

Medicare Advantage Plans 210 Park Ave. | Suite 2900 | Oklahoma City, OK 73102-5621

<GenerationDate>

<FirstName> <MiddleInitial> <LastName>

<Address I >

<Address2>

<City>, <State> <Zip>

Dear <FirstName> <LastName>,

The goal of this survey is to help us understand your health and specific healthcare needs so we can work together to help provide you with the services to reach your health goal(s).

The information submitted in this survey will be used internally by our Care Management Department and may be shared with your Primary Care Physician (PCP) if there are gaps in care that need to be addressed.

Any information provided will not be used against you in any way or impact the services you obtain from the health plan.

Completion and submission of the confidential Health Survey implies consent to its stated use; however, you do have the option to decline completion of this survey. This survey can also be completed on the Global Health website.

Translation Services: We offers interpretation services for our members. Professional
Certified Medical Interpreters allow our members access to culturally sensitive translation
services when speaking to our health plan staff. Call our Customer Care call center at I-844280-5555 between 8:00 AM to 8:00 PM, seven days a week (October I - March 31) and 8:00
AM and 8:00 PM, Monday through Friday (April I – September 30). TTY users may call 711.

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Health Survey

Please complete this survey. The goal of this survey is to help us understand your health, and specific health-care needs so we can work together to help provide you with the services to reach your health goal(s). Your answers **WILL NOT** affect your benefits. We may share your information with your primary care provider. If you have any questions regarding this please contact Customer Care - I-844-280-5555 (TTY: 711) 8:00 AM-8:00 PM, seven days a week, (Oct I-Mar 31), 8:00 AM-8:00 PM, Monday-Friday (April I-Sept 30).



