Health Risk Assessment (HRA) Form

Please email completed form with Subject: "Broker HRA" to CareCoordinationManagement@SCANHealthPlan.com

Broker Information

Agent Name:	Agent NPN:
Agent Email:	Agent Phone:

- *A Health Risk Assessment is a short survey that helps the health plan know more about a member's health, psychosocial status, functional status, cognitive concerns, and mental health.*
- *Additional assessments may be completed.*
- *Information collected from the Health Risk Assessment is used to develop an Individualized Care Plan (ICP), which is shared with the member and member's primary care doctor.*
- *By submitting this form to SCAN, I attest that I performed the HRA and took reasonable measures to make sure that the enrollee understood the purpose of the HRA and the questions being asked, that the HRA accurately captures the enrollee's responses, that I have abided by all the terms and conditions of my contract with SCAN and the HRA instructions, and that the PHI/data collected is subject to the terms of the contract with SCAN.*

☐ *I understand and agree to the above information regarding Health Risk Assessments.*

Today's Date:	Agent Signature:

Member Information

Member Name:	Plan Enrolled:
Date of Birth:	Medicare ID # (MBI):

SCAN Health Survey

The questionnaire is completely optional; your SCAN benefits will not be affected in anyway if you complete and return the questionnaire or choose not to. SCAN will only share the information with your medical group.

Demographic Questions:

1. What is your preferred language?
   ☐ English ☐ Spanish ☐ Other ☐ Prefer not to answer

2. What ethnicity do you identify as?
   ☐ Caucasian/White ☐ Hispanic/Latino ☐ African American/Black
   ☐ Asian ☐ American Indian/Alaska Native ☐ Mixed Race
   ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline

3. What is your sexual orientation? (Who you are attracted to)
   ☐ Lesbian, gay, or homosexual ☐ Straight or heterosexual
   ☐ Bisexual ☐ Other ☐ Decline

4. What is your current gender identity? (How you see yourself)
   ☐ Male ☐ Female ☐ Transgender Male
   ☐ Transgender Female ☐ Not Listed ☐ Decline

Household Questions:

5. What best describes your current living arrangements?
   ☐ Live Alone ☐ Live with other family ☐ Live with others, not family
   ☐ Live with significant other ☐ Live with child ☐ Decline

6. Are you worried about losing your housing?
   ☐ I have stable housing ☐ I do not have housing
   ☐ I have unstable housing ☐ Decline
   ☐ I have concerns about the stability of my housing

7. Do you sometimes run out of money to pay for food, rent, bills, and medicine?
   ☐ Yes, but I can manage ☐ Yes, I have difficulty
   ☐ No ☐ Decline

8. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
   ☐ Yes ☐ No

Health Questions:

9. Compared to other people your age, would you say your health is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

10. How many days a week do you exercise at least 30 minutes?
☐ None ☐ One or Two ☐ Three or four ☐ Five or more

11. During the past 4 weeks, how much did pain interfere with your normal activities or work?
☐ Extremely ☐ Quite a bit ☐ Moderately ☐ Not at all ☐ A little bit

12. Rate the level of your pain on a 1–10 scale, with "1" meaning "no pain" and "10" meaning "extreme pain."
Enter Number: _____

13. Where is your pain (list body parts)?

14. How are you managing your pain (select all that apply)?
☐ Prescription ☐ Over the Counter Medication ☐ Exercise
☐ Physical Therapy ☐ Alternative Therapy ☐ Rest
☐ No Treatment ☐ Other

15. How many times have you fallen to the ground in the last year?
☐ None ☐ One or Two ☐ Three or more

16. In the past year how many times have you gone into an emergency room?
☐ None ☐ One or Two ☐ Three or more

17. Do you need help taking medications?
☐ Yes ☐ No

18. Is there anything that prevents you from taking medications as prescribed (select all that apply)?
☐ Scheduling ☐ I don't believe in medications
☐ Side Effects ☐ Difficulty filling prescriptions
☐ Transportation/Access ☐ Forgetfulness
☐ Not sure how to take ☐ No system for managing
☐ Cost ☐ Other
☐ Visual Problems ☐ Nothing

19. Have you seen your primary care doctor in the last year?
☐ Yes ☐ No

20. Have you had any changes in thinking, remembering, or making decisions?
☐ Yes ☐ No

21. Over the last two weeks, how often have you been bothered by any of the following problems:

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

22. Do you need help with any of these actions/activities?

	Unable to do this activity	Yes, I need assistance	No, I do this myself
a. Walking:	☐	☐	☐
b. Taking a bath or shower:	☐	☐	☐
c. Using the toilet:	☐	☐	☐
d. Eating (able to feed yourself)	☐	☐	☐
e. Dressing	☐	☐	☐

23. Advance healthcare directives are written instructions describing the healthcare you'd like to receive if you're not able to speak for yourself. Do you have written instructions for your care?
☐ Yes ☐ No ☐ Do not know

24. Are you afraid of anyone or is anyone hurting you?
☐ No
☐ Yes*- Please explain _____

_____

* Note to Broker: If yes, follow established protocol for reporting and escalation.

25. What is the best phone number to reach you at?

_____

26. What is your email address?

_____