29. What is your preferred language for written materials? Check one:

- ☐ Choose not to disclose
- ☐ Arabic
- ☐ Braille
- ☐ Burmese
- ☐ English
- ☐ Hmong
- ☐ Karen
- ☐ Large Print
- ☐ Rohingya
- ☐ Russian
- ☐ Serbian
- ☐ Somali
- ☐ Spanish
- ☐ Urdu
- ☐ Vietnamese
- ☐ Other: _____

30. Are you comfortable communicating with iCare (your health plan) in the language of your choice? Check one:

- ☐ Yes
- ☐ No
- ☐ Choose not to disclose

31. What is the highest level of school that you have finished? Check one:

- ☐ Less than high school degree
- ☐ High school diploma, GED, or equivalent
- ☐ More than high school
- ☐ Choose to not disclose

***IF YOU ARE UNDER THE AGE OF 18, YOU MAY SKIP QUESTIONS 32-35.**

*32. What is your sex assigned at birth? (Male/female at birth is based on hormones, body parts and organs.) This may help us make sure you know the health screenings you need to stay healthy like a mammogram. Check one:

- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Choose not to disclose

*33. What is your current gender identity? (Gender identity is linked to a person sense of being male, female, both or neither.) Gender identity can change over time. Check one:

- ☐ Choose not to disclose
- ☐ Male
- ☐ Female
- ☐ Transgender male/trans man/female-to-male
- ☐ Transgender female/trans woman/male-to-female
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional gender category or other, please specify: _____

*34. What are your pronouns? We want to make sure we refer to our members in a respectful manner. Check one:

- ☐ Choose not to disclose
- ☐ He/Him
- ☐ She/Her
- ☐ They/Them
- ☐ Other: _____

*35. What is your sexual orientation? Sexual orientation is the emotional, physical, romantic, sexual and/or spiritual attraction, desire or affection for other people. It can change over time. Check one:

- ☐ Choose no to disclose
- ☐ Heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Queer
- ☐ Pansexual
- ☐ Bi-sexual
- ☐ Asexual
- ☐ None of the above

(continued on next page)

36. Are there cultural and/or religious practices we should be aware of when addressing your health care and social needs? Check one:

☐ Yes ☐ No ☐ Choose to not disclose

Please explain: _____

37. Do you identify as having a disability? Check one:

☐ Yes ☐ No ☐ Choose to not disclose

Do you require any accommodations for your disability? Check one:

☐ Yes ☐ No ☐ Choose to not disclose

What accommodations do you require? _____

What group do you feel applies to you? Check one:

- ☐ Physical disability
- ☐ Intellectual/Developmental disability
- ☐ Frail elderly
- ☐ Severe and persistent mental illness
- ☐ Choose not to disclose
- ☐ Other: _____

38. What is your housing situation today? Check one:

☐ I have housing ☐ I do not have housing

Where are you staying? Check all that apply:

- ☐ Staying with others
- ☐ In a hotel
- ☐ In a shelter
- ☐ Living outside on the street
- ☐ In a car
- ☐ A park

Other: _____

In the past year have you or anyone you live with been unable to get any of the following when it was really needed? Check all that apply:

- ☐ Choose not to disclose
- ☐ Food
- ☐ Utilities
- ☐ Clothing
- ☐ Childcare
- ☐ Medicine or other health care
- ☐ Phone
- ☐ Other: _____

39. 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 appointment or from getting my medications
☐Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐No
☐Choose not to disclose

40. Do you need help accessing digital health tools such as health apps, smart devices or fitness trackers? Check one:

☐ Yes ☐ No ☐ Don't know

41. Do you need help using telehealth benefits? Check one:

☐ Yes ☐ No ☐ Don't know

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-777-4376 (TTY: 1-800-947-3529).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-777-4376 (TTY: 1-800-947-3529).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-777-4376 (TTY: 1-800-947-3529).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電。1-800-777-4376 (TTY: 1-800-947-3529).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-777-4376 (TTY: 1-800-947-3529).

Arabic: تنبيه: إذا كنتم تتحدثون العربية، تتوفر لكم مساعدة لغوية مجانية. اتصلوا بالرقم 4376-777-800-1 (هاتف نصي: 1-800-947-3529).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-777-4376 (телетайп: 1-800-947-3529).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-777-4376 (TTY: 1-800-947-3529) 번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-777-4376 (TTY: 1-800-947-3529).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-777-4376 (TTY: 1-800-947-3529).

Laotian: ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-800-777-4376 (TTY: 1-800-947-3529).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-777-4376 (ATS: 1-800-947-3529).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-777-4376 (TTY: 1-800-947-3529).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-777-4376 (TTY: 1-800-947-3529) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-777-4376 (TTY: 1-800-947-3529).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-777-4376 (TTY: 1-800-947-3529).

