Health Risk Assessment

Member Name:	**Home Phone:**
Member Healthcare ID:	**Cell Phone:**
Member MBI:	**Other:**
DOB:	
State:	**Assessment DATE:**
Address:	

QUESTIONS	ANSWERS
General Information	
Assessment Method:	☐ In-person ☐ Mailed ☐ **Sales/Broker** ☐ Telephonic ☐ Televisit ☐ Welcome Kits ☐ Other: _____
Broker Writing Number:	
Assessment Type:	☐ Initial Assessment ☐ Annual ☐ Referral ☐ Change in health status ☐ Clerical error
Who is completing this form?	☐ Member ☐ Other: _____
Phone for person completing the form	_____
Are you of Hispanic, Latino, or Spanish origin?	☐ No, not Hispanic, Latino or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, another Hispanic, Latino, or Spanish origin *Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on:* _____ ☐ I choose not to answer
Please select the racial category or categories which you most closely identify with:	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or another Pacific Islander ☐ Hispanic or Latino ☐ White ☐ Multiracial: _____ ☐ Something else: _____ ☐ I choose not to answer
What language do you prefer we use when speaking to you or sending you materials?	☐ Arabic ☐ Chinese ☐ Creole ☐ English ☐ French ☐ Mandarin ☐ Russian

	☐ Somali ☐ Spanish ☐ Tagalog ☐ Vietnamese ☐ Something else: _____
What is your sexual orientation? (Please choose the option that best describes you.)	☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else, please describe: _____ ☐ I don't know ☐ I choose not to answer
What is your highest level of school completed?	☐ Less than a high school diploma ☐ High school diploma/ GED ☐ Vocational / Trade school ☐ Some college ☐ College degree (associates or bachelor's) ☐ Graduate degree ☐ I choose not to answer
What is your living situation?	☐ Live in a home that I own ☐ Live in a home/ apartment that I rent ☐ Live with family member ☐ Live in a shelter ☐ Live in foster care ☐ Live in a group home ☐ Live in an assisted living facility ☐ Nursing home ☐ Homeless/ unsheltered ☐ Something else: _____ ☐ I choose not to answer
Do you have any preferences or considerations we should be aware of? Please select all that apply.	☐ Cultural preferences: _____ ☐ Religion/ Spiritual needs or preferences: _____ ☐ Hearing difficulty: _____ ☐ Vision problems: _____ ☐ None ☐ Something else: _____
Have you been diagnosed with or are currently being treated for any of the following behavioral health conditions? Please select all that apply.	☐ I have never been diagnosed or treated for any behavioral health conditions ☐ ADHD (attention deficit hyperactivity disorder) ☐ Anxiety ☐ Autism ☐ Bipolar Disorder ☐ Depression ☐ Psychotic disorder (Schizophrenia) ☐ Substance use disorder ☐ Other: _____
Do you use illegal substances or prescription medications not prescribed for you? (such as cocaine, heroin, opioids)	☐ Yes ☐ No ☐ I choose not to answer
In the past year, have you consumed alcohol daily, needed to drink in the morning, or have people annoyed you by criticizing your drinking?	☐ Yes ☐ No ☐ I choose not to answer

Are you interested in assistance from one of our healthy lifestyles programs for weight management or tobacco cessation?	☐ Tobacco Cessation ☐ Weight Management ☐ I am not interested ☐ I choose not to answer

General Health	
Do you have a main health concern right now?	☐ Yes: _____ ☐ No ☐ I choose not to answer
Have you been diagnosed with or are you currently being treated for any of the following health conditions? Please select all that apply.	☐ I have never been diagnosed or treated for any health conditions ☐ Asthma ☐ Cancer (actively being treated) ☐ Cognitive (memory concerns, such as dementia) and/or development limitations ☐ COPD (chronic obstructive pulmonary disease) ☐ Diabetes ☐ Kidney failure/dialysis ☐ Heart failure ☐ Stroke ☐ HIV/AIDS ☐ Liver disease, such as cirrhosis or ascites ☐ High blood pressure ☐ Neurologic disorder (such as epilepsy, multiple sclerosis ☐ Blood disorders (this covers those with anemia, sickle cell or clotting deficiencies) ☐ Other: _____
Do you worry about your memory or have you been told by friends or family that they are worried about your memory?	☐ Yes ☐ No ☐ I choose not to answer
Do you have pain?	☐ Yes ☐ No ☐ I choose not to answer
If yes, where is your pain located?	_____
Rate your pain on a 1-10 scale(10 worst)	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐ I choose not to answer
In the past 6 months, how often have you visited the emergency room or stayed overnight in the hospital?	☐ One time or not at all ☐ 2 to 5 times ☐ more than 6 times ☐ I choose not to answer
Are you taking your medications as prescribed?	☐ Yes ☐ No ☐ I am not prescribed medications ☐ I choose not to answer
Have you fallen in the last 6 months that resulted in medical care?	☐ Yes ☐ No ☐ Unsure
If yes, please describe:	_____

Are you currently pregnant?	☐ Yes ☐ No ☐ Unsure ☐ I choose not to answer ☐ N/A

Service Coordination	
Are you currently receiving any long-term services and supports, such as personal attendant services, day activity services, or emergency services?	☐ Yes ☐ No
Do you need assistance for yourself or your child with any of the following?	☐ I choose not to answer ☐ Bathing/ Showering ☐ Hygiene ☐ Dressing ☐ Walking/ Mobility ☐ Toileting ☐ Eating ☐ Grocery shopping ☐ Meal preparation ☐ Housework/ cleaning ☐ Managing finances ☐ Climbing stairs

Social Determinants of Health	
What is your housing situation today?	☐ 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) ☐ I have housing today, but I am worried about losing housing in the future ☐ I have housing ☐ I choose not to answer
In the past year, have you or any family members you live with been unable to get food when it was really needed?	☐ Yes ☐ No ☐ 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.	☐ Yes, it has kept me from medical appointments or getting medications ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things I need ☐ No ☐ I choose not to answer
Do you feel physically and emotionally safe where you currently live?	☐ Yes ☐ No ☐ Unsure ☐ I choose not to answer
In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.	☐ Clothing ☐ Utilities ☐ Child Care ☐ Medicine or any healthcare (medical, dental, mental health, vision)

	☐ Phone ☐ Money ☐ Training/ Employment ☐ Other ☐ I choose not to answer

Future Medical Care	
Do you have a living will or an advanced directive in place (a document of your medical care wishes if you are unable to provide them)?	☐ Yes ☐ No
Do you want information on living wills and advanced directives?	☐ Yes ☐ No

Behavioral Health	
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 ☐ I choose not to answer
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 ☐ I choose not to answer
In the past year, have you thought about harming yourself?	☐ Yes ☐ No ☐ I choose not to answer
Do you currently have any thoughts about harming yourself?	☐ Yes ☐ No ☐ I choose not to answer

SEND PAPER HRAs to: MolinaBrokerHRA@molinahealthcare.com