HIGHMARK WHOLECARE

YEARLY HEALTH REVIEW

Please use blue or black ink or #2 pencil   Shade Ovals Like This → ●   Not Like This → ⊗ ⊘

This survey asks questions about your health history and health behaviors. There are no right or wrong answers. We just want to know what's true for you.

Acknowledgement of Terms of Use of the Yearly Health Review

I understand that by completing and submitting this survey, "I accept" the following:

- Taking part in this survey is completely voluntary. I understand that completing or refusing the Health Assessment Survey, and any results, will NOT affect my eligibility for enrollment and/or benefits.
- The health information I receive after taking the survey will give me advice that may help me improve or maintain healthy habits. This health information does not diagnose illnesses or health problems, and it does not replace my health care provider's advice and prescribed course of treatment.
- My answers and the health information I receive are private. However, this information may be shared with my health care provider to help improve my health.
- My health plan may create and share summary reports with third parties, such as a hospital or health care providers. Those reports will only include aggregate, de-identified information and will not contain my name or any other identifying information about me.
- Highmark Wholecare is able to help coordinate any physical and behavioral health care needs. In order to do this effectively, we need you to sign a consent form to share information with appropriate providers. Would you like to receive one of these forms to complete? ○ Yes ○ No

Instructions

- Use a blue or black ink pen or No. 2 pencil only.
- Please select ONE answer per question, unless instructed to do otherwise.
- Please answer all questions unless instructed to skip to another question.

MEMBER INFORMATION

Member ID [| | | | | | |]   Today's Date [|] / [|] / [| | |]

First Name [ ]

Last Name [ ]

Preferred Name [ ]   **Select if the number provided is a Cell Phone:** ○ Cell

Phone Number ([| |]) [| |] - [| | |]   **If yes, do you want to receive text messages? You can opt out at any time.** ○ Yes ○ No

Email [ ]

Who is completing this form?

○ The member/myself ○ A family member ○ A designated caregiver ○ Other

When were you born?

☐☐ / ☐☐ / ☐☐☐☐
MM DD YYYY

What was your gender assigned at birth?

○ Male ○ Female ○ Other ○ Prefer not to answer

How would you describe your gender?

○ Male ○ Female ○ Transgender Male ○ Transgender Female
○ Non-Conforming ○ Prefer not to answer

Preferred Pronouns:

○ He/Him/His ○ She/Her/Hers ○ They/Them/Theirs ○ Prefer not to answer

Sexual Identity:

○ Heterosexual (straight) ○ Gay ○ Lesbian ○ Bisexual ○ Asexual
○ Unsure ○ Prefer not to answer

What language do you prefer to speak?

○ English ○ Spanish ○ Other, specify:

What is your race, ethnicity or identity?

○ White
○ Black
○ Hispanic or Latino
○ Asian
○ Native Hawaiian or other Pacific Islander
○ Two or more
○ Native American or Alaska Native
○ Prefer not to answer
○ Other

Are you a veteran?

○ Yes ○ No

How tall are you? Feet ☐ Inches ☐☐ **What is your weight?** ☐☐☐ Pounds

1. **Do you currently have any of the following health conditions? (mark all that apply)**

○ None
○ Little/No appetite
○ Asthma/trouble breathing
○ Depression/stress/anxiety
○ Cardiac disease
○ COPD/lung diseases
○ Diabetes/blood sugar
○ High Blood Pressure
○ Kidney disease
○ Cancer
○ Chronic or uncontrolled pain
○ HIV/AIDS
○ Liver Disease/Hepatitis
○ Wound that won't heal
○ Other, specify: _____

2. Are you ever afraid or worried about any of the following? (Mark all that apply)

- ○ Being hit or hurt by anyone close to you
- ○ Being ignored or forgotten by someone who should be helping you
- ○ Feeling safe in my home or community
- ○ Running out of food
- ○ Feeling lonely/having a lack of companionship
- ○ None of these
- ○ Other

3. In the past 2 weeks, how often have you had little interest or pleasure in doing things?

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

4. During the past year, have you experienced changes in thinking, remembering, or decision-making? For example, have you had more difficulty remembering people, places, or things? Have you had more difficulty making decisions?