| | Date: | Agent name and ID (if agent assisted): | | | |
|--|--------|---|--------|------------|-------------|
| Note Black or African American American Indian Alaska Native Native Hawaiian Samoan Other Pacific Islander Asian Indian Chinese Filipino Japanese Rorean Vietnamese Other Asian Guamanian or Chamorro I choose not to answer | Name | : Gender: | | | |
| White Black or African American American Indian Alaska Native Native Havaiian Samoan Other Pacific Islander Asian Indian Chinese Filipino Japanese Japanese Worker Asian Guamanian or Chamorro I choose not to answer 2. What is your Ethnicity? Not Hispanic, Latino/a or Spanish Origin Cuban Mexican, Mexican American, Chicano/a Puerto Rican Another Hispanic, Latino/a or Spanish Origin I choose not to answer 3. What is your primary language? English Spanish Other: I choose not to answer 4. Please check if you have, had or have been treated for any of the following Chronic Conditions. Alzheimer's Disease/Dementia Autoimmune Disease (Multiple Sclerosis/Myasthenia Gravis) Asthma Arthritis or Pain in Joints Cancer Congestive Heart Failure COVID-19 Diabetes Cardiovascular Disease/Dementia Autoimmune Disease (Multiple Sclerosis/Myasthenia Gravis) Asthma Arthritis or Pain in Joints Cancer Congestive Heart Failure COVID-19 Diabetes Diabetes Epilepsy/Scizures Heart Problems/Heart Disease/Peripheral/Vascular Disease Depression/Metal Illness Epilepsy/Scizures Heart Problems/Heart Disease/Peripheral/Vascular Disease Depression/Metal Illness Epilepsy/Scizures Heart Problems/Heart Disease/Peripheral/Vascular Disease Depression/Metal Illness Epilepsy/Scizures Heart Problems/Heart Disease/Peripheral/Vascular Disease Cover Kidney Disease Depression/Metal Illness Epilepsy/Scizures Heart Problems/Heartington's Disease Immune Disorder (HIV or AIDS) Neurodegenerative Disease (Parkinsonis/Huntington's Disease) Other: Spease Check the following conditions you are receiving medical treatment for: Foot/Andel/Leg Swelling Sudden Change in Weight Open Sores, Wounds, or Ulcers on Your Skin Alf checked yes, Pelase check the following conditions you are receiving medical treatment for: Foot/Andel/Leg Swelling Sudden Change in Weight Open Sores, Wounds, or Ulcers on Your Skin No No No No No | DOB: | Marital Status: Single Married Separated Divorced Wid | wot | | |
| White Black or African American American Indian Alaska Native Native Havaiian Samoan Other Pacific Islander Asian Indian Chinese Filipino Japanese Japanese Worker Asian Guamanian or Chamorro I choose not to answer 2. What is your Ethnicity? Not Hispanic, Latino/a or Spanish Origin Cuban Mexican, Mexican American, Chicano/a Puerto Rican Another Hispanic, Latino/a or Spanish Origin I choose not to answer 3. What is your primary language? English Spanish Other: I choose not to answer 4. Please check if you have, had or have been treated for any of the following Chronic Conditions. Alzheimer's Disease/Dementia Autoimmune Disease (Multiple Sclerosis/Myasthenia Gravis) Asthma Arthritis or Pain in Joints Cancer Congestive Heart Failure COVID-19 Diabetes Cardiovascular Disease/Dementia Autoimmune Disease (Multiple Sclerosis/Myasthenia Gravis) Asthma Arthritis or Pain in Joints Cancer Congestive Heart Failure COVID-19 Diabetes Diabetes Epilepsy/Scizures Heart Problems/Heart Disease/Peripheral/Vascular Disease Depression/Metal Illness Epilepsy/Scizures Heart Problems/Heart Disease/Peripheral/Vascular Disease Depression/Metal Illness Epilepsy/Scizures Heart Problems/Heart Disease/Peripheral/Vascular Disease Depression/Metal Illness Epilepsy/Scizures Heart Problems/Heart Disease/Peripheral/Vascular Disease Cover Kidney Disease Depression/Metal Illness Epilepsy/Scizures Heart Problems/Heartington's Disease Immune Disorder (HIV or AIDS) Neurodegenerative Disease (Parkinsonis/Huntington's Disease) Other: Spease Check the following conditions you are receiving medical treatment for: Foot/Andel/Leg Swelling Sudden Change in Weight Open Sores, Wounds, or Ulcers on Your Skin Alf checked yes, Pelase check the following conditions you are receiving medical treatment for: Foot/Andel/Leg Swelling Sudden Change in Weight Open Sores, Wounds, or Ulcers on Your Skin No No No No No | Phone | Number: Application/Member ID: | | | _ |
| Samoan Other Pacific Islander Asian Indian Chinese Filipino Japanese Norean Vietnamese Other Asian Guamanian or Chamorro I choose not to answer | I. V | Vhat's your race? | | | |
| Korean Vietnamese Other Asian Guamanian or Chamorro I choose not to answer | | ☐ White ☐ Black or African American ☐ American Indian ☐ Alaska Native ☐ Native H | awaiia | เท | |
