



Medicare Advantage Health Assessment Survey

Dear Member:

Thank you for your membership with MVP Health Care. At MVP we want to make sure you are getting the best health care possible. One way we do this is by getting to know you and helping you meet your unique health care needs.

Please help us with your health care by answering the following survey. There are no right or wrong answers. If you are not able to complete this survey by yourself, please have a family member or caregiver assist you.

The information you provide will remain **confidential** and will in no way affect your health benefits or your enrollment with MVP. Please return the survey in the enclosed self-addressed, postage-paid envelope.

When we receive your completed survey, an MVP case manager will work closely with members who are identified as having specific health care needs. The case manager is a highly trained nurse clinician who is committed to working with our Members to guide them through today's health care system. The case manager works closely with your primary care doctor to coordinate your care. Your primary care doctor will always direct your medical treatment, while the case manager provides extra support to both you and your doctor.

If you have any questions about the survey, please call our Customer Care Center at 1-800-665-7924. TTY users should call 1-800-662-1220. Representatives are available to serve you Monday – Friday, 8 am – 8 pm and Saturday, 8 am – 4 pm.

Sincerely,

A handwritten signature in black ink that reads "John M. Palmerini". The signature is fluid and cursive, with the first letters of each name being capitalized and prominent.

John M Palmerini
Health Services Research

Return the survey in the envelope provided to:

Health Services Research • MVP Health Care • 220 Alexander Street • Rochester, NY 14607

1. In general, would you say your health is:

- ₁ Excellent
- ₂ Very Good
- ₃ Good
- ₄ Fair
- ₅ Poor

2. In the past 12 months, how many times have you stayed overnight as a patient in a hospital?

- ₁ Never
- ₂ 1 time
- ₃ 2 up to 3 times
- ₄ 3 or more times

3. In the past 12 months, how many times have you been seen in the emergency room?

- ₁ Never
- ₂ 1 time
- ₃ 2 times
- ₄ 3 or more times

4. In the past 12 months, how many times have you visited a physician or clinic?

- ₁ Never
- ₂ 1 time
- ₃ 2 to 3 times
- ₄ 4 to 6 times
- ₅ 7 or more times

5. How long have you been a patient of your primary care doctor?

- ₁ I am a new patient
- ₂ Less than 2 years
- ₃ Over 2 years

6. In the past 12 months, did you have diabetes?

- ₁ Yes
- ₂ No

7. Have you ever had coronary heart disease (hardening of the arteries)?

- ₁ Yes
- ₂ No
- ₃ Don't Know

8. Have you ever had pains associated with the heart and chest (angina pectoris)?

- ₁ Yes
- ₂ No
- ₃ Don't Know

9. Have you ever had a heart attack (myocardial infarction)?

- ₁ Yes
- ₂ No
- ₃ Don't Know

10. Have you ever had any other heart attack?

- ₁ Yes
- ₂ No
- ₃ Don't Know

11. Is there a friend, relative or neighbor who would take care of you for a few days, if necessary?

- ₁ Yes
- ₂ No

12. Please check all those conditions for which you are **currently** receiving medical treatment.

- ₁ Breathing problems
- ₂ High blood pressure
- ₃ Heart problems
- ₄ Urinary problems (e.g. leaking urine)
- ₅ Arthritis
- ₆ Serious memory loss
- ₇ Ankle/leg swelling
- ₈ Cancer
- ₉ Dialysis

13. Do you live: (Check one answer)

- ₁ Alone
- ₂ Spouse (husband / wife)
- ₃ Son or daughter
- ₄ Other family: _____
- ₅ Other non-family: _____

14. Do you have any adult children living **within a two hour drive**?

- ₁ Yes
- ₂ No → **GO TO QUESTION 16**

15. If you needed help, would you ask your children for assistance?

- ₁ Yes
- ₂ No

16. Where do you live? (Check one answer)

- ₁ Your own home, apartment, condominium, or mobile home
- ₂ An assisted-living apartment or board and care home
- ₃ A nursing home
- ₉ Other: _____

17. For each of the activities listed below, please check the box to indicate if you are able to do this (1) without help, (2) need some help, or (3) cannot do this at all without help.

	(1) Able to do this without help	(2) Need some help	(3) Cannot do this at all without help	
Bathing	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	A
Dressing	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	B
Eating	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	C
Toileting	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	D
Getting out of a chair	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	E
Getting out of bed	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	F
Walking	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	G
Climbing stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	H
Taking medications	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	I
Meal preparation	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	J
Housekeeping chores	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	K
Shopping and errands	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	L
Doing laundry	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	M
Transportation	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	N
Money management	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	O

18. Do you receive assistance from friends or family for any of the above tasks?

- ₁ Yes
- ₂ No

19. How many times have you fallen in the last few months?

- ₁ Never
- ₂ 1 time
- ₃ 2 or more times

20. Are you currently receiving medical assistance or Medicaid?

- ₁ Yes
- ₂ No
- ₉ Don't Know

21. In general, how many different prescription medicines do you take regularly? (Only count those your physician told you to take)

- ₁ None
- ₂ 1 to 2
- ₃ 3 to 4
- ₄ 5 or more

22. Do you receive any shots regularly (for example, insulin or B12)?

- ₁ Yes
- ₂ No

23. Do you use a catheter, oxygen supplies, or inhalers?

- ₁ Yes
- ₂ No

24. Are you currently participating in any clinical trials (e.g., special medical procedures or drugs under exploration with a physician)?

- ₁ Yes
- ₂ No

25. In the past 6 months, have you lost 10 pounds without trying?

- ₁ Yes
- ₂ No
- ₉ Don't Know

26. How is your eyesight? (This means your eyesight while wearing glasses or contacts, if you use them.)

- ₁ Excellent
- ₂ Good
- ₃ Fair
- ₄ Poor
- ₅ Do not wear glasses or contacts

27. Are you currently receiving any home health care services from a nurse or personal care aide?

- ₁ Yes
- ₂ No

28. Do you often feel sad or blue?

- ₁ Yes
- ₂ No

29. Are you?

- ₁ Male
- ₂ Female

30. What is your date of birth?

Month		Day		Year			

31. Do you need or want an interpreter to communicate with a doctor or health care practitioner?

- ₁ Yes
- ₂ No

32. What language do you speak most of the time at home?

- ₁ English
- ₂ Spanish
- ₃ Italian
- ₄ German
- ₅ Other: _____

33. This survey was completed by:

- ₁ Self/Member
- ₂ Spouse of member
- ₃ Other family member
- ₉ Other: _____