brand new day
HEALTHCARE YOU CAN FEEL GOOD ABOUT

Health Risk Assessment (HRA)

Answering the questions below helps us find ways to help you continue to feel good and improve your health. Please answer as many questions as you can and return this form in the pre-paid envelope. **You can earn $25 in rewards when you mail in your completed HRA!**

Medicare ID#	**Member ID#**	**Plan**	**Effective Date**

Member First Name	**Member Last Name**	**Date of Birth**	**Gender**
			☐ **M** ☐ **F** ☐ **Other**

Address	**City**	**State**	**Zip Code**

Home Phone Number	**Cell Phone Number**	**Email Address**

What is your preferred method of communication? ☐ Cell Phone ☐ Home Phone

Do you use any of the following at home?

☐ Tablet or Smartphone ☐ Laptop or Desktop Computer

Do you have access to internet at home? ☐ Yes ☐ No

Are you open to a virtual / telehealth visit with your provider? ☐ Yes ☐ No

If you have Medi-Cal, who is your Medi-Cal doctor if different from your Medicare doctor?

If you have Medi-Cal, who is your health plan (insurance provider)?

If you have Medi-Cal, who is your dental doctor?

If you have Medi-Cal, who is your Medi-Cal Enhanced Care Manager (ECM), or social worker, who coordinates your Medi-Cal services? What's their phone number?

If you have Medi-Cal, what services are you currently using?

- ☐ In home support services (IHSS)
- ☐ Community based adult services (CBAS)
- ☐ Medi-Cal Transportation Services
- ☐ Medi-Cal Dental benefits
- ☐ Community Support Providers through Medi-Cal
- ☐ Housing and homelessness providers
- ☐ County mental health
- ☐ County Substance use disorder services
- ☐ Alzheimer association
- ☐ Home and community based services (1902 waiver program)
- ☐ Regional Center services

Primary Care Doctor:

Are you:

- ☐ Employed
- ☐ Unemployed
- ☐ On permanent disability
- ☐ On short term disability
- ☐ Retired

What is your preferred spoken language for healthcare?

- ☐ English
- ☐ Spanish
- ☐ Chinese (including Cantonese, Mandarin, Hokkien, other varieties)
- ☐ Korean
- ☐ Vietnamese
- ☐ Prefer not to answer
- ☐ Other, please specify ____________________

What is your preferred written language for health care?

- ☐ English
- ☐ Spanish
- ☐ Chinese (including Cantonese, Mandarin, Hokkien, other varieties)
- ☐ Korean
- ☐ Vietnamese
- ☐ Prefer not to answer
- ☐ Other, please specify ____________________

Section A: Medical

A1: In general how would you rate your health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

A2: In the last 12 months, have you stayed overnight as a patient in a hospital or Care Facility (Nursing Home)?

☐ No ☐ 1-2 times ☐ 3-5 times ☐ Greater than 6 times

A3: Do you have Chronic pain? ☐ Yes ☐ No

If yes, where?: ____

A4: On a scale of 0 (no pain) to 10 (severe pain, disabling), how would you rate your pain over the last 30 days?

Answer (0-10):________________

A5: How often do you exercise per week?

☐ 5 or more days ☐ 3-4 days ☐ 1-2 days ☐ Seldom ☐ Never

A6: What is your height? __________ **A7:** What is your weight?______________lbs.

A8: Have you received any of the following? Check all that apply:

☐ Flu shot ☐ Pneumonia Vaccine ☐ Colonoscopy ☐ COVID Vaccine

A9: Has your doctor told you that you have? Check all that apply:

☐ Heart Failure
☐ Cardiovascular Disease
☐ Anxiety
☐ Arthritis
☐ Cancer
☐ Dementia
☐ High Cholesterol
☐ Other:______________________________________
☐ Blood Clots
☐ Irregular Heart Rates
☐ Osteoporosis
☐ Peripheral Vascular Disease
☐ Diabetes/High Blood Sugar
☐ High Blood Pressure
☐ Liver Cirrhosis
☐ Urinary Incontinence
☐ Dialysis
☐ Pulmonary Disease/COPD
☐ Chronic Kidney Disease
☐ Depression
☐ Schizophrenia
☐ Bipolar
☐ None of Above

A10: Do you have any allergies? ☐ Yes ☐ No

If yes, what: ____

A11: How often do you forget to take your medicine?

☐ Almost every day ☐ 2-4 times per week ☐ 1 time per week ☐ Rarely or never

Section B: Behavioral Health

*For **B1** & **B2**, how often have you been bothered by the following over the last 30 days?*

B1: Little interest or pleasure in doing things you use to do:

☐ Not at all ☐ More than half the days ☐ Several days ☐ Nearly everyday

B2: Feeling down, depressed, or hopeless:

☐ Not at all ☐ More than half the days ☐ Several days ☐ Nearly everyday

B3: Do you, or your family / friends have concerns about your memory? ☐ Yes ☐ No

B4: How often do you feel isolated from others?

