



289 LaClair Street, Coos Bay, Oregon 97420

541-269-7400 * 1-800-264-0014 * TTY 711

HEALTH RISK ASSESSMENT 2025

INITIAL / ANNUAL / UPDATE

NAME:	ADDRESS:
PRONOUNS:	
PHONE:	MARITAL STATUS:
DOB:	EMAIL:
GENDER: M / F	OREGON HEALTH PLAN (OHP) ID#:
RACE: PLEASE CIRCLE ONE American Indian / Alaska Native Asian Black / African American Hispanic / Latino Multiracial Native Hawaiian / Other Pacific Islander White Other: I choose not to answer this question	PLAN TYPE: PLEASE CIRCLE ONE CCOA – Medical, Dental, Behavioral Health, Transportation CCOB – Medical, Dental, Transportation CCOE – Behavioral Health, Transportation CCOG – Behavioral Health, Dental, Transportation INFORMATION SHARING AND GATHERING Advanced Health protects your information. All information is used to identify your needs. This survey will be reviewed by the care team serving you. This will be shared with providers to reduce how many times you are asked the same questions. You do not have to answer any questions that do not apply. You have the right to refuse care coordination.
ETHNICITY: PLEASE CIRCLE ONE Hispanic or Latino Not Hispanic or Latino I choose not to answer this question	

Advanced Health offers Care Coordination to all Members. Care Coordination can help you understand your benefits. It can help you:

- access therapy and substance use disorder help.
- find providers and get appointments.
- with transitions of care.
- find resources like housing, food, safety, climate risk devices, work, school, and health related social needs!
- create a care plan to meet your needs.

*Are you interested in participating in care coordination? YES NO

Is English your primary language? YES NO

How well is your understanding of English? Good Some None

What language are you most comfortable speaking? English Spanish Chinese Vietnamese
 Russian Hindi American Sign Language Other

Do you need an interpreter? YES NO

You can ask Advanced Health Customer Service for a language interpreter. This help is free.

*Are you blind, deaf, or hard of hearing? YES NO

Do you use any assistive devices to see or hear, such as glasses or hearing aids? YES NO

Do you have any cultural needs? YES NO (Such as health beliefs and customs)

Please explain: _____

What is your gender? (check all that apply) Girl, Woman Boy, Man non-binary Agender/No gender Questioning Not Listed: Please specify: _____ I don't know I don't know what this question is asking I don't want to answer

How do you describe your sexual orientation or gender identity? (check all that apply) Same-gender loving Same-sex loving Lesbian Gay Bisexual Pansexual Straight (attracted mainly to or only other gender(s) or sex(s) Asexual Questioning I don't know Not Listed:

Please specify: _____ I don't know what this question is asking I don't want to answer

Do you have someone you want us to talk to about your health? (Ex: spouse, relative, significant other, friend, caregiver, or case manager) YES NO

Name: _____ Relationship: _____ Contact information: _____

Do we have permission to talk to this person about your health and healthcare needs today? YES NO

- Verbal Authorization is only good for one day. A Release of Information will need to be on file. Our Customer Service team can send you a Release of Information if requested. –

Would you like us to send you a Release of Information? YES NO

* Have you been discharged from the armed forces of the United States? YES NO I choose not to answer

What is the highest level of school that you have finished? Less than high school degree High school diploma or GED More than high school I choose not to answer

Do you need assistance with transportation for your appointments? YES NO

Would you like additional information about your transportation benefit? YES NO

PHYSICAL HEALTH NEEDS

Who is your Primary Care Provider? _____

When was your last visit? 0-6 Months 6-12 months 1 year

Are you having any pain? Yes No

In the past 7 days if you have pain, how much?

