

Health Risk Assessment

This Health Risk Assessment is voluntary and your answers will not affect your enrollment or coverage.

Member's first name:	Member's last name:	Middle initial:
Clever Care member ID number:	Date of birth:	HRA completion date:
Member phone number:	Primary Care Provider (PCP)/Doctor name:	
How was the HRA completed:		
☐ Telephone ☐ Face-to-Face ☐ Telehealth/Virtual ☐ Paper		
If applicable, list all individuals who helped complete this form (i.e. provider, family member, friend, broker):		
Name(s):	Relationship to member:	
Broker Name:	Broker NPN:	

Information About Me

1. Please describe any cultural, religious, or personal preferences that should be considered in your care.

2. a. What is your current living situation?

- ☐ I have a stable place to live
☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park). Explain: _____

b. Are you worried about losing your housing?

- ☐ No
 ☐ Yes, explain: _____

3. Who do you currently live with?

- ☐ Living alone
 ☐ Living with spouse, family or friend (Name: _____)
☐ Other: _____

4. Do you feel safe in your current living situation?

- ☐ Yes
 ☐ No, explain: _____

5. In the past 12 months, how often did transportation issues prevent you from getting medical care?

- ☐ Never
 ☐ Sometimes
 ☐ Usually
 ☐ Always

6. In the past 12 months, were you unable to obtain basic needs? (Select all that apply)

- ☐ Food ☐ Utilities ☐ Phone ☐ Clothing
☐ Health care (medical, dental, mental health, vision)
☐ Other: _____ ☐ None

7. Do you have an Advance Directive or Living Will in place to ensure your medical wishes are followed if you are ever unable to speak for yourself (e.g., due to illness or injury)?

- ☐ Yes, my wishes are documented in an Advance Directive or Living Will.
☐ No, I do not currently have written instructions or documentation in place.

Pain Screening

8. In the past 2 weeks, have you had pain?

☐ No

☐ Yes → **At its worst, how severe is your pain (0 to 10 with 10 being the worst)?**



☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have you talked to your doctor or someone else about how to manage your pain?

- ☐ Yes, who? _____
☐ No

9. Please select if you use any of the following equipment:

- ☐ Don't have/use any equipment
☐ Dentures ☐ Medical alert device ☐ Lift chair
☐ Hearing aid ☐ Transfer equipment ☐ Glasses/contact lenses
☐ Bedside commode ☐ Incontinence supplies (pads, liners) ☐ Bathing equipment
☐ Walker/Cane ☐ Wheelchair (manual, electric)
☐ Other: _____
☐ List equipment you need but do not have: _____

Communication Connections

10. In the past 6 months, how well do you feel you've been able to communicate your health care needs or concerns to your providers/doctors?

- ☐ Very well ☐ Sometimes well ☐ Not well

11. In the past 6 months, how often were instructions from your providers/doctors easy to understand?

- ☐ Always, I had no trouble understanding ☐ Sometimes, I had trouble understanding ☐ Never, I had trouble understanding

12. What is the highest level of school that you have finished?

- ☐ More than high school degree ☐ High school diploma/GED ☐ Less than high school degree

My Health

13. In general, how would you rate your overall health? (Select one)

☐  Excellent

☐  Good

☐  Fair

☐  Poor

14. Over the past two weeks, how often have you been bothered by any of the following problems?

	 Not at all	 Several days	 More than half of the days	 Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐

15. In the past 12 months, have you had problems with memory or thinking?

☐ Yes

☐ No

☐ Unsure

16. How often do you feel lonely or isolated?

☐ Never

☐ Sometimes

☐ Often

17. Do you have someone you can rely on for help if needed?

☐ Yes

☐ No

18. In the past 4 weeks, how much stress have you experienced?

☐ Not at all

☐ Somewhat

☐ Quite a bit

19. Please list all medications, frequency, and dosage you are taking, including alternative therapy and herbal medicines.

Medication Name	Dosage/Strength	How often are you taking it?

