Clover Health

2024 Getting to Know You (Health Assessment) Survey

This health assessment survey information is used to help us get to know you better. Your responses will be kept private and secure. The information will not be used for a discriminatory purpose. You can change this information in the future by completing a new Getting to Know You survey form online at **cloverhealth.com/you**

We want to help you be as healthy as you can be with healthcare tailored to you. Completing this form will help us make sure you have access to the services you need.

There are three ways to complete and submit this form:
1. Complete this paper survey and return it to us. The return address is at the end of the form.
2. Complete the survey online at **cloverhealth.com/you**
3. Complete the survey over the phone with a member services representative. Call Member Services at **1-888-778-1478 (TTY 711) 8 am-8 pm local time**, 7 days a week*.

First Name:	Last Name:
Clover Health Member ID# or Medicare #:	
Date of Birth (mm/dd/yyyy):	
What is your gender? ☐ Male ☐ Female ☐ Choose not to disclose	
What is your ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I choose not to answer.	
What is your race? (Check all that apply.): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other: _____ ☐ I choose not to answer.	

What language do you prefer when discussing your healthcare? (For example, messages about your benefits, talking with your doctor, marketing materials.)

☐ English ☐ Spanish ☐ Korean ☐ Other: _____

☐ I choose not to answer.

1. Do you have a landline, mobile phone number, and/or email address?

Land Line: ☐☐☐-☐☐☐-☐☐☐☐

Mobile Phone: ☐☐☐-☐☐☐-☐☐☐☐

By providing your mobile number and opting in to receive text communications (message and data rates may apply), you consent to receiving information related to your membership with Clover Health via text message (SMS). Texts may include, but are not limited to, application submission confirmation, health plan materials, notification of programs and services available to you, health reminders, and marketing communications.

*You may opt out of text messages at any time by texting 'STOP' in response to a text message, or by contacting Clover Health Member Services at **1-888-778-1478**.*

Email Address: _____

☐ I do not have an email address.

By providing your email address, you consent to receiving information related to your membership with Clover Health via email. Emails may include, but are not limited to, application submission confirmation, health plan materials, notification of programs and services available to you, health reminders, and marketing communications.

*You may opt out of email communications at any time by clicking the 'UNSUBSCRIBE' link within any email message, or by contacting Clover Health Member Services at **1-888-778-1478**. You may also request a hard copy of any material that Clover Health delivers via email.*

2. Can we send you emails rather than mail? We can send many of our communications through email.

☐ Yes ☐ No

3. Are you comfortable using a computer or smartphone?

☐ Yes ☐ No ☐ *I'm not sure*

4. Would you try a virtual care or telehealth appointment for a health assessment or simple care needs?

☐ Yes ☐ No ☐ *I'm not sure*

5. Do you have an emergency contact?

☐ Yes ☐ No

6. Emergency Contact Name: _____

7. Emergency Contact Phone Number:

☐☐☐-☐☐☐-☐☐☐☐

8. How is this person related to you?

☐ Family ☐ Friend ☐ Other: _____

We will not talk with this person about your health unless you give us permission to do so. If you would like to give us permission to talk with this person, please complete the Voluntary Authorization for Disclosure of PHI form included in your Welcome Kit. You may also find the form online at **cloverhealth.com/phi-auth** *or call* ***1-888-778-1478*** *to request from Member Services.*

9. Who do you live with? (Check all that apply.):

☐ I live alone.

☐ Spouse or partner

☐ Other family

☐ Friend(s)

☐ Hired caregiver(s)

10. Do you use any of the following to help you walk or get around? (Check all that apply.):

☐ Crutches ☐ Walker ☐ Cane ☐ Wheelchair ☐ Scooter ☐ Hospital bed

☐ Other: _____ ☐ None of the above ☐ I choose not to answer.

11. Do you need help from another person to do any of the following activities? (Check all that apply.):

☐ Basic housekeeping (for example, laundry, washing dishes, vacuuming, etc.)

☐ Using the toilet ☐ Putting on or taking off clothing ☐ Walking within my home

☐ Taking your medications ☐ Taking a bath or shower ☐ Getting out of bed and into a chair

☐ Basic transportation (for example, getting to the doctor, pharmacy, grocery store, etc.)

☐ Completing errands (for example, picking up medications or groceries)

☐ None of the above ☐ I choose not to answer.