Somali: DIGTOONI: Haddii aad ku hadasho afka Soomaaliha, adeegyada caawimada luqadda waxaa laguu heli karaa iyagoo bilaash ah. Wac 1-800-777-4376 (TTY: 1-800-947-3529).

Burmese: ကျေးဇူးပြု၍ နားဆင်ပါ - သင်သည် မြန်မာစကားပြောသူဖြစ်ပါက၊ သင့်အတွက် အခမဲ့ဖြင့် ဘာသာစကားကူညီရေး ဝန်ဆောင်မှုများ ရရှိနိုင်သည်။ 1-800-777-4376 (TTY: 1-800-947-3529) တွင် ဖုန်းခေါ်ဆိုပါ။

Serbo-Croatian: PAŽNJA: Ako govorite srpsko-hrvatski imate pravo na besplatnu jezičnu pomoć. Nazovite 1-800-777-4376 (telefon za gluhe: 1-800-947-3529).

iCare
INDEPENDENT CARE HEALTH PLAN

iCare Customer Service: 1-800-777-4376 (TTY: 711)
Our customer service is available 24 hours a day, 7 days a week.
Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.
www.iCareHealthPlan.org
iCare is a Humana Inc. subsidiary.

Health Risk Screening

Thank you for taking the time to complete this survey. We ask several health-related questions. We also ask questions about your race, ethnicity, language, gender identity, pronouns, sex assigned at birth, and sexual orientation. We have a diverse group of members. Asking this information helps us provide every member with the best health care possible. Your care management team uses this information to provide appropriate services for you. Also, when your provider asks us to approve a service for you, we tell your provider your preferred language. We also group this information together, without names, and use it to:

- Look for unfair differences in getting health care and health outcomes between groups.
- Create programs to improve the health of our members.
- Create educational materials.

Your information is private and protected. We take the following actions to protect your personal information:

- We train staff on how to keep your information private.
- We limit access to this information to staff working with you.
- We require passwords to access your information.
- We cannot use this information to deny you services, coverage, and benefits. It is not used for underwriting.

You also have the right to choose not to answer. Your answers have no impact on your benefits or the services you receive from iCare. You will not lose your benefits or services or have less benefits or services by answering these questions. If you want more information on how iCare uses or shares your information, please see our privacy policy on our web at https://www.icarehealthplan.org/Utility-Navigation/Privacy-Policy.htm. If you would like a paper copy of our privacy policy, call Customer Service at 1-800-777-4376 to request a copy to be mailed to you.

Please answer the questions below along with the four-question form from your welcome letter and return them in the enclosed envelope. No stamp is required. iCare will pay for the postage.

Please call iCare if you need assistance filling out this survey. Call 1-800-777-4376 (TTY: 711) and ask to speak to someone on the Medicaid Care Team. Our office hours are Monday through Friday, 8:30 a.m. to 5:00 p.m. Customer Service is available 24 hours a day, 7 days a week.

Member Name: _____

Medicaid ID#: _____

Member Mailing Address: _____

IC462 DHS approved 10/2/2024

PLEASE PRINT YOUR ANSWERS

1. Do you require assistance from anyone to complete this survey? Check one:

☐ Yes ☐ No ☐ Choose not to disclose

If you needed assistance filling out this form, please print the person's name and relationship to the member:

_____

Do you have any hearing or speech issues? Do you have any thinking or processing issues? Either could affect how you communicate. Check one:

☐ Yes ☐ No ☐ Choose not to disclose

Please explain:

_____

2. How would you rate your overall health? Check one:

☐ Excellent ☐ Fair

☐ Very Good ☐ Poor

☐ Good ☐ Choose not to disclose

3. What is your height? _____

4. What is your weight?_____

5. What was your most recent blood pressure reading? _____

6. Do you have a family history of any of the following conditions? Check all that apply:

☐ Acid Reflux/Gerd ☐ COPD ☐ Osteoarthritis

☐ Asthma ☐ Diabetes ☐ Osteoporosis

☐ Cancer ☐ High Blood Pressure ☐ Rheumatoid Arthritis

☐ Chronic Pain ☐ High Cholesterol ☐ Other: _____

☐ Congestive Heart Failure ☐ Heart Disease

7. Has a doctor ever diagnosed you with any of the following conditions? Check all that apply:

☐ Acid Reflux/Gerd ☐ High Blood Pressure

☐ Asthma ☐ High Cholesterol

☐ Cancer ☐ Heart Disease

☐ Chronic Pain ☐ Osteoarthritis

☐ Congestive Heart Failure ☐ Osteoporosis

☐ COPD ☐ Rheumatoid Arthritis

☐ Diabetes ☐ Other: _____

(continued on next page)