Some A lot N/A no pain

If yes, where is the pain and for how long have you had this pain? _____

Have you had a recent injury? Yes No

What is the injury? _____

Do you have any urgent or emergent healthcare needs? Yes No

If so, please explain: _____

*Has your doctor said you have a serious or chronic illness like one listed below? YES NO

If yes circle illness:

Heart High Blood Pressure Diabetes Cancer Lung or Breathing Problems Chronic
Pain Stroke Hearing Problems Vision Problems Bladder or Kidney Problems Liver
Problems Tuberculosis HIV/AIDS Allergies Asthma N/A Other: _____

Would you like additional educational materials about your health? YES NO

(For Women only) *Are you currently pregnant? YES NO

*If yes, has your doctor told you that you are high risk? YES NO

When was your last PAP Test / Mammogram? _____

In general, what would you say your health is? Poor Fair Good Excellent

Have you had a colonoscopy? YES NO DATE: _____

*Have you been hospitalized over the last 6 months? YES NO

If so, why and when? _____

Have you visited the ED in the past year? YES NO

If so, why and when? _____

Do you need help getting or taking your medications? YES NO

How many medications do you take daily? _____

Please list your conditions and medications that you take.

Do you have any allergies? (Food/Medication/Environmental)? YES NO

If yes, what allergies? _____

Do you usually eat a diet that includes fruits, vegetables, and whole grains? YES NO

Height: _____ Weight: _____ Blood Pressure, if known:

Has your doctor recommended you gain/lose weight? YES NO

Have you had any significant weight gain/loss in the last 90 days? YES NO

In the past 7 days, how often did you exercise for at least 20 minutes in a day?

Every day 3-6 days 1 to 2 days -0- days

In the past 7 days have had any problems staying or falling asleep? YES NO

ORAL HEALTH NEEDS

Who is your Dentist? _____

When was your last visit? 0-6 Months 6-12 months 1 year More than a year

Do you know if you have Dental benefits? YES NO

Have you ever been afraid to access or unable to access dental care? YES NO

Have you had dental pain that comes and goes in the past 6 months? YES NO

Pain or aching from chewing, or sensitivity to hot or cold in the past 6 months? YES NO

Have you had a tooth pulled because of a cavity within the past 6 months? YES NO

Have you had a broken tooth? YES NO

Have you had any ongoing dental pain that keeps you from normal activities such as sleeping, work, school, etc.? YES NO

Would you like additional information about your Dental Benefit? YES NO

SOCIAL HEALTH NEEDS

What is your current work situation? Unemployed Part-time or temporary work Full-time work
 Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver):
_____ I choose not to answer

What kind of work do you do? _____

At any point in the past 2 years, has season or migrant farm work been you or your family's main source of income? Yes No I chose not to answer

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. I choose not to answer

Do you have access to a smart phone/computer? Yes NO

Do you have a state ID Card? Yes No

Would you like information on getting one? Yes No

Do you run out of food before you are able to afford to buy more? Yes No

Are you currently receiving SNAP (Food Assistance) benefits? Yes No

Would you like information about applying for SNAP benefits? Yes No

Would you like a list of local food banks? Yes No

Do you have any clothing needs? Yes No

Do you feel safe in your neighborhood? Yes No

Do you feel physically and emotionally safe where you currently live (in your home)? Yes No

I choose not to answer

In the past year, have you been afraid of your partner or ex-partner? Yes No I have not had a partner in the past year I choose not to answer

Have you missed any rent or mortgage payments in the last 6 months? Yes No

Have you received an eviction notice? Yes No

Have your utilities, such as water or electricity, been shut off in the last 6 months? YES NO

What is your living arrangement now? **(Circle)**

Own or Rent Home/Apt Assisted Living Live with friend/relative Foster Home Retirement Home
Nursing Home *I do not have housing (staying with others, in a hotel, in a shelter, living outside on
the street, on a beach, in a car, or in a park I choose not to answer this question

How many family members, including yourself, do you currently live with? Please list: _____ I choose not to answer

*Have you recently experienced homelessness or are at risk of becoming homeless? YES NO

Do you want help changing your living situation? YES NO

In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or any correctional facility? YES NO I choose not to answer

Are you a refugee? YES NO I choose not to answer

Are you a foster parent or have children in foster care? YES NO I choose not to answer

FUNCTIONAL NEEDS

Are you living with other disabilities such as an Intellectual or a Developmental Disability or Physical Disability?

