CA HRA

Member Name:	**Home Phone: ( )**
Responder's Name:	**Cell Phone: ( )**
Member MBI:	**Other: ( )**
Relationship to Member:	
Member Healthcare ID:	**DATE: / /**
DOB:	**Proposed Effective DATE: / /**
State:	
Broker Writing Number:	

	QUESTION	RESPONSE
	HRA Details I.	
	* For CA Members Only.	
	Talking Points: Thank you for taking the time to speak with me today. I would like to spend some time going over your health history. It will take us about twenty minutes. If more time is needed, we can schedule an additional session.	
1	Was the Pre-Call Review note completed?	☐ Yes ☐ No
2	Date of HRA Conducted	
3	Assessment Method	☐ In-Person ☐ Broker Agent ☐ Mailed ☐ Telephonic
4	Respondent	☐ Member ☐ Caregiver ☐ Other
	Other Respondent	
	Caregiver	
5	Do you have a language need other than English?	☐ Arabic ☐ Creole ☐ French ☐ Mandarin ☐ Russian ☐ Somali ☐ Spanish ☐ Vietnamese ☐ Other language ☐ None
	Other Language	
	Please expand on members language needs	

6	Do you have any special preferences we should be aware of?	☐ Cultural Preferences ☐ Hearing Impairment ☐ Literacy ☐ Religion/Spiritual needs or preferences ☐ Visual Impairment ☐ None ☐ Other Special preferences
	Expand on any Cultural preferences	
	Expand on any Hearing Impairment preferences	
	Expand on any Literacy preferences	
	Expand on any Religion/Spiritual needs or preferences	
	Expand on any Visual Impairment preferences	
	Expand on any special preferences	
HRA Details II.		
7	What is your main health concern right now?	
8	Are you pregnant?	☐ Yes ☐ No ☐ N/A
	Do you have any problems with your lungs, like Asthma, Chronic Obstructive Pulmonary Disease or Cystic Fibrosis?	
10	Asthma	☐ Yes ☐ No
	Comment	
11	Chronic Obstructive Pulmonary Disease	☐ Yes ☐ No
	Comment	
12	Cystic Fibrosis	☐ Yes ☐ No
	Comment	
	Do you have any problems with your heart or circulation like atrial fibrillation, coronary artery disease, peripheral arterial disease, congestive heart failure or stroke?	
13	Atrial fibrillation	☐ Yes ☐ No
	Comment	

14	Coronary Artery Disease/ Peripheral Arterial Disease	☐ Yes ☐ No
	Comment	
15	Congestive Heart Failure	☐ Yes ☐ No
	Comment	
16	Cerebral Vascular Accident/Stroke	☐ Yes ☐ No
	Comment	
17	Hypertension	☐ Yes ☐ No
	Comment	
	Do you have any problems with your kidneys like chronic kidney disease or end stage renal disease on dialysis?	
18	Chronic Kidney Disease	☐ Yes ☐ No
	Comment	
19	End Stage Renal Disease on dialysis	☐ Yes ☐ No
	Comment	
	Has your doctor diagnosed you with a Behavioral health condition such as Depression, Schizophrenia or Bipolar disorder?	
20	Depression	☐ Yes ☐ No
	Comment	
21	Schizophrenia	☐ Yes ☐ No
	Comment	
22	Bipolar	☐ Yes ☐ No
	Comment	
	Do you have any conditions affecting your brain like seizures, memory (dementia) or stroke?	
23	Seizures	☐ Yes ☐ No

	Comment	
24	Cerebral Vascular Accident/Stroke	☐ Yes ☐ No
	Comment	
25	Dementia	☐ Yes ☐ No
	Comment	
26	Alzheimer's Disease	☐ Yes ☐ No
	Comment	
27	Other brain conditions	☐ Yes ☐ No
	Other brain conditions	
28	Do you have cirrhosis?	☐ Yes ☐ No
	Comment	
29	Do you have sickle cell?	☐ Yes ☐ No
	Comment	
30	Do you have HIV or AIDS?	☐ HIV ☐ AIDS ☐ Neither
	Comment	
31	Do you have active cancer that is being treated with chemo, radiation or surgery?	☐ Yes ☐ No
	Comment	
32	Do you have diabetes (sugars)?	☐ Yes ☐ No
	Comment	
33	Do you have rheumatoid arthritis?	☐ Yes ☐ No
	Comment	

