



PO Box 15804, Tampa, FL 33684-9846

Health & Wellness Material

FRH23HATP1

Health Assessment Tool (HAT)

Please complete this annual survey. This information will help us understand your health needs. Your answers WILL NOT affect your benefits. We may share your information with your primary care provider(s). If you have any questions regarding this form, please call 1-800-401-2740. TTY: 711

Please disregard this request if you have recently mailed a completed Health Assessment Tool.

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Gender: _____

Phone number: _____

Member ID: _____

A. Physical Health Rating

1. On a usual basis, how do you rate your health? (check one) Excellent Good Fair Poor

2. What is your height? (whole numbers) _____ Feet _____ Inches 3. What is your weight? (whole numbers) _____ lbs.

B. Activities of Daily Living

4. How much help do you need with the following? (check one box for each activity)

Activity	No Help Needed	Some Help Needed	Complete Help Needed
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting out of Bed or Chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking your Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the Bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remembering & Decision Making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. If you need help, do you have someone close by or a caregiver who helps you? Yes No Hospice N/A

C. Health History & Treatment

6. When did you last see your Primary Care Physician? (check one) Less than 6 months More than 6 months 12 months ago or greater

If you have not seen your Primary Care Physician in the last 6 months, please call the office to schedule an appointment.

7. Do you currently use any medical equipment such as oxygen, electric bed or wheelchair in your home? Yes No

8. Are you receiving any nursing, therapy or home health care in your home? Yes No

9. Do you have blindness or trouble seeing even when wearing glasses? Yes No

10. Do you have deafness or trouble hearing even when wearing a hearing aid? Yes No

11. Have you received: (check all that apply) Flu shot in the past year Pneumonia shot in the past 5 years Unsure

12. Have you had a Pap test in the past 2 years? Yes No Unsure N/A

13. Have you had a mammogram in the past 2 years? Yes No Unsure N/A

14. Have you had a colon cancer check in the last 10 years? Yes No Unsure

15. Please check whether you have any of the following: (CHECK ALL THAT APPLY)

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Depression or Other Mental Health Issues
<input type="checkbox"/>	COPD or Emphysema or Chronic Bronchitis	<input type="checkbox"/>	Organ Transplant
<input type="checkbox"/>	Frequent Falls	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Heart Attack or blocked arteries	<input type="checkbox"/>	Skin Ulcer/Nonhealing Wound
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Other _____

16. If you are concerned about your health, do you know what steps you can take to improve your health? (check one)
 I am not concerned about my health. I am concerned and know steps that I can take.
 I am concerned, and my doctor is working with me. I am concerned and I would like information on steps to improve my health.

17. Is there anything preventing you from taking steps to improve your health? (check one)
 No Yes, and I would like a call to discuss. Yes, and I am working on it.

D. Lifestyle & Well-being

18. Do you use tobacco? (smoke, chew, snuff, vape or in any other form) Yes No Want to quit
19. Does drinking alcohol interfere with your personal or work life? Yes No N/A, I Don't Drink
20. Do you feel you get enough physical activity/exercise? Yes No Want to improve
21. Do you feel that your diet supports a healthy lifestyle? Yes No Want to improve
22. Do personal or family health issues result in loss of work/daily activities? Yes No Unsure
23. What is your living situation today? (check one)
 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)
24. Do you feel safe where you live? (check one) Yes No
25. Within the past 12 months, you worried that your food would run out before you got money to buy more? (check one)
 Often true Sometimes true Never true
26. 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? Yes No

27. Over the past 2 weeks, how often have you been bothered by any of the following feelings?
A. Feeling down, depressed or hopeless Not at All Several Days More than Half the Days Nearly Every Day
B. Little interest or pleasure in doing things Not at All Several Days More than Half the Days Nearly Every Day

28. Are you experiencing any of the following common effects or feelings of stress?
 (Check all that apply): Anxiety Drug/Alcohol Abuse Irritability/Anger Sadness /Depression Social Withdrawal
 Chest Pain Headache Muscle tension/Pain Sleep Problem Upset Stomach
If you have any of the above symptoms or feel that you are depressed, please set up an appointment with your PCP.

29. Would you like information on how you can get help for these feelings? Yes No

30. Would you like information on Health Care Advance Directives such as a Living Will? Yes No

E. Demographics

31. Do you identify with a particular cultural or spiritual group? Yes, _____ No Do not wish to answer
32. What is your preferred language? English Spanish French Creole Other: _____
33. What is your ethnicity? Hispanic Non-Hispanic Other: _____ Decline to Answer
34. What race do you belong to? African American Alaskan Native American Indian Asian Caucasian
 Pacific Islander or Native Hawaiian Other: _____ Decline to Answer