Clever Care HEALTH PLAN

Health Risk Assessment

Please answer all questions below

Member first name	Member last name	Member MI
DOB (mm/dd/yyyy)	Member ID	Date of HRA
Name of the person and contact number (if this assessment was not completed by member)	Signature	
Primary Care Provider		

Do you use any of the following at home?

☐ Tablet ☐ Smartphone ☐ Cell phone ☐ Computer ☐ Cable ☐ TV ☐ None

Do you have access to the internet at home? ☐ Yes ☐ No

Are you open to virtual/telehealth visits with your case manager? ☐ Yes ☐ No

INFORMATION ABOUT ME

1. My primary language?

☐ Armenian	☐ English	☐ Mandarin	☐ Thai
☐ Cambodian	☐ Japanese	☐ Spanish	☐ Vietnamese
☐ Cantonese	☐ Korean	☐ Tagalog	☐ Other: _____

2. I need interpreter services. ☐ Yes ☐ No

a. If yes, were interpreter services provided during this assessment? ☐ Yes ☐ No

3. My current living situation today is:

☐ I have a steady place to live

☐ I have a place to live today, but I am worried about losing it in the future

☐ I do not have a steady place to live

4. Is there a friend, relative, or neighbor who would take care of you for a few days if necessary?

☐ Yes ☐ No

5. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY

- ☐ Pests such as bugs, ants, or mice
- ☐ Lead paint or pipes
- ☐ Oven or stove not working
- ☐ Water leaks
- ☐ Mold
- ☐ Lack of heat
- ☐ Smoke detectors missing or not working
- ☐ None of the above

6. What is the highest level of education you completed?

- ☐ 8th grade or lower
- ☐ Some high school
- ☐ High school graduate or GED
- ☐ Some college/2-year college
- ☐ 4-year college
- ☐ More than 4-year college

7. Do you have trouble understanding instructions at the doctor's office? ☐ Yes ☐ No

8. In the last 12 months, have you stayed overnight as a patient in the hospital?

☐ No ☐ 1–2 times ☐ 3–5 times ☐ >6 times

9. Do you have an Advance Directive? ☐ Yes ☐ No

MY EVERYDAY LIFE

10. For each section, please select the answer that describes you the most:

Feeding

☐ Unable ☐ Needs help cutting, spreading butter, etc., or requires modified diet ☐ Independent

Bathing

☐ Dependent ☐ Independent

Grooming

☐ Needs help with personal care ☐ Independent face/hair/teeth/shaving (implements provided)

Bowel

☐ Incontinent (or needs to be given enemas) ☐ Occasional accident ☐ Continent

Bladder

☐ Incontinent, or catheterized and unable to manage alone ☐ Occasional accident ☐ Continent

Toilet Use

☐ Dependent ☐ Needs some help, but can do something alone
☐ Independent (on and off, dressing, wiping)

Transfers (Bed to Chair and Back)

☐ Unable, no sitting balance ☐ Major help (one or two people, physical), can sit
☐ Minor help (verbal or physical) ☐ Independent

Mobility (On Level Surfaces)

☐ Immobile or < 50 yards ☐ Wheelchair independent, including corners, > 50 yards
☐ Walks with help of one person (verbal or physical) > 50 yards
☐ Independent (but may use any aid; for example, stick) > 50 yards

Stairs

☐ Unable ☐ Needs help (verbal, physical, carrying aid) ☐ Independent

11. 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?

- ☐ Food
- ☐ Utilities
- ☐ Clothing
- ☐ Child/elder care
- ☐ Medicine
- ☐ Phone
- ☐ Healthcare (medical, dental, mental health, vision)
- ☐ Other _____

12. Has lack of transportation kept you getting to and from medical appointments, picking up medications, and/or shopping for groceries? ☐ Yes ☐ No

RELATIONSHIPS AND COMMUNICATION CONNECTIONS

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

a. ☐ Never b. ☐ Rarely c. ☐ Sometimes d. ☐ Often e. ☐ Always

MY HEALTH CONCERNS

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

☐ Excellent ☐ Good ☐ Fair ☐ Poor

15. Do you have any health problems? Check all health conditions you know of.

- ☐ None
- ☐ Dementia
- ☐ Diabetes
- ☐ Cancer Type: _____
- ☐ Cardiovascular disease/high blood pressure
- ☐ Pulmonary disease (asthma/COPD)
- ☐ Mental health
- ☐ Other: _____

