ Other: _____

35. **Do you see your dental provider every 6 month for routine care?**

36. **Do you have high health needs or medical issues?**
☐ No ☐ Yes (please explain): _____

37. **Do you use tobacco products (cigarettes, chew, snuff, pipes, cigars, vapor cigarettes)?** ☐ Yes ☐ No

38. **Do you have any health concerns you need help with?** _____

_____

_____

39. **Are you receiving help with any of the following?**
☐ Congestive Heart Failure (CHF) ☐ Hepatitis C ☐ Heart Disease ☐ Diabetes
☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Tuberculosis HIV/AIDs
☐ Other (please explain): _____

Medications

40. **In the past 60 days have you had trouble remembering to take some or all of your medications?** ☐ Yes ☐ No

41. **In the past 60 days have you avoided taking a medication because of a side effect, cost, difficulty understanding direction or other concern?** ☐ Yes ☐ No

Behavioral Health

42. **Do you need help with drug or alcohol use?** ☐ Yes ☐ No

43. **Do you have a mental illness?** ☐ Yes ☐ No

If you need another language, large print, Braille, CD, tape or another format, call Member Services at (541) 229-4842 or TTY (541) 440-6304.