YES NO I choose not to answer

Do you need help with any of the following (please circle any that may apply)?

- Washing/bathing Using toilet Swallowing/chewing Preparing meals Getting Dressed
- Getting in/out bed or chair Using the phone Housekeeping/Laundry Shopping
- Medication Management Walking Making Decisions

Do you use any Durable Medical Equipment such as a wheelchair or brace or walker? YES NO

What DME and how have your Durable Medical Equipment items been purchased previously? _____

Do you have a family history of any of the following? YES NO If yes circle illness:

- Heart High Blood Pressure Diabetes Cancer Lung or Breathing Problems Chronic Pain Stroke Hearing Problems Vision Problems Bladder or Kidney Problems Liver Problems Tuberculosis HIV/AIDS Allergies Asthma N/A Other

BEHAVIORAL HEALTH NEEDS

*Are you experiencing any of the following (If yes circle any that apply)?

Anxiety Depression Stress Lack of emotional/social support Physical or Emotional Abuse N/A

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 I choose not to answer

*Have you been diagnosed with a behavioral or emotional illness? YES NO If yes Please list: _____

How would you describe your support system? _____

Are you suicidal or feel like you want to hurt yourself? YES NO

Would you like assistance getting connected to Behavioral Health services? YES NO

Would you like additional information about your Behavioral Health Benefit? YES NO

For immediate crisis assistance: COOS CRISIS LINE (541) 266-6800 CURRY CRISIS LINE (877) 519-9322

Do you use tobacco (smoke, vape or chew)? YES NO N/A

Do you use alcohol? YES NO If yes, how often: _____

*Do you Use/Abuse any prescription, legal, or illegal substances? YES NO Opioid/IV YES NO

If yes, how often? _____

*Are you enrolled in a medication assistance treatment program? YES NO

Would you like help with a referral for Drug and/or Alcohol Treatment? YES NO N/A

Have you completed Life Planning Activities or an Advanced Directive? YES NO

If yes, where is this located? _____

If not, would you like more information? YES NO

If yes, we will mail you an advance directive.

*Are you currently working with another program/case worker or another agency? YES NO

If yes, which agency: _____

Do you have another insurance? YES NO

If yes, which one? _____

What is your ID#? _____ This will help us coordinate your benefits.

Which is your main insurance? None/uninsured Medicaid CHIP Medicaid Medicare Other Public Insurance (not CHIP) Other Public Insurance (CHIP) Private Insurance

Have you recently been part of a different Coordinated Care Organization? YES NO

If yes, which one? _____ This will help us coordinate your benefits.

MEMBER SELF ASSESSMENT

Compared to 1 year ago, how would you rate your physical health in general? Excellent Good Better Poor Not at all I choose not to answer _____

Compared to 1 year ago, how would you rate your dental health in general? Excellent Good Better Poor Not at all I choose not to answer _____

Compared to 1 year ago, how would you rate your emotional health in general? Excellent Good Better Poor Not at all I choose not to answer _____

*Risk Indicator

If you need immediate care coordination help, please call Member Services at 541-269-7400 or 1-800-264-0014 or TTY 711.

English

You can get this handbook in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 541-269-7400 or TTY 711 or 800-735-1232. We accept relay calls.

-

You can get help from a certified and qualified health care interpreter.

Spanish

Puede obtener este documento en otros idiomas, en letra grande, braille o en un formato que usted prefiera. También puede recibir los servicios de un intérprete. Esta ayuda es gratuita. Llame al servicio de atención al cliente 541-269-7400 o TTY 711 or 800-735-1232. Aceptamos todas las llamadas de retransmisión.

