

Health Risk Assessment (HRA) Form

Please email completed form with Subject: **"Broker HRA"** to BrokerHRA@scanhealthplan.com

Broker Information

Agent Name:	Agent NPN:
Agent Email:	Agent Phone:
<ul style="list-style-type: none"> • 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, that it 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. 	
<input type="checkbox"/> I understand and agree to the above information regarding Health Risk Assessments.	
Today's Date:	Agent Signature:

Member Information

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

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? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to answer	3. What is your sexual orientation? (Who you are attracted to) <input type="checkbox"/> Lesbian, gay, or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Other <input type="checkbox"/> Decline
2. What ethnicity do you identify as? <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Mixed Race <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline	4. What is your current gender identity? (How you see yourself) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Not Listed <