20. How often do you take your medications as prescribed?

☐ Always

☐ Usually

☐ Never → What prevents you from taking your medications as prescribed? _____

21. Do you have any of the following listed health problems? Select all that apply.

Autoimmune disorders

- ☐ Dermatomyositis
- ☐ Polyarteritis nodosa
- ☐ Polymyalgia rheumatica
- ☐ Polymyositis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid arthritis
- ☐ Scleroderma
- ☐ Systemic lupus erythematosus

☐ **Cancer** (actively monitoring)

Cardiovascular disorders

- ☐ Cardiac arrhythmias
- ☐ Chronic heart failure
- ☐ Coronary artery disease
- ☐ Peripheral vascular disease
- ☐ Valvular heart disease
- ☐ Chronic venous thromboembolic disorder

☐ **Chronic alcohol or drug dependency**

Chronic and disabling mental health conditions

- ☐ Bipolar disorders
- ☐ Major depressive disorders
- ☐ Paranoid disorder
- ☐ Schizophrenia
- ☐ Schizoaffective disorder

Chronic gastrointestinal disease

- ☐ Pancreatitis
- ☐ Inflammatory bowel disease

Chronic kidney disease/ESRD

- ☐ Must be on dialysis

Chronic lung disorders

- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Emphysema

Conditions associated with cognitive impairment

- ☐ Dementia
- ☐ Alzheimer's

Conditions with functional challenges

- ☐ Spinal cord injuries
- ☐ Paralysis
- ☐ Arthritis

☐ **Diabetes**

☐ **Hepatitis B** or ☐ **Hepatitis C**

Immunodeficiency and Immunosuppressive disorders

- ☐ HIV/AIDS

Neurologic disorders

- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Spinal Cord Injury
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
- ☐ Huntington's disease
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Polyneuropathy
- ☐ Spinal stenosis
- ☐ Stroke or related neurologic deficit

☐ **Non-alcoholic fatty liver disease**

☐ **Post-organ transplantation care**

Severe hematologic disorders

- ☐ Aplastic anemia
- ☐ Hemophilia
- ☐ Immune thrombocytopenic purpura
- ☐ Myelodysplastic syndrome
- ☐ Sickle-cell disease (excluding sickle-cell trait)

22. How many days a week do you exercise for at least 30 minutes?

- ☐ None ☐ One or two ☐ Three or four ☐ Five or more

23. In the past 12 months, how many times did you visit the emergency room or stay in the hospital?

- ☐ None ☐ One or two ☐ Three or more

24. In the past 12 months, how many times have you fallen?

- ☐ None ☐ One or two ☐ Three or more

25. Do you have any safety concerns in your home, such as unsecured rugs, poor lighting, unsafe stairs/bathrooms, or non-working smoke and carbon monoxide detectors?

- ☐ No ☐ Yes, explain: _____

My Everyday Life

26. Caregiver: Is there someone who regularly helps you care for your home or yourself, or regularly helps with errands or other things (such as family, friend, home care)? What is the caregiver's phone number?

☐ No

☐ Yes, caregiver name: _____

caregiver phone: _____

27. What is your ability to complete these tasks?

	 I don't need help	 I need some help or use equipment	 I always need help
Bathing	☐	☐	☐
Grooming	☐	☐	☐
Getting dressed	☐	☐	☐
Getting to and from the toilet	☐	☐	☐
Transferring in and out of chair or bed	☐	☐	☐
Walking, not climbing stairs	☐	☐	☐
Shopping	☐	☐	☐
Preparing meals	☐	☐	☐
Feeding yourself	☐	☐	☐
Using the telephone	☐	☐	☐
Housekeeping	☐	☐	☐
Laundry	☐	☐	☐

Alcohol/Tobacco

28. Do you drink alcohol?

☐ No

☐ Yes, are you interested in quitting or reducing your intake?

☐ Yes

☐ No

29. Do you currently use tobacco products (cigarettes, cigars, snuff, chew, vape, electronic cigarettes)?

☐ No

☐ Yes, are you interested in quitting or reducing your intake?

☐ Yes

☐ No

Health Goals

30. What are your health goals? (Select at least one)

- ☐ Follow a nutritious and healthy diet to maintain or improve my health
- ☐ Complete an annual wellness exam with my primary care provider (PCP)/doctor
- ☐ Work on maintaining or increasing my balance and strength to avoid falls
- ☐ Talk with my doctor to develop a regular exercise plan
- ☐ Other personalized goal: _____

31. How confident are you in achieving your goals?

- ☐ Very confident ☐ Somewhat confident ☐ Not confident

32. Are there any barriers that make it hard to achieve your goal(s)?

- ☐ No
- ☐ Yes – Select all that apply:
 - ☐ Transportation
 - ☐ Lack of time
 - ☐ Other _____
 - ☐ Lack of motivation
 - ☐ Lack of resources/equipment