Clover Health

2023 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 send it back in the enclosed postage-paid envelope.
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. Between April 1 and Sept. 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

First Name:	Last Name:
Clover Health Member ID# or Medicare ID#:	
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 ☐ Chinese ☐ Hindi ☐ Arabic

☐ Armenian ☐ Russian ☐ Farsi ☐ French ☐ German ☐ Tagalog

☐ Greek ☐ Haitian Creole ☐ Italian ☐ Navajo ☐ Portuguese ☐ Polish

☐ Vietnamese ☐ American Sign Language ☐ 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. Do you have an emergency contact?

☐ Yes ☐ No

3. Emergency Contact Name: _____

4. Emergency Contact Phone Number:

5. 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.*

6. What is your housing 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 or shelter, outside on the street or in a park, on a beach, in a car or abandoned building, or in a bus or train station.)

☐ I choose not to answer.

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

☐ I live alone.

☐ Spouse or partner

☐ Other family

☐ Friend(s)

☐ Hired caregiver(s)

8. 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.

9. Within the past 12 months, the food you bought didn't last and you didn't have enough money to buy more?

☐ Often true ☐ Sometimes true ☐ Never true

10. During the past 12 months, have you or anyone you live with been unable to get any of the following when it was really needed? (Check all that apply.):

☐ Food

☐ Medicine or any healthcare (for example, Medical, Dental, Vision, Mental Health)

☐ Transportation that gets me to medical appointments, meetings, work, or getting things needed for daily living

☐ Someone to help me with my care and/or household needs

☐ Equipment I need to be safe (for example, walker, commode chair, grab bars, etc.)

☐ Phone

☐ Utilities (water, sewage, electric, gas, oil, or trash collection)

☐ Clothing

☐ Child care

☐ Internet and/or digital technology (for example, smartphone, tablet, or computer with internet access)

☐ Other: _____

☐ None of the above

☐ I choose not to answer.

11. 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.

12. 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.

13. 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.

14. Who helps you?

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

☐ Not applicable. I don't need help.

15. 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)

☐ None of the above

16. 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.

17. 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.

18. 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

19. 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.

20. When was your last flu shot? *(Please enter the year.)*

21. What is your height?

feet inches

22. What is your weight?

pounds

23. 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.

24. Based on some of your answers, would you be interested in someone contacting you to offer help?

☐ Yes ☐ No

25. 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.

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 471
Jersey City, NJ 07303

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

Email this form as an attachment to:
PO_Box_471@cloverhealth.com

*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.