-

Usted puede obtener ayuda de un intérprete certificado y calificado en atención de salud.

Russian

Вы можете получить это документ на другом языке, напечатанное крупным шрифтом, шрифтом Брайля или в предпочитаемом вами формате. Вы также можете запросить услуги переводчика. Эта помощь предоставляется бесплатно. Звоните по тел. 541-269-7400 или TTY 711 or 800-735-1232. Мы принимаем звонки по линии трансляционной связи.

-

Вы можете получить помощь от аккредитованного и квалифицированного медицинского переводчика.

Vietnamese

Quý vị có thể nhận tài liệu này bằng một ngôn ngữ khác, theo định dạng chữ in lớn, chữ nổi Braille hoặc một định dạng khác theo ý muốn. Quý vị cũng có thể yêu cầu được thông dịch viên hỗ trợ. Sự trợ giúp này là miễn phí. Gọi 541-269-7400 hoặc TTY (Đường dây Dành cho Người Khiếm thính hoặc Khuyết tật về Phát âm) 711 or 800-735-1232. Chúng tôi chấp nhận các cuộc gọi chuyển tiếp.

-

Quý vị có thể nhận được sự giúp đỡ từ một thông dịch viên có chứng nhận và đủ tiêu chuẩn chuyên về chăm sóc sức khỏe.

Arabic

طريقة على مطبوعة أو ، كبير بخط مطبوعة أو ، أخرى بلغات وثيقة هذا على الحصول يمكنكم المساعدة هذه إن . شفهي مترجم طلب يمكنكم كما . لديكم المفضلة الصيغة حسب أو برايل نستقبل . 711 or 800-735-1232 الكاتبة المبرقة أو 541-269-7400 على اتصلو . مجانية المحولة المكالمات .

-

الصحية الرعاية مجال في ومؤهل معتمد مترجم من المساعدة على الحصول يمكنكم

Somali

Waxaad heli kartaa warqadan oo ku qoran luqaddo kale, far waaweyn, farta dadka indhaha aan qabin wax ku akhriyaan ee Braille ama qaabka

aad doorbidayso. Waxaad sidoo kale codsan kartaa turjubaan. Taageeradani waa lacag la'aan. Wac 541-269-7400 ama TTY 711 or 800-735-1232. Waa aqbalnaa wicitaanada gudbinta.

-

Waxaad caawimaad ka heli kartaa turjubaanka daryeelka caafimaadka oo xirfad leh isla markaana la aqoonsan yahay.

Simplified Chinese

您可获取本文件的其他语言版、大字版、盲文版或您偏好的格式版本。您还可要求提供口译员服务。本帮助免费。致电541-269-7400 或 TTY 711 or 800-735-1232。我们会接听所有的转接来电。

-

您可以从经过认证且合格的医疗口语翻译人员那里获得帮助。

Traditional Chinese

您可獲得本信息函的其他語言版本、大字版、盲文版或您偏好的格式。您也可申請口譯員。以上協助均為免費。請致電541-269-7400 或聽障專線 711 or 800-735-1232。我們接受所有傳譯電話。

-

您可透過經認證的合格醫療保健口譯員取得協助。

Korean

이문서는 다른 언어, 큰 활자, 점자 또는 선호하는 형식으로 받아보실 수 있습니다. 통역사를 요청하실 수도 있습니다. 무료 지원해 드립니다. 541-269-7400 또는 TTY 711 or 800-735-1232에 전화하십시오. 저희는 중계 전화를 받습니다.

-

공인 및 자격을 갖춘 의료서비스 전문 통역사의 도움을 받으실 수 있습니다.

Chuukese

En mi tongeni angei ei taropwe non pwan ew fosun fenu, mese watte mak, Braille ika pwan ew format ke mwochen. En mi tongeni pwan tingor emon chon chiaku Ei aninis ese fokkun pwan kamo. Kokori 541-269-7400 ika TTY 711 or 800-735-1232. Kich mi etiwa ekkewe keken relay.