☐ Hardly ever ☐ Some of the time ☐ Often

B5: Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

B6: How often do you have a drink containing alcohol?

☐ Never ☐ 2 to 3 times a month ☐ 4 or more times a week

☐ Monthly or less ☐ 2 to 4 times a week ☐ 2 to 4 times a month

B7: Do you smoke cigarettes or use tobacco? ☐ Yes ☐ No

B8: How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons? ☐ None ☐ 1 or more

Section C: Activities Of Daily Living

C1: Do you live in:

☐ An independent house, apartment, condo, or mobile home ☐ A nursing home

☐ An assisted living apartment or board and care home ☐ Homeless/Shelter

C2: Are you using Home Health services? ☐ Yes ☐ No

C3: Who do you live with?

☐ Spouse ☐ Children or other relative ☐ Alone ☐ Friend ☐ Other

C4: Is there a friend, relative, caregiver or neighbor who helps you with your medical needs?

☐ Yes ☐ No If yes, who?: ______________________________

C5: Do you ever think your caregiver has a hard time giving you all the help you need?

☐ Yes ☐ No

C6: Do you have an Advanced Directive/POLST or Living Will? ☐ Yes ☐ No

C7: Do you have someone that helps you make healthcare decisions (power of attorney)?

☐ Yes ☐ No

If yes, who?______________________________Phone number:____________________

C8: Are you afraid of anyone or is anyone hurting you? ☐ Yes ☐ No

C9: Is anyone using your money without your okay? ☐ Yes ☐ No

C10: Have you had a conversation with your provider regarding whether or to what extent you want life sustaining treatment(s)?

☐ Yes ☐ No

C11: Have you fallen in the past month? ☐ Yes ☐ No

C12: Are you afraid of falling? ☐ Yes ☐ No

C13: Are you currently using Durable Medical Equipment or medical devices? ☐ Yes ☐ No

C14: If yes to C13, please select which equipment or medical devices below:

☐ Wheelchair	☐ Pressure Mattress	☐ Hospital Bed	☐ Toilet Seat
☐ Walker	☐ CPAP Machine/Sleep Apnea	☐ Oxygen	☐ Bath Chair
☐ Cane	☐ Commode	☐ Diapers	☐ Catheter

C15: Managing medications:

☐ I do not have difficulty ☐ Yes, I have difficulty ☐ I am not able to do this activity unassisted

C16: Filling out health forms:

☐ I do not have difficulty ☐ Yes, I have difficulty ☐ I am not able to do this activity unassisted

C17: Answering questions during a doctors visit:

☐ I do not have difficulty ☐ Yes, I have difficulty ☐ I am not able to do this activity unassisted

C18: Are you currently using hospice or palliative care services? ☐ Yes ☐ No

C19: Do you have difficulty with any of the following:

- ☐ Feeding yourself
- ☐ Bathing
- ☐ Grooming
- ☐ Bowel incontinence or accidents
- ☐ Bladder incontinence or accidents
- ☐ Toilet use
- ☐ Transfer (ex: bed to chair and back)
- ☐ Mobility (on level surfaces)
- ☐ Going up or down stairs
- ☐ Managing money
- ☐ Food preparation
- ☐ Laundry
- ☐ Housekeeping
- ☐ Going out to visit family or friends
- ☐ Getting a ride to the doctor or to see your friends
- ☐ Using your phone
- ☐ Going shopping for food

C20: If you have difficulty with any of the above actions, are you getting the help you need with these actions?

☐ Yes ☐ No

C21: Do you sometimes run out of money to pay for rent, bills, and medicine?

☐ Yes ☐ No

C22: Within the past 12 months, you worried that your food would run out before you got money to buy more.

☐ Often true ☐ Sometimes true ☐ Never true

C23: Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

☐ Often true ☐ Sometimes true ☐ Never true

C24: 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)

C25: 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

☐ Mold

☐ Lead paint or pipes

☐ Lack of heat

☐ Oven or stove not working

☐ Smoke detectors missing or not working

☐ Water leaks

☐ None of the above

C26: Can you live safely and move easily around in your home? ☐ Yes ☐ No

If no, does the place where you live have:

Good lighting	☐ Yes	☐ No
Good heating	☐ Yes	☐ No
Good cooling	☐ Yes	☐ No
Rails for any stairs or ramps	☐ Yes	☐ No
Hot water	☐ Yes	☐ No
Indoor toilet	☐ Yes	☐ No
A door to the outside that locks	☐ Yes	☐ No
Stairs to get into your home or stairs inside your home	☐ Yes	☐ No
Elevator	☐ Yes	☐ No
Space to use a wheelchair	☐ Yes	☐ No
Clear ways to exit your home	☐ Yes	☐ No

C27: 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

Sales Agent Information

If someone helped you fill out this application he/she must complete the information below and sign:

Name of Staff/Agent/Broker (Print Name)

Signature	**Date**

Relationship to Enrollee	**Agent NPN**

Agent Phone Number	**Agent License Number**	**FMO**

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