Clever Care HEALTH PLAN

Health Risk Assessment

Member's first name:	Member's last name:	Middle initial:
Clever Care member MBI number:	Date of birth:	HRA completion date:
Email address:	Member phone number:	
Primary Care Provider (PCP) name:	How was the HRA completed: ☐ Telephone ☐ Face-to-Face ☐ Telehealth/Virtual	
Broker Name:	NPN of the person completing the form:	

Information About Me

Please describe anything related to your culture, beliefs, religious practices, or anything else important to you that would help us serve you better.

1. What is your current housing situation?

☐ I have a stable place to live

Are you worried about losing your housing?

☐ No ☐ Yes, explain: _____

☐ 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: _____

2. Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No

3. Who do you currently live with?

☐ Living alone ☐ Living with spouse, family or friend

☐ Other (explain):

_____

4. In the past year, have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ N/A

5. **Are you currently employed?**

☐ Yes ☐ No

6. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living.**

☐ Yes, it has kept me from medical appointments.

☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things I need such as groceries.

☐ No

7. **In the past year, have you or any family members you live with been unable to get any of the following due to lack of money, access, or availability when needed? Select all that apply.**

☐ Food ☐ Medicine ☐ Child/elder care

☐ Utilities ☐ Phone ☐ Clothing

☐ Healthcare (medical, dental, mental health, vision)

☐ Other: _____

☐ None

8. **Do you have an Advance Directive in place?** (a way to make sure that your designated medical power of attorney is able to communicate your medical wishes if you cannot speak for yourself)

☐ Yes ☐ No

Pain Screening

9. **Are you experiencing any pain now or in the last two weeks?**

☐ 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

☐ No

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

☐ Dentures ☐ Medical alert device ☐ Lift chair

☐ Brace (leg, back) ☐ Transfer equipment ☐ Cane

☐ Incontinence supplies (pads, liners) ☐ Glasses/contact lenses ☐ Adaptive eating equipment

☐ Bathing equipment ☐ Walker ☐ Bedside commode

☐ Hearing aid ☐ Wheelchair (manual, electric)

☐ Other: _____

☐ Doesn't have/use any equipment

☐ List equipment you need but do not have: _____

Communication Connections

11. How well do you feel you can communicate your health care needs or concerns to your providers (including in-home, medical, and mental health providers)?

- ☐ Excellent, no issues
- ☐ Good, I feel confident I am communicating well most of the time
- ☐ Fair, I can communicate some but not all needs or concerns
- ☐ Poor, I usually have trouble understanding

Explain: _____

12. Do you have trouble understanding healthcare providers instructions regarding your healthcare?

- ☐ Excellent, I have no trouble understanding
- ☐ Good, I rarely have trouble understanding
- ☐ Fair, I sometimes have trouble understanding
- ☐ Poor, I usually have trouble understanding

Explain: _____

13. 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

14. Overall, how would you rate your health? (Please select one.)

☐  Excellent ☐  Good ☐  Fair ☐  Poor

15. 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
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

16. How often do you feel lonely or isolated from those around you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

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

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

- ☐ Heart disease (heart attack, heart failure)
- ☐ High blood pressure
- ☐ Diabetes (high blood sugar)
- ☐ Lung disease (asthma, COPD)
- ☐ Mental health (depression, anxiety)
- ☐ Other (stroke, thyroid, cancer): _____

19. Please list the medications, frequency, and dosage you are taking, including over-the-counter and supplements.

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

20. Do you have any drug allergies?

☐ No ☐ Yes, list: _____

21. Do you use any alternative therapy or herbal medicines to treat your health conditions?

☐ No ☐ Yes

If yes, which ones and what do they help with _____

If yes, is your doctor aware you use this therapy? ☐ Yes ☐ No

22. Do you understand your medications and why you take them?

☐ Yes ☐ No, why? _____

23. Within the last 6 months have you had difficulty in obtaining medications prescribed to you?

☐ No ☐ Yes, why? _____

24. Are you physically active? (e.g., walking, group classes, stationary bike, etc.)

☐ No ☐ Yes

If yes, how many days and minutes to engage in physical activity:

	15 minutes	30 minutes	45 minutes	1 hour or more
Every day	☐	☐	☐	☐
Once a week	☐	☐	☐	☐
Twice a week	☐	☐	☐	☐
Three times a week	☐	☐	☐	☐

25. In the past year, have you stayed overnight or longer in a hospital?

☐ No ☐ Yes, how many times? Why? _____

26. In the past year, did you go to a hospital emergency room?

☐ No ☐ Yes, how many times? Why? _____

27. In the past year, have you spent time in a nursing facility?

☐ No ☐ Yes, how many times? Why? _____

28. In the last 12 months have you experienced any falls in your home or while out in the community?

☐ No ☐ Yes, how many times? Why? _____

My Everyday Life

29. 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)?

☐ No ☐ Yes, caregiver name: _____

30. 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	☐	☐	☐
Managing your medications	☐	☐	☐
Managing your household finances	☐	☐	☐

Alcohol/Tobacco

31. Do you drink alcohol?

☐ No ☐ Yes

If yes: Are you interested in quitting or reducing your intake? ☐ Yes ☐ No

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

☐ No ☐ Yes

If yes: Are you interested in quitting or reducing your intake? ☐ Yes ☐ No

Health Goals

33. What are your health goals for everyday life? Please select at least one of the health goals listed below.

- ☐ Complete an annual wellness exam with my primary care provider (PCP)
- ☐ Volunteer for a local organization, such as the library, an animal shelter, or soup kitchen
- ☐ Work on maintaining or increasing my balance and strength to avoid falls
- ☐ Talk with my doctor to develop a regular exercise plan
- ☐ Follow a nutritious and healthy diet to maintain or improve my health
- ☐ Other personalized goal _____

34. Are there any barriers that may keep you from accomplishing your goal(s)?

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

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