

Filling out this form is voluntary. You will not be denied care based on your answers. Your answers are confidential. **This form will help us connect you to the right services and support.**

*Indicates Required

Name of Health Net Member (Last Name, First)

Date of Birth (MMDDYYYY)

*Medi-Cal ID Number:

Email:

Preferred name and Pronouns:

1. How would you rate your health? Excellent Very Good Good Fair Poor

2. What is your height (enter response in feet/inches)?

Feet 2 3 4 5 6 7 Unknown

Inches 0 1 2 3 4 5 6 7 8 9 10 11 Unknown

3. What is your weight (enter response in pounds)?

4. Do you have a doctor or health care provider? Yes No

5. Have you seen your doctor or health care provider in the last 6 months? Yes No

6. How many times have you been in the hospital in the last 6 months?

None One Time Two Times Three Four Times Five or more

7. How many times have you been in the Emergency Department in the last 6 months?

None One Time Two Times Three Four Times Five or more

8. How many medicines do you take that are prescribed by your doctor or health care provider?

0 1-3 4-7 8-14 15 or more

9. Have you received a flu shot in the last 12 months? Yes No

10. Do you see a doctor for any chronic medical conditions? Yes No

If yes, check all that apply: Asthma/Lung Problems Heart Problems HIV or AIDS

Diabetes Kidney Disease Seizures Other

11. Do you need to see a doctor within the next 60 days? Yes No

12. Do your gums bleed when you brush your teeth? Yes No

13. Have you had dental pain in the last month? Yes No

14. How long has it been since you last visited a dentist or dental clinic for any reason?

Less than 12 months More than 12 months

15. Would you like to work with a nurse, social worker, community health worker, or promotora to plan for your health-care?

Yes No

16. Has transportation to get to your medical appointments ever been a problem? Yes No
17. Are you having trouble making appointments with your doctor? Yes No
18. Are you having trouble getting your prescription medications? Yes No
19. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, oxygen, or ostomy bag?
 Yes No
20. Do you have a condition that limits your activities or what you can do? Yes No
21. Have you needed help with personal care such as bathing, getting dressed, or changing bandages in the last six (6) months? Yes No
22. Are you pregnant? Yes No
- 22a. If pregnant, are you currently seeing a doctor for the pregnancy? Yes No
- 22b. Do you plan to get pregnant in the next 12 months? Yes No
23. Do you see a doctor regularly for a mental health condition such as anxiety, depression, bipolar disorder, or schizophrenia? Yes No
24. Over the past month (30 days), how many days have you felt lonely? (Check one.)
 None—I never feel lonely Less than 5 days From 5 to 15 days
 More than half the days (more than 15 days) Most days—I always feel lonely
25. Where do you live? (Check all that apply) House Apartment Complex Board and Care Facility
 Residential treatment Assisted Nursing Permanent Supported
 Protective Housing Currently Unhoused Other
26. Are you worried about losing your housing? Yes No
27. Who do you live with? Live alone Live with spouse or significant other Live with caregiver
 Live with children or other relatives or friends Live with other residents in my facility/program
28. In the past 3 months, have you worried that your food would run out before you had money to buy more?
 Yes No
29. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
 Yes No
30. Health Net has benefits available to support Justice Involved individuals/returning community members. 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
31. Answering the question below will help us better support your health and well-being in a respectful way. Which of the following best describes you? (check one for each line)
- A. Straight (heterosexual) Lesbian Gay Bisexual Other Not Sure/Questioning
- B. Male Female Transgender Transgender (Female) Genderqueer Other