Bright HealthCare™

Health Risk Assessment (HRA)

ATTENTION: IF YOU HAVE COMPLETED AND SUBMITTED THIS FORM TO US, YOU DON'T NEED TO COMPLETE IT AGAIN.

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!**

MBI# | **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

Primary Care Doctor:

What is your preferred spoken language for healthcare?

☐ English ☐ Chinese ☐ Vietnamese ☐ Prefer not to answer

☐ Spanish ☐ Korean ☐ Other, please specify:):_____

What is your preferred written language for health care?

☐ English ☐ Chinese (including Cantonese, Mandarin, Hokkien, other varieties) ☐ Korean ☐ Other, please specify

☐ Spanish ☐ Vietnamese ☐ Prefer not to answer

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
☐ Blood Clots
☐ Irregular Heart Rates
☐ Osteoporosis
☐ Peripheral Vascular Disease
☐ Diabetes/High Blood Sugar
☐ High Blood Pressure
☐ Liver Cirrhosis
☐ Urinary Incontinence
☐ Kidney Dialysis
☐ None of Above
☐ Other: _____

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 ☐ N/A

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, or neighbor who helps you with your medical needs?

☐ Yes ☐ No

If yes, who?: _____

C5: Do you have an Advance Directive? ☐ Yes ☐ No

C6: Do you have someone that helps you make healthcare decision?

☐ Yes ☐ No

If yes, who?_____Phone number:_____

C7: Have you had a conversation with your provider regarding whether or to what extent you want life sustaining treatment(s)?

☐ Yes ☐ No

C8: Have you fallen in the past month? ☐ Yes ☐ No

C9: Are you currently using Durable Medical Equipment or medical devices?

☐ Yes ☐ No

C10: If yes to C9, 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

C11: Managing medications:

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

C12: Do you have In Home Supportive Services ☐ Yes ☐ No

C13: Do you have difficulty with any of the following:

☐ Feeding yourself	☐ Mobility (on level surfaces)
☐ Bathing	☐ Going up or down stairs
☐ Grooming	☐ Managing money
☐ Bowel incontinence or accidents	☐ Food preparation
☐ Bladder incontinence or accidents	☐ Laundry
☐ Toilet use	☐ Housekeeping
☐ Transfer (ex: bed to chair and back)	

C14: In the past 12 months, did you ever eat less than you should because there was not enough money for food?

☐ Yes ☐ No

C15: Do you have housing? ☐ Yes ☐ No

C16: Are you worried about losing your housing? ☐ Yes ☐ No

C17: Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?

☐ 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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