34	Other conditions	☐ Other ☐ None
	Other condition	
35	Have you visited the emergency room in the past 6 months?	☐ Yes ☐ No
	If Yes, how many emergency room visits?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 10+
	If Yes, reason(s) for ER visit(s)?	
36	Have you stayed overnight in the hospital in the past 6 months?	☐ Yes ☐ No
	If Yes, how many hospital stays?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 10+
	If Yes, reason(s) for hospital stay(s)?	
37	Do you understand what your medications are for and why you are taking them?	☐ Yes ☐ No ☐ No prescribed medications ☐ Not Addressed
	I would like to ask you about how you think you are managing your health conditions.	
38	a) Do you need help taking your medicines?	☐ Yes ☐ No
39	b) Do you need help filling out health forms?	☐ Yes ☐ No

40	c) Do you need help answering questions during a doctor's visit?	☐ Yes ☐ No
41	Notes:	
HRA Details III.		
42	18 and Over	
	Compared to others your age, would you say your health is: (Adult only question)	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Not Addressed
43	Have you had any changes in thinking, remembering, or making decisions?	☐ Yes ☐ No
44	18 and Over	
	Could you please tell me the:	
	Month	☐ Correct ☐ Incorrect ☐ Not Addressed
	Date (day of month OR day of week)	☐ Correct ☐ Incorrect ☐ Not Addressed
	Year	☐ Correct ☐ Incorrect ☐ Not Addressed
	Current President	☐ Correct ☐ Incorrect ☐ Not Addressed
	Expand on cognitive assessment	
	If any responses to month, date, year, president are incorrect, Ask to speak with caregiver	
	Caregiver	
	Caregiver Phone	
45	Have you received your flu shot this year?	☐ Yes ☐ No ☐ Not Addressed

	What is your housing situation today?	A. I do not have housing (I am 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) ☐ B. I have housing today, but I am worried about losing housing in the future ☐ C. I have housing ☐ D. I choose not to answer ☐
46	What is your current living situation?	☐ Homeless ☐ Lives Alone ☐ Lives in a group home ☐ Lives in a nursing facility ☐ Lives in a shelter ☐ Lives in an assisted living facility ☐ Lives with other family ☐ Lives with others unrelated ☐ Lives with spouse ☐ Lives in out of home placement ☐ Lives in out of state medical facility ☐ None of the above ☐ Other
	Other Living situation	
	Expand on living condition	
	In the past year, have you or any family members you live with been unable to get food when it was really needed?	A. Yes ☐ B. No ☐ C. I choose not to answer ☐
	Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.	A. Yes, it has kept me from medical appointments or getting medications ☐

		B. Yes, it has kept me from non-medical meetings, appointments, work, or getting things I need ☐
		C. No ☐
		D. I choose not to answer ☐
47	Can you live safely and move easily around in your home?	☐ Yes ☐ No
	If no, does the place where you live have	
	a) Good lighting	☐ Yes ☐ No
	b) Good heating	☐ Yes ☐ No
	c) Good cooling	☐ Yes ☐ No
	d) Rails for any stairs or ramps	☐ Yes ☐ No ☐ N/A: No Stairs
	e) Hot water	☐ Yes ☐ No
	f) Indoor toilet	☐ Yes ☐ No
	g) A door to the outside that locks	☐ Yes ☐ No
	h) Stairs to get into your home or stairs inside your home	☐ Yes ☐ No
	i) Elevator	☐ Yes ☐ No
	j) Space to use a wheelchair	☐ Yes ☐ No ☐ N/A: Member does not require a wheelchair
	k) Clear ways to exit your home	☐ Yes ☐ No
48	Have you fallen in the last month?	☐ Yes ☐ No

49	Are you afraid of falling?	☐ Yes ☐ No ☐ Not Addressed
	Reason Not Addressed	
50	Do you need help with any of these actions?	
	a) Taking a bath or shower	☐ Yes ☐ No ☐ Not Addressed
	b) Going up stairs	☐ Yes ☐ No ☐ Not Addressed
	c) Eating	☐ Yes ☐ No ☐ Not Addressed
	d) Getting Dressed	☐ Yes ☐ No ☐ Not Addressed
	e) Brushing teeth, brushing hair, shaving	☐ Yes ☐ No ☐ Not Addressed
	f) Making meals or cooking	☐ Yes ☐ No ☐ Not Addressed
	g) Getting out of a bed or a chair	☐ Yes ☐ No ☐ Not Addressed
	h) Shopping and getting food	☐ Yes ☐ No ☐ Not Addressed
	i) Using the toilet	☐ Yes ☐ No ☐ Not Addressed
	j) Walking	☐ Yes ☐ No ☐ Not Addressed
	k) Washing dishes or clothes	☐ Yes ☐ No ☐ Not Addressed
	l) Writing checks or keeping track of money	☐ Yes ☐ No ☐ Not Addressed