| 2. What is your Ethnicity? Not Hispanic, Latino/a or Spanish Origin Cuban Mexican, Mexican American, Chicano/a Puerto Rican Another Hispanic, Latino or Spanish Origin I choose not to answer 3. What is your primary language? English Spanish Other: I choose not to answer 4. Please check if you have, had or have been treated for any of the following Chronic Conditions. Alzheimer's Disease/Dementia Autoimmune Disease (Multiple Sclerosis/Myasthenia Gravis) Asthma Arthritis or Pain in Joints Cancer Congestive Heart Failure COVID-19 Diabetes Diabetes Epilepsy/Seizures Hart Problems/Heart Disease/Heart Attack Stroke Ridney Disease High Blood Pressure High Cholestero/Triglycerides Immune Disorder (HIV or AIDS) Lung Disease (Emphysema, Chronic Obstructive Pulmonary Disease-COPD) Organ Transplant (Liver, Kidney, etc.) Neurodegenerative Disease (Parkinson's/Huntington's Disease) Other: 5. Please check the following conditions you are currently experiencing: Foot/Ankle/Leg Swelling Sudden Change in Weight Open Sores, Wounds, or Ulcers on Your Skin Alf checked yes, please check the following conditions you are receiving medical treatment for: Foot/Ankle/Leg Swelling Sudden Change in Weight Open Sores, Wounds, or Ulcers on Your Skin Sudden Change in Weight Open Sores, Wounds, or Ulcers on Your Skin No b-Have you had a face-to-face (in-person or virtual) visit with your doctor for an Annual Physical Exam or Yes No No No preference No No No No No No No N | | ☐ Samoan ☐ Other Pacific Islander ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japan | nese | | |
| Note Hispanic, Latino/a or Spanish Origin | | ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Guamanian or Chamorro ☐ I choose not to | o ansv | ver | |
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| English Spanish Other: I choose not to answer | | ☐ Another Hispanic, Latino or Spanish Origin ☐ I choose not to answer | | | |
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| Chronic Conditions. Alzheimer's Disease/Dementia | | ☐ English ☐ Spanish ☐ Other: ☐ I choose not to answer | | | |
| Alzheimer's Disease/Dementia | | • | | | |
| Arthritis or Pain in Joints | 9 | Chronic Conditions. | | | |
| Cardiovascular Disease/Coronary Artery Disease/Peripheral Vascular Disease Depression/Mental Illness Epilepsy/Seizures Heart Problems/Heart Disease/Heart Attack Stroke Kidney Disease High Blood Pressure High Cholesterol/Triglycerides Immune Disorder (HIV or AIDS) Lung Disease (Emphysema, Chronic Obstructive Pulmonary Disease-COPD) Organ Transplant (Liver, Kidney, etc.) Neurodegenerative Disease (Parkinson's/Huntington's Disease) Other: Other: Other: Open Sores, Wounds, or Ulcers on Your Skin A. If checked yes, please check the following conditions you are receiving medical treatment for: Foot/Ankle/Leg Swelling Sudden Change in Weight Open Sores, Wounds, or Ulcers on Your Skin Other Sores, Wounds, or Ulce | | | | | |
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| High Blood Pressure | | ☐ Cardiovascular Disease/Coronary Artery Disease/Peripheral Vascular Disease ☐ Depression/Mental IIIr | iess | | |
| Lung Disease (Emphysema, Chronic Obstructive Pulmonary Disease-COPD) | | ☐ Epilepsy/Seizures ☐ Heart Problems/Heart Disease/Heart Attack ☐ Stroke ☐ Kidney Dise | ase | | |
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| G. Health Care Access and Treatment: a. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? b. Have you had a face-to-face (in-person or virtual) visit with your doctor for an Annual Physical Exam or Wellness Visit in the past 12 months? c. Do you consent to a face-to-face visit with your doctor? d. Do you have a preference for in-person or virtual? e. Are you currently enrolled in hospice? f. Are you currently receiving renal dialysis treatment? g. How many times have you been to the emergency room in the past 12 months? Open Sores, Wounds, or Ulcers on Your Skin In the past 12 months, a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months on Your Skin In the past 12 months, as a late of the past 12 months, as a late of the past 12 months on Your | Λlfc | | | | |
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| g. How many times have you been to the emergency room in the past 12 months? None I-3 times More than 3 | | | | | _ |
| | | | | | |
| ii. How many urnes have you been admitted to the hospital in the past 12 months? | - | | | | |
| i. When was your last complete dilated eye exam? Never Less than 12 months ago More than 12 months ago | | · · · · · · · · · · · · · · · · · · · | _ | | |

