



Welcome to Yamhill Community Care, your Oregon Health Plan insurance. As part of your care team, please tell us how we can support your health. Complete the following questions. Return this survey in the envelope we sent, no stamp is needed. Care Management is your point of contact for care coordination needs and a care manager is available to you and may call you. You can also call us at 833-257-2191.

Member Name: _____ **Member ID Number:** _____ **Gender:** _____

Date of Birth: _____ **Phone number:** _____ **Preferred Language:** _____

1. How would you rate your general health?

- Excellent Good
 Fair Poor

2. What physical health condition(s) do you feel affect your daily life?

3. Tell us about your teeth, do you have any of the following:

- Mouth Pain Missing Teeth
 Cavities Dentures
 I don't have any of these
 Other

4. Tell us about your mood or mental health. Do you feel any of the following:

- Down, blue, hopeless
 Unable to sleep
 Anxiety or anxiousness
 Scattered/unable to slow your thoughts
 I don't feel any of these
 Other

5. Do you need help finding any of the following providers to help you get care?

- Primary Care Specialist
 Dentist Mental health or
 Substance use Provider

PCP Name (if you have one):

6. Do you need help with any of the following activities (check all that apply)

- Dressing Eating or preparing food
 Bathing Organizing and taking
 Walking medications

What else would you like to share?

7. Do you have a job?

- Yes, full time Yes, part time
 I'm retired No, I am not working
 at this time

8. What is your living arrangement:

- Alone With spouse or family
 Community living I don't have a
 consistent home



9. Please check the items below you are not able to purchase as needed:

- | | |
|-----------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Food including vegetables and fruit | <input type="checkbox"/> Clothing |
| <input type="checkbox"/> Housing (rent, house payment) | <input type="checkbox"/> I am able to purchase everything I need |
| <input type="checkbox"/> Utilities (Electric, Gas, Water, etc.) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Transportation (own or public) | |

10. Do you use Alcohol?

- Yes No

11. Do you use tobacco?

- Yes No

12. Do you have any concerns related to substance use?

- Yes No

**13. Do you have any other needs related to Hearing, Visual Impairment, or other?
Please describe:**

14. Which of the following best describes you? Please select one answer:

- | | |
|------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> White or Caucasian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Multiracial or Biracial |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> A race/ethnicity not listed here |
| <input type="checkbox"/> Native American or Alaskan Native | <input type="checkbox"/> I prefer not to answer |

15. Are you a Veteran of the Armed Forces, Reserves, or Guard?

- Yes No

16. Do you or anyone in your family have a history of a health condition? If yes, please tell us which condition.

17. Care Management is free and part of your insurance coverage. What would you like us to help you with to get the most out of your health care?

Seeing your primary care provider is key to great health. Care Management can help you schedule an appointment.

If you have any questions, need this in large print, braille or a different language, please call us Monday through Friday, 8 a.m. to 5 p.m., at 833-257-2191 (TTY:711).