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

5. Activities of Daily Living are basic everyday actions that everyone needs to live independently at home or in the community. How often do you need assistance with the following Activities of Daily Living?

Maintaining personal hygiene (bathing/showering, grooming, oral care)

○ No assistance needed ○ Some assistance needed ○ Assistance needed most of the time ○ Assistance always needed

Dressing (choosing appropriate clothing and putting it on your body)

○ No assistance needed ○ Some assistance needed ○ Assistance needed most of the time ○ Assistance always needed

Eating (the act of feeding oneself, not necessarily preparing the food)

○ No assistance needed ○ Some assistance needed ○ Assistance needed most of the time ○ Assistance always needed

Using the bathroom (being able to get on and off the toilet and clean oneself

○ No assistance needed ○ Some assistance needed ○ Assistance needed most of the time ○ Assistance always needed

Mobility (going from sitting to standing, getting in and out of bed, walking from one place to another)

○ No assistance needed ○ Some assistance needed ○ Assistance needed most of the time ○ Assistance always needed

6. In general, how would you rate your overall health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

7. Do you have or need assistance with any of the following? (Mark all that apply)

- ⬭ Speech Impairment (require special materials)
- ⬭ Hearing Impairment (require special equipment)
- ⬭ Visual Impairment (require special equipment)

8. In the past 7 days, how many days has pain kept you from doing daily activities such as bathing, dressing, or walking?

⬭ None ⬭ 1 ⬭ 2 ⬭ 3 ⬭ 4 ⬭ 5 ⬭ 6 ⬭ 7

9. Exercise is important for staying healthy. How active are you when you exercise?

- ⬭ Light (examples: stretching or short walks, slow walking)
- ⬭ Moderate (example: brisk walking)
- ⬭ Heavy (examples: jogging or swimming)
- ⬭ Very heavy (examples: fast running or stair climbing)
- ⬭ I am currently not active
- ⬭ I want to be more active
- ⬭ I do not want to be more active

10. A healthy diet includes fresh fruit and vegetables, high fiber and low fat. In a normal week, how often are you choosing to eat healthy?

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

11. In the past 2 weeks, how often have you felt down, depressed or hopeless?

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

12. In the past year, how often have you used alcohol or other drugs?

- ⬭ None at all
- ⬭ Several days
- ⬭ More than half the days
- ⬭ Nearly every day

13. If you use alcohol or other drugs, are you interested in quitting?

- ○ I do not use
- ○ Yes, I am ready to quit
- ○ No, I am not interested in quitting

14. Are you in recovery from alcohol and/or other drugs? If "no", skip to question #18.

- ○ Yes
- ○ No

15. If yes, for how long?

- ○ Fewer than 3 months
- ○ 3 months to less than 6 months
- ○ 6 months to less than 12 months
- ○ 1-3 years
- ○ 4-6 years
- ○ 7-10 years
- ○ 11 or more years

16. How well are you maintaining recovery?

- ○ Not very well at all
- ○ Not well
- ○ Alright
- ○ Well
- ○ Very well

17. How well do you feel supported by others in maintaining recovery?

- ○ Not very well at all
- ○ Not well
- ○ Alright
- ○ Well
- ○ Very well

18. In the past year, how often have you used tobacco or tobacco substitutes (such as e-cigarettes or vaping)?

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

19. If using tobacco or tobacco substitutes (such as e-cigarettes or vaping), are you interested in quitting?

- ○ I do not use
- ○ Yes, I am ready to quit
- ○ No, I am not interested in quitting

20. How often do you use seat belts when you drive or ride in the car?

- ○ Never
- ○ Sometimes
- ○ Always
- ○ Don't know

21. Are you having any difficulty taking your medications as directed by your doctor? (Mark all that apply)

- ⬭ I don't use any medications
- ⬭ I don't understand enough about the medication
- ⬭ Side effects
- ⬭ Forget to take
- ⬭ Difficult to take
- ⬭ Doctor or pharmacy issues
- ⬭ Cannot pay cost of medications
- ⬭ Cannot get transportation to the pharmacy
- ⬭ No problems
- ⬭ Other

22. If you use any medical equipment such as wheelchairs, beds, or breathing machines, is the equipment meeting your needs?