-

En mi tongeni kopwe angei aninis seni emon mi certified ika qualified ren chon chiaku ren health care.

Ukrainian

В и можете отримати цей довідник іншими мовами, крупним шрифтом, шрифтом Брайля або у форматі, якому ви надаєте перевагу. Ви також можете попросити надати послуги перекладача. Ця допомога є безкоштовною. Дзвоніть по номеру телефону 541-269-

7400 або телетайп у 711 or 800-735-1232. Ми приймаємо всі дзвінки, які на нас переводять.

-

В и можете отримати допомогу від сертифікованого та кваліфікованого медичного перекладача.

Farsi

می توانید این نامه را به زبان های دیگر، درشت خط، بریل یا قالب ترجیحی دیگری دریافت کنید. می توانید مترجم شفاهی نیز درخواست کنید. این کمک رایگان است. با تماس بگیرید. تماس های رله را 711 or 800-735-1232 TTY یا #CustomerService# می پذیریم.

-

می توانید از یک مترجم شفاهی دارای گواهی و باکفایت در زمینه بهداشت و

Swahili

Unaweza kupata herufi hii kwa lugha zingine, kwa herufi kubwa, kwa lugha ya maandishi kwa vipofu au namna yeyote unayopendelea. Unaweza pia kuomba mkalimani. Msaada huu ni wa bure. Piga #CustomerService# au TTY 711 or 800-735-1232. Tunakubali simu za kupitisha ujumbe.

-

Unaweza pata usaidizi kutoka kwa mkalimani wa huduma ya afya aliyehitimu.

Burmese

ဤစာကို အချားဘာသာစကားမ်း၊ ပံ့ပိုးပံ့ပိုးလုံးဖုန်း၊ မ်ကျမငွားအကြက
ဘေးရးလု သို/မဟုတု သငို/မိုးဝိစက္ကည့ ပံ့ပိုးပံ့ပိုး ရယူနိုင်ပါသည်။ သင့်ည
စကားပျပန္တစဉ်းလည့း တောငးဆိုင်ပါသည်။ ဤအကူအညီသည
အခမဲ့ပျစွါပါသည်။ #CustomerService# သို/မဟုတု 711 or 800-735-1232 ကို
ဖုန်းဆက်ပါ။ ထည့်ပေးခေးဆိုင်မီးမ်းကို ကြေးပို့ပို့/ လက်ခံပါသည်။

-

သင့်ည သင့်နားဆေးလက္ခဏာရုံးဝင် အရည်ခင်းပီသည့ က်နားမေးရး
စောင့်ပေးပေးကွ; စကားပျပန္တစဉ်းလည့း အကူအညီရယူနိုင်ပါသည်။

Amharic

ይህንን ደብዳቤ በሌሎች ቋንቋዎች፣ በትልቅ ህትመት፣ በብሬይል ወይም እርስ በሚመርጡት
መልክ ማግኘት ይቻላል። በተጨማሪም አስተርጓሚ መጠየቅም ይቻላል። ይህ ድጋፍ የሚሰጠው
በነጻ ነው። ወደ #CustomerService# ወይም TTY 711 or 800-735-1232 ይደውሉ።
የሪሌይ ጥሪዎችን እንቀበላለን።

-

ፍቃድ ካለው እና ብቃት ካለው የጤና እንክብካቤ አስተርጓሚ ድጋፍ ማግኘት ይቻላል።

Romanian

Puteți obține această scrisoare în alte limbi, cu scris cu litere majuscule, în
Braille sau într-un format preferat. De asemenea, puteți solicita un
interpret. Aceste servicii de asistență sunt gratuite. Sunați la

#CustomerService# sau TTY 711 or 800-735-1232. Acceptăm apeluri adaptate persoanelor surdomute.

-

Puteți obține ajutor din partea unui interpret de îngrijire medicală certificat și calificat.