Member Health Risk Assessment

Member Information

Member Name*		Member Date of Birth*	Age
Member Address			
Member Phone #	Member ID #	Emergency Contact Name & Phone #	
Date Completed:	Who is Completing This Form for You?		

Health Assessment **All Required*

1. What is your gender?

   ☐ Male ☐ Female ☐ Other: ______________________

2. What is your race or ethnicity?

   ☐ African American ☐ American Indian or Alaskan Native
   ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ White Non-Hispanic
   ☐ Hispanic or Latino ☐ Multiracial ☐ Other ______________

3. What is your highest level of education?

   ☐ Elementary School (K-5) ☐ Middle School (6-8) ☐ High School (9-12)
   ☐ High School graduate ☐ Some College ☐ College Graduate
   ☐ Graduate School ☐ Vocational/Trade School ☐ GED
   ☐ N/A

4. What is your preferred language to speak at home?

   ☐ English ☐ Spanish ☐ Other ______________________

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BY MOLINA HEALTHCARE

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5. What is your living situation?
   - ☐ Own ☐ Live with family ☐ Rent ☐ Homeless ☐ Live with friends
   - ☐ Other ______________________________

6. Are you currently pregnant?
   - ☐ Yes ☐ No

7. Have you had at least one well visit with your primary care provider in the last year?
   - ☐ Yes ☐ No ☐ I don't have a primary care provider

8. For children/youth ages birth through 18 years of age, do you understand what vaccines (shots) are needed and are you up to date on shots?
   - ☐ I'd like information ☐ I am up to date on shots ☐ Other ____________________ ☐ N/A

9. Has a doctor ever told you that you have the following?
   - ☐ Diabetes ☐ High blood pressure ☐ Heart disease ☐ Kidney disease ☐ Cancer
   - ☐ Asthma ☐ COPD ☐ Allergies ☐ HIV/AIDS ☐ Hepatitis
   - ☐ Schizophrenia ☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ ADHD
   - ☐ Autism Spectrum Disorder ☐ Developmental Delay ☐ N/A ☐ Other

10. Over the last two 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

11. Over the last two weeks, how often have you been feeling down, depressed or hopeless?
    - ☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day

12. In the last two weeks, have you thought about harming yourself?
    - ☐ Yes ☐ No

13. Do you currently take prescription medicine?
    - ☐ Yes ☐ No

    If yes, do you understand what your medications are for and why you are taking them?
    - ☐ Yes ☐ No

14. Do you currently use any of the following?
    - ☐ Hearing aids ☐ Glasses or contact lenses ☐ Wheelchair or walker
    - ☐ Other assistive devices ☐ N/A

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15. How often do you exercise?

☐ 2-3 times per week ☐ Once per week ☐ Rarely ☐ Never

16. Do you use drugs or alcohol?

☐ Yes ☐ No

If yes:

Have you ever felt that you ought to cut down on your drink or drug use?

☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use?

☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use?

☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?

☐ Yes ☐ No

17. How often do you use alcohol?

☐ Every day ☐ Two or more days per week ☐ Rarely ☐ Never

☐ Other

18. Do you use cigarettes or nicotine products such as e-cigarettes/vape or dip/chew?

☐ Yes ☐ No ☐ I would like help quitting

19. In general, how would you rate your overall health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

20. Stress is when you feel tense, nervous or anxious, or you can't sleep at night because your mind is troubled. How stressed would you say you are?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

☐ I choose not to answer this question

21. How often do you see or talk to people you care about? *(For Example: Talking to friends on the phone, visiting friends or family, going to church or club meetings)*

☐ Less than once per week ☐ 1-2 times per week ☐ 3-5 Times per week

☐ 5 or more times per week ☐ I choose not to answer this question

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22. Do you need help with any of the following? *(Mark all that apply)*

☐ Food ☐ Clothing ☐ Housing ☐ Employment
☐ Mobility ☐ Getting to medical appointments ☐ Safety ☐ N/A

23. Do you need help with performing any of the following daily activities?

☐ Accessing medication ☐ Bathing ☐ Eating ☐ Dressing
☐ Shopping ☐ Managing finances ☐ N/A

24. Are you experiencing challenges at school or at work with which you would like assistance?

☐ Yes ☐ No

25. Compared to one year ago, my health is worse.

☐ Yes ☐ No

26. Have you received dental care as recommended in the past year? (At least one visit to the dentist for adults 21 and over and at least every 6 months for children ages 1-20.)

☐ Yes ☐ No

27. Have you been to the emergency room in the last three months?

☐ Yes ☐ No

If yes, how many times have you been to the ER in the last three months?

____

28. Have you been admitted ot the hospital in the last three months?

☐ Yes ☐ No

If yes, how many times have you been admitted to the hospital in the last three months?

____

29. Would you like your health plan to contact you about any other health concerns?

☐ Yes ☐ No

Send us your completed Health Risk Assessment Form (HRA):

Email: CareManagement_KY@passporthealthplan.com

Mail to:
Passport Health Plan by Molina Healthcare
Attn: Care Management Dept.
5100 Commerce Crossing Drive Louisville, KY 40229

If you need help filling out your HRA, call us at 1-833-959-2398.

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