16. What are your health goal(s)?

- ☐ Decreased risk of disease
- ☐ Better management of chronic disease
- ☐ Easier breathing and sleeping
- ☐ Improved mobility and stamina
- ☐ Weight management
- ☐ Less pain
- ☐ Improved mental health
- ☐ Other _____

17. What would motivate you to reach your health goal?

- ☐ Pain management
- ☐ Praise and support to help build confidence
- ☐ Other _____
- ☐ Gym membership
- ☐ Feeling more comfortable in clothing/self

18. Pain Screening

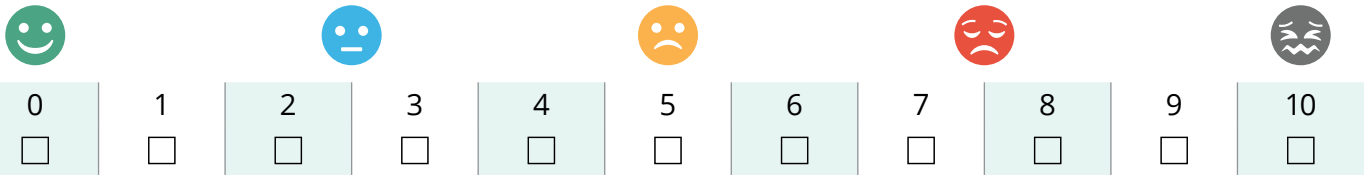
Are you experiencing any pain now or in the last 2 weeks? ☐ Yes ☐ No (If no skip to question 19)

Has your pain affected your function or quality of life (e.g., activity level, mood, relationships, sleep or work)? ☐ Yes ☐ No

How often do you experience pain?

☐ Constantly ☐ Several times a day ☐ A few times a week ☐ Sometimes

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 about your pain? ☐ Yes ☐ No

SPECIAL EQUIPMENT/ASSISTIVE DEVICES I USE OR NEED

19. Do you have or need any of the following equipment?

	Yes	Needs		Yes	Needs
Dentures	☐	☐	Supplies e.g., incontinence pads	☐	☐
Cane	☐	☐	Bedside commode	☐	☐
Walker	☐	☐	Bathing equipment	☐	☐
Wheelchair (manual, electric)	☐	☐	Transfer equipment	☐	☐
Lift chair	☐	☐	Adaptive eating equipment	☐	☐
Hearing aids	☐	☐	Other (Specify) _____	☐	☐
Medical phone alert	☐	☐	None ☐		

MY ALCOHOL/TOBACCO/SUBSTANCE USE

20. How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

☐ Never ☐ Weekly
☐ Once or twice ☐ Daily or almost daily
☐ Monthly

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

☐ No ☐ If yes, how much per day and how many years _____

22. How many times in the past year have you used prescription drugs for non-medical reasons or recreational drugs? (methamphetamines, cannabis, barbiturates, cocaine, ecstasy, hallucinogens, or narcotics, etc.)

☐ Never ☐ Weekly
☐ Once or twice ☐ Daily or almost daily
☐ Monthly

23. Have you experienced any falls in the past month? ☐ Yes ☐ No

24. Are you physically active? (e.g., walking, group classes, stationary bike, etc.) ☐ Yes ☐ No

If yes, how many days and minutes do you 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	☐	☐	☐	☐

What is your height? _____ft _____in What is your weight? _____lbs

In the past 6 months, have you lost or gained over 10 pounds without meaning to? ☐ Yes ☐ No

MY EMOTIONAL & MENTAL HEALTH

25. Have you been seen by a mental health provider within the last 6 months?

a. ☐ Yes, describe _____
b. ☐ No

26. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?

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

27. 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	☐	☐	☐	☐

28. Do you, your family/friends have concerns about your memory? ☐ Yes ☐ No

MY SCREENINGS/IMMUNIZATION/VACCINES

29. Have you had a flu shot in the last 12 months?

☐ Yes, where _____ ☐ No

30. Have you received a COVID vaccine?

☐ Yes ☐ No

31. Have you had a pneumonia vaccine?

☐ Yes, when _____ ☐ No

32. Have you had a colonoscopy?

☐ Yes, when & where _____ ☐ No