| 7. Activities of Daily Living | | | | | | |
|--|-----------------|------------------|--|--|--|--|
| a. Do you need help with bathing, dressing yourself, preparing meals, feeding yourself, or using the bathroom? | ☐ Yes | ☐ No | | | | |
| b. Do you need help walking, getting up from a chair or getting out of bed? | ☐ Yes | ☐ No | | | | |
| c. Do you need help taking your medications as prescribed? | Yes | ☐ No | | | | |
| d. Do you have a caregiver to assist with meeting your needs listed above? | ☐ No | □N/A | | | | |
| e. In the past 12 months, how many times have you fallen: Never Once More than once | | | | | | |
| f. Do you currently use assistive devices and/or durable equipment to walk, bathe, shower, or use the bathroom, i.e., cane, raised toilet seat, etc.? | , a wheelchair, | r, walker, No | | | | |
| g. Are you currently bothered with pain? Please rate your pain. (1-3 being very little pain, 4-6 being moderate pain, and 7-10 being severe pain) | | | | | | |
| 8. Behavioral and Social | | | | | | |
| a. In the past 3 months, have you chronically felt sad, and/or depressed? | ☐ Yes | ☐ No | | | | |
| b. In the past 3 months, have you experienced changes in thinking, remembering or decision making? | Yes | ☐ No | | | | |
| c. If you answered, yes to the question b, does this impact your daily activity? | ☐ Yes | ☐ No | | | | |
| d. Do you use tobacco products? | ☐ Yes | ☐ No | | | | |
| e. If you answered yes to the Question d, would you like to receive educational information to help quit tobacco use? | ☐ Yes | ☐ No | | | | |
| f. Do you drink more than two alcoholic beverages each day? | Yes | ☐ No | | | | |
| g. In the last 12 months, have you used illegal drugs or substances? | ☐ Yes | ☐ No | | | | |
| h. If you answered yes to Question g, would you like assistance to address illegal drug/substance use? | ☐ Yes | ☐ No | | | | |
| i. Do you socialize with others regularly? | Yes | ☐ No | | | | |
| j. Do you engage in exercise regularly, as tolerated? | ☐ Yes | ☐ No | | | | |
| k. Do you currently feel threatened or that you are being physically, mentally, or sexually abused? | ☐ Yes | ☐ No | | | | |
| I. Do you experience feelings of stress related to your health, finances, family or social relationships, work, etc.? | Yes | ☐ No | | | | |
| m. In general, how would you rate your overall health? | ☐ Fair | □Poor | | | | |
| n. In the past 3 months, have you had difficulty meeting your living expenses? | ☐ Yes | ☐ No | | | | |
| o. Within the past 12 months, you worried that your food would run out before you got money to buy more? | ☐ Yes | ☐ No | | | | |
| ☐ Often true ☐ Sometimes true ☐ Never true | | | | | | |
| p. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more. | | | | | | |
| ☐ Often true ☐ Sometimes true ☐ Never true | | | | | | |
| q. What is your living situation today? | | | | | | |
| ☐ I have a steady place to live ☐ I have a place to live today, but I am worried about losing it in the future | | | | | | |
| I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park.) | | | | | | |
| r. Are you able to afford your medications? | ☐ Yes | ☐ No | | | | |
| s. Do you have an advanced directive or living will? | ☐ Yes | ☐ No | | | | |
| t. What is the highest level of education you completed? Grade School High School Vocational School College | | | | | | |
| u. How well can you read? | | | | | | |
| v. Are you able to access and understand your health information electronically? | ☐ Yes | ☐ No | | | | |

| 9. Medical Treatment/Vaccinations | | | | | | | | |
|---|-------|------|--|--|--|--|--|--|
| a. How many different medications do you take daily? | ; | | | | | | | |
| b. When was your last flu shot? Never Within the last 12 months More than 12 months a | ıgo | | | | | | | |
| c. When was your last pneumonia shot? Never Less than 10 years ago More than 10 years | s ago | | | | | | | |
| d. Have you received the COVID-19 vaccinations? | Yes | ☐ No | | | | | | |
| e. If you have received the COVID-19 vaccinations, are you up to date on your booster? | ☐ Yes | ☐ No | | | | | | |

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