8. Do you have any of the following behavioral health conditions? Check all that apply:

☐ Anxiety ☐ Schizophrenia

☐ Bipolar Disorder ☐ Other:

☐ Depression

9. Are you taking any medications for your medical or behavioral health conditions? Check one:

☐ Yes ☐ Unsure

☐ No ☐ Choose not to disclose

How many medications are you taking for your medical or behavioral health conditions? Check one:

☐ 0-4 ☐ 5 or more

Do you have any problems with getting your medications? Check one:

☐ Yes ☐ No

Do you have any problems with taking your medications? Check one:

☐ Yes ☐ No

What problems do you have with getting or taking your medications? Please explain below:

_____

10. Is there something our Care Management team can do to assist you better manage your condition? Check one:

☐ Yes ☐ No ☐ Choose not to disclose

Please explain: _____

11. Do you have a provider that you regularly see or a clinic that you regularly use for primary care? Check one:

☐ Yes ☐ No ☐ Choose not to disclose

What is the name of your primary provider? _____

Do you have any cultural, linguistic, religious, or other preferences for your primary care provider? Check one:

☐ Yes ☐ No ☐ Choose not to disclose

Please explain: _____

12. Do you have a provider that you regularly see or a clinic that you regularly use for behavioral health? Check one:

☐ Yes ☐ No ☐ Choose not to disclose

What is the name of your behavior health provider? _____

13. Do you have a dentist that you regularly see? Check one:

☐ Yes ☐ No ☐ Choose not to disclose

What is the name of your dentist? _____

14. Do you have any specialists that you regularly see? Check one:

☐ Yes ☐ No ☐ Choose not to disclose

What is the name of your specialist(s)? _____

(continued on next page)

15. Do you have a vision provider that you regularly see? Check one:

☐ Yes ☐ No ☐ Choose not to disclose

What is the name of your vision provider? _____

16. Are you pregnant? Check one:

☐ Yes ☐ Unsure ☐ N/A

☐ No ☐ Choose not to disclose

When is your due date? _____

Do you have an OB provider? Check one:

☐ Yes ☐ No

Are you interested in becoming pregnant? Check one:

☐ Yes ☐ Unsure

☐ No ☐ Choose not to disclose

17. Do you need physical help from another person to help you with any of the following Activities of Daily Living? Check all that apply:

☐ Bathing ☐ Stair Climbing

☐ Dressing/Grooming ☐ Toileting

☐ Eating/Feeding-self ☐ Transportation (Wheelchair Van, SMV)

☐ Mobility

18. Do you need help from another person with any of the following Instrumental Activities of Daily Living? Check all that apply:

☐ Housekeeping ☐ Meal Preparation

☐ Laundry ☐ Taking Medications

☐ Managing Money ☐ Using the telephone

19. When you need help, who supports you? Check all that apply:

☐ Family Member ☐ Spouse

☐ Friend ☐ I have no support, need help

☐ Paid Help ☐ No help needed

20. Have you been to the emergency room or urgent care in the past 6 months? Check one:

☐ Yes ☐ Unsure

☐ No ☐ Choose not to disclose

What reason do you go to the ER or urgent care? _____

21. Have you been in the hospital in the past 6 months (medical and/or behavioral)? Check one:

☐ Yes ☐ Unsure

☐ No ☐ Choose not to disclose

(continued on next page)

22. Do you smoke or use other tobacco products (Chewing Tobacco/Vape)? Check one:

☐ Yes ☐ I would like help quitting

☐ No ☐ Choose not to disclose

23. Do you ever drink or use recreational drugs? Check one:

☐ Every day ☐ Never

☐ 2 or more days per week ☐ I would like help quitting

☐ Rarely ☐ Choose not to disclose

23. What are your strengths? Please explain:

_____

_____

24. Is there anything that you would like a Care Management Associate to assist you with in the future? Check one:

☐ Yes ☐ No

Please explain: _____

_____

25. How do you identify your ethnicity? Circle one:

☐ Hispanic or Latino ☐ Choose not to disclose

☐ Not Hispanic or Latino

Other: _____

26. How do you identify your race? Check all that apply:

☐ American Indian or Alaskan Native ☐ Hispanic

☐ Asian or Pacific Islander ☐ Native Hawaiian

☐ Black or African American ☐ Other Pacific Islander

☐ Caucasian ☐ Other: _____

27. How well do you speak English? Check one:

☐ Very well ☐ Not at all

☐ Well ☐ Choose not to disclose

☐ Not well

28. What is your preferred language for health care? Check one:

☐ Choose not to disclose ☐ Russian

☐ American Sign Language ☐ Serbian

☐ Arabic ☐ Somali

☐ Burmese ☐ Spanish

☐ English ☐ Vietnamese

☐ Hmong ☐ Other: _____

☐ Karen

☐ Rohingya

(continued on next page)