

The information you provide to us on this form helps us develop a care plan with your primary care provider (PCP) and specialists. It also helps ensure your enrollment into PHP California is easy as possible. Questions? Call Member Services at (800) 263-0067, 8:00 a.m. to 8:00 p.m., Monday through Friday. TTY users should call 711. Or visit us at www.php-ca.org.

Name: _____ Email Address: _____

Birthdate: _____ Best Phone No.: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

What is the best day/time to reach you? _____

What is the best way to communicate with you? ☐ Best Phone No. ☐ USPS Mail ☐ Email ☐ Text

Sex: _____ Gender: _____ Sexual Orientation: _____

Height: _____ Weight: _____ Last Blood Pressure Reading: _____

What was your last viral load (VL) count? VL: _____ Date: _____

Do you have any food or medication allergies? ☐ Yes ☐ No *If "yes," please list:* _____

Do you have any other diagnosis other than HIV/AIDS?

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart Failure/Enlarged Heart	<input type="checkbox"/> COPD	<input type="checkbox"/> Obesity	<input type="checkbox"/> Kidney Dialysis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Depression	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Other Substance Use	<input type="checkbox"/> History of TB	<input type="checkbox"/> HIV Wasting	<input type="checkbox"/> Chronic Diarrhea
<input type="checkbox"/> Active HIV Opportunistic Infection	<input type="checkbox"/> Cognitive Impairment		
<input type="checkbox"/> HIV Opportunistic Cancer in Remission	<input type="checkbox"/> HIV Opportunistic Infection under Prophylaxis		

<i>Please place an "X" in the cell that represents your answer to the following:</i>	Yes	No
Have you ever felt you should cut down on your drinking and/or recreational or prescription drug use?		
Have people annoyed you by criticizing your drinking or drug use?		
Have you ever felt bad or guilty about your drinking or drug use?		
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		

How would you rate your overall health? (Select one.) ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Please list your prescriptions, dosage and how often you take them: _____

Do you have any trouble refilling your prescriptions? ☐ Yes ☐ No

<i>Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.</i>	Often True	Sometimes True	Never True
Within the past 12 months, you worried that your food would run out before you got money to buy more.			
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.			

Are you on a special diet? ☐ Yes ☐ No

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).

Do you live alone? ☐ Yes ☐ No

Think about the place you live. Do you have problems with any of the following? (Choose all that apply)

☐ Pests such as bugs, ants, or mice

☐ Lead paint or pipes

☐ Oven or stove not working

☐ Smoke detectors missing or not working

☐ Mold ☐ Lack of heat

☐ Water leaks ☐ None of the above

Any recent vision changes? ☐ Yes ☐ No

Any recent hearing changes? ☐ Yes ☐ No

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

Over the past 2 weeks, please place an "X" in the cell that represents your answer:	Not at all	Several days	More than half of the days	Nearly every day
Little interest or pleasure doing things				
Feeling down, depressed or hopeless				
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Stay in the house most or all of the time				

Please place an "X" in the cell that represents your answer to the following:	Yes	No
Have you had any problems with urine leakage?		
Do you have unprotected sex?		
Have you been treated for an STD in the last 12 months? If "yes," which one(s)? _____		
In the previous month, have you gone to urgent care?		
Were you seen in the emergency room in the last six (6) months?		
In the last 12 months, have you stayed overnight as a patient in hospital? If "yes," which hospital? _____		
Have you seen your PCP in the last six (6) months? Who is your primary care provider (PCP)? _____		
Are you receiving any other services, i.e., dialysis, physical therapy, medical equipment, etc.? If "yes," what services? _____		
Have you had any problems with balance or walking?		
Are you physically active (e.g., walking, stationary bike, treadmill, etc.)?		
Have you fallen (without having been pushed) in the last three (3) months?		
Have you ever spent time in correctional facilities, jails, or prisons? *Your response to this question will not affect your eligibility or enrollment in the plan.		

What is your smoking status?

☐ Current (Every Day) ☐ Current (Some Days)

☐ Previous ☐ Never

Please place an "X" in the cell that represents your answer to the following:	Yes	No
Have you had a flu shot in the last 12 months?		
Have you had a shot for pneumonia in the last five (5) years?		
Have you had the first two COVID shots?		
Have you had any COVID booster shots?		
Have you had any other shots in past year?		
Have you had any problems with short-term memory? (e.g., what did you have for dinner last night?)		
Have you had any problems with your long-term memory? (e.g., where were you born?)		
Do you have trouble understanding instructions?		
If you have pain, on a scale of 0-10, what is your pain level? (0=no pain, 10=the most pain you have ever felt): _____ Where is your pain: _____		

Do you use any of the following to get around?

☐ None ☐ Cane ☐ Walker ☐ Wheelchair

☐ Prosthetic Device ☐ Powered Vehicle

(Scooter) ☐ Other: _____

Rate the following activities with an "X" in the cell that represents your answer:	No Trouble	Need Some Help	Need Help
Bathing			
Getting dressed			
Getting to and from the toilet			
Shopping			
Preparing meals			
Feeding yourself			
Using the telephone			
Housekeeping			
Laundry			
Managing medications			
Managing household finances			
This completed form can be returned to: PHP California P.O. Box 46160 Los Angeles, CA 90046			

Signature

Date