12. If you do need help with these activities, do you have someone to help you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always ☐ No (unable to afford)

☐ Other: _____ ☐ None of the above ☐ I choose not to answer.

13. Who helps you?

☐ Paid caregivers ☐ Family ☐ Friend(s) ☐ Other: _____

☐ Not applicable. ☐ I don't need help.

14. In the past year, have you been treated for any of the following conditions? (Check all that apply.):

☐ Vascular disease (peripheral vascular disease, varicose veins on leg(s) with ulcers, leg cramps, or pain with walking)

☐ Chronic lung disease (emphysema, asthma, smoker's cough, COPD)

☐ Diabetes (type 1 or type 2)

☐ Congestive heart failure (pulmonary, hypertension, heart failure)

☐ Chronic kidney disease (repeated abnormal kidney blood test stated by doctor and/or known stage)

☐ Other: _____

☐ None of the above

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Check all that apply):

☐ Yes, it has kept me from medical appointments

☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need

☐ No

☐ I choose not to answer this question

16. What is your housing situation today?

☐ I have housing

☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)

☐ I choose not to answer this question

17. Are you worried about losing your housing?

☐ Yes

☐ No

☐ I choose not to answer this question

17a. If you answered yes to question 17 above, are you worried about losing your housing within the next 6 months?

☐ Yes

☐ No

18. Thinking about the place you live, do you have problems with any of the following? (Check all that apply.):

☐ Bug infestation ☐ Mold ☐ Lead paint or pipes ☐ Inadequate heating or cooling

☐ Unavailable or non-functioning oven, stove, or refrigerator

☐ Unavailable or non-functioning smoke detectors

☐ Water leaks

☐ Other: _____

☐ None of the above

☐ I choose not to answer.

19. In the past year, have you or anyone you live with been unable to get any of the following when it was really needed? (Check all that apply.):

☐ Yes ☐ No Food

☐ Yes ☐ No Clothing

☐ Yes ☐ No Utilities

☐ Yes ☐ No Child Care

☐ Yes ☐ No Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)

☐ Yes ☐ No Phone

☐ Yes ☐ No Utilities

☐ Yes ☐ No Other (please write): _____

☐ None of the above

☐ I choose not to answer.

19a. If you answered yes to question 19, Is this currently impacting you personally?

☐ Yes ☐ No

20. Do you currently smoke (such as smoking cigarettes, vaping, etc.), or have you smoked in the past?

☐ Current smoker ☐ Former smoker ☐ Never smoked ☐ I choose not to answer.

21. How often do you have a drink containing alcohol (such as beer, wine, etc.)?

☐ Never ☐ Monthly or less ☐ 2–4 times a month ☐ 2–3 times a week ☐ 4 or more times a week
☐ I choose not to answer.

22. How often does anyone, including family and friends, physically or emotionally (insult, talk down to you, etc.) hurt you or threaten to?

☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently ☐ Never

23. Over the past 2 weeks, how often have you been bothered with feeling down, depressed, hopeless, or have little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

☐ I choose not to answer.

24. Have you received a flu shot since January 1 of this year?

☐ Yes ☐ No

25. What is your height?

☐☐ feet ☐☐ inches

26. What is your weight?

☐☐☐ pounds

27. Do you have the following healthcare coverage or benefits? (Check all that apply.):

☐ Medicaid ☐ Veteran benefits ☐ Private insurance ☐ Other public insurance (including CHIP)

☐ Other: _____

☐ None ☐ I choose not to answer.

28. Do you have a primary care provider, or PCP (the main doctor who coordinates your care)?

☐ Yes

Provider Name: _____

Provider Address: _____

Provider Phone #: _____

☐ No, I would like help finding a PCP.

☐ No, I do not need or want help finding a PCP.

If you would like to speak with a care manager about the concerns you answered above, please call our Care Management Department at **1-888-995-1689** from 8am–6pm ET, Monday through Friday *or* email **wellnessmanagers@cloverhealth.com**.

Thank you for completing this survey. Please send it back to us as soon as you can. If you have any questions, please call 1-888-778-1478 (TTY 711) 8 am–8 pm local time, 7 days a week.*

Please mail this form to:
Clover Health
P.O. Box 21164
Eagan, MN 55121

Or fax this form to:
ATTN: Mailroom
1-866-508-0865

*Between April 1 and September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Clover Health is a Preferred Provider Organization (PPO) and a Health Maintenance Organization (HMO) with a Medicare contract. Enrollment in Clover Health depends on contract renewal.