- ⬭ I don't use any equipment
- ⬭ Yes, equipment meets my needs
- ⬭ No, equipment does not meet my needs (examples: old, broken, or not the right size)
- ⬭ I need equipment, but I do not have any

23. What is your current living situation?

- ⬭ Live alone in house/apartment
- ⬭ Live with family/friends
- ⬭ No permanent residence
- ⬭ Assisted living
- ⬭ Other (examples: group home, halfway house, shelter, temporary housing)

24. What is your level of support?

- ⬭ Good support system
- ⬭ Supports are limited, but I am managing
- ⬭ No support system, I would like help finding resources for support
- ⬭ No support system, I would not like help finding resources for support

25. Who can you go to for support? (Mark all that apply)

- ⬭ Spouse/Significant other
- ⬭ Other family
- ⬭ Friends/Neighbors
- ⬭ Church members
- ⬭ Power of Attorney/Guardian
- ⬭ Community Groups
- ⬭ Agency (AAA, waiver program)
- ⬭ Online support

26. A primary care provider (PCP) is a doctor, nurse practitioner or other qualified medical professional who knows your health history and is the person you see for preventive care, screening tests and general health concerns. Do you have a primary care provider? If yes, then who are you seeing as your PCP?

- ○ Yes, _____
- ○ No

27. Which of the following screenings, exams or vaccinations have you had within the last year? (Mark all that apply)

- ○ Annual physical exam
- ○ Dental exam
- ○ Eye/vision exam
- ○ Breast cancer screening (mammogram)
- ○ Cervical cancerscreening (pap smear)
- ○ Colorectal cancer screening (colonoscopy)
- ○ Flu vaccine
- ○ Pneumonia vaccine
- ○ COVID-19 vaccine
- ○ None

28. How can we help or assist you in meeting your goals? (Mark all that apply)

- ○ Help finding transportation
- ○ Help with healthy eating
- ○ Help finding housing resources, help with a financial concern, or help with finding a job
- ○ Help finding or scheduling health care
- ○ Help finding medical care or getting to the doctor
- ○ Help finding a pharmacy or getting medicine
- ○ Help with exercise
- ○ Help finding mental health care or help for mental health concerns
- ○ Help with smoking cessation
- ○ Help with alcohol or drug use
- ○ Help to feel safer
- ○ Help at home
- ○ Help with managing conditions like high cholesterol, high blood pressure, and diabetes
- ○ Nothing at this time
- ○ Other _____

29. Thank you for your time! A member of your Highmark Wholecare team will be reaching out to you soon. What is the best way for us to reach you?

- ○ Telephone: (Please provide phone number if different than listed above)_____
- ○ SMS/Text message: (Please provide Cellphone number if different than listed above)_____
- ○ Email (Please provide email address if different than listed above)_____
- ○ Mail (Please provide address if different than listed above)_____

Highmark Wholecare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Highmark Wholecare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Highmark Wholecare:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- o Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- o Qualified interpreters
- o Information written in other languages

If you need these services, contact Member Services at 1-800-685-5209, 8 a.m - 8 p.m., 7 days a week from October 1 through March 31. From April 1 through September 30 our business hours are 8 a.m. – 8 p.m., Monday through Friday. TTY users should call 711.

If you believe that Highmark Wholecare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Appeals and Grievances
Attention: 1557 Coordinator
PO Box 22278
Pittsburgh, PA 15222

Phone: 1-844-207-0336
Fax: 1-412-255-4503

You can file a grievance by mail, or by fax. If you need help filing a grievance, Appeals and Grievances is available to help you. Additional information can be found at https://highmarkwholecare.com/nondiscrimination-notices.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-685-5209 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-685-5209 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-685-5209 (TTY 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-685-5209 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-685-5209 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-685-5209 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-685-5209 (TTY 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-685-5209 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-685-5209 (TTY 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-685-5209 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، بمساعدتك. هذه خدمة مجانية . سيقوم شخص ما يتحدث العربية (TTY 711) 1-800-685-5209ليس عليك سوى الاتصال بنا على.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-685-5209 (TTY 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-685-5209 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-685-5209 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-685-5209 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-685-5209 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-685-5209 (TTY 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association (“Highmark Wholecare”).