	m) Getting a ride to the doctor or to see your friends	☐ Yes ☐ No ☐ Not Addressed
	n) Doing house or yard work	☐ Yes ☐ No ☐ Not Addressed
	o) Going out to visit family or friends	☐ Yes ☐ No ☐ Not Addressed
	p) Using the phone	☐ Yes ☐ No ☐ Not Addressed
	q) Keeping track of appointments	☐ Yes ☐ No ☐ Not Addressed
	If yes to any of the above,	
	Are you getting all the help you need with these actions?	☐ Yes ☐ No
	Notes:	
51	Do you have family members or others willing and able to help you when you need it?	☐ Yes ☐ No
52	Do you ever think your caregiver has a hard time giving you all the help you need?	☐ Yes ☐ No ☐ N/A: No Caregiver
	Expand on taking care of self and available supports	
53	Do you sometimes run out of money to pay for food, rent, bills, and medicine?	☐ Yes ☐ No
54	Is anyone using your money without your ok?	☐ Yes ☐ No ☐ Not Addressed
	Reason Not Addressed	
	18 and Over	
	Living will and Advance Directive Questions	
	An advanced directive is a form that lets your loved ones know your health care choices if you are too sick to make them yourself. Do you have a living will or an advanced directive in place?	☐ Yes ☐ No ☐ Not Addressed
	What type of document is it?	

	Does your PCP/Doctor have a copy?	☐ Yes ☐ No
	Comment	
	Could I send you more information?	☐ Request further information ☐ Declined discussion
	Reason Not Addressed	

HRA Details IV.		
	I have a few questions that I would like to ask you they involve your thoughts about your mental health and mental health care.	
	13 and Over	
	Cage Aid	
	Are Cage Aid questions able to be addressed?	☐ Yes ☐ No
	In the last three months, have you felt you should cut down or stop drinking or using drugs?	☐ Yes ☐ No
	In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?	☐ Yes ☐ No
	In the last three months, have you felt guilty or bad about how much you drink or use drugs?	☐ Yes ☐ No
	In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?	☐ Yes ☐ No
	Do you feel like you have a problem with drugs or alcohol?	☐ Yes ☐ No
	If yes to any of the above,	
	Do you want a Case Manager to call you to **provide support/education**?	☐ Yes ☐ No
	Reason Cage Aid not able to be addressed	
	PHQ-2 and other BH questions	
	Are PHQ-2 questions able to be addressed?	☐ Yes ☐ No
	Over the last 2 weeks how often have you had little interest or pleasure in doing things?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day
	Over the last 2 weeks how often have you been feeling down, depressed or hopeless?	☐ Not at all ☐ Several Days

		☐ More than half the days ☐ Nearly every day
	Reason PHQ-2 not able to be addressed	

HRA Details V.		
	PHQ-2 Score	
	Over the past month (30 days), how many days have you felt lonely?	☐ None – I never feel lonely ☐ Less than 5 days ☐ More than half the days (more than 15) ☐ Most days – I always feel lonely ☐ Not addressed
	Thoughts that you would be better off dead, or hurting yourself? Do you have a plan?	☐ Yes ☐ No ☐ Not addressed
	Comment	
	1. Keep the member SAFE by keeping them on the phone. 2. Verbalize your desire to assist the member. 3. Signal to co-worker for help without going on hold. 4. Employ immediate assistance from a first responder (911 etc.) 5. Follow the crisis policy.	
	Are you afraid of anyone or is anyone hurting you?	☐ Yes ☐ No ☐ Not addressed
	Comment	
	Thank you for taking the time to complete the survey. Someone may be reaching out to you. If you need a little extra help taking care of your health, we could discuss your needs in an "Interdisciplinary Care Team" or what we also call an "ICT" meeting. We would include the members of your care team, for example your primary care doctor, your case manager, your caregiver and yourself. The team can meet in person or by phone and work together to come up with a plan to meet your health care needs.	
	Check this box as confirmation that the above was communicated to the member?	☐ Confirmed
	Did member request ICT meeting?	☐ Yes ☐ No ☐ Not addressed – for MHRA's only
	Section Complete	☐ Yes

[Disclaimers: Molina Healthcare is a DSNP and HMO plan with a Medicare contract. DSNP plans have a contract with the state Medicaid program. Enrollment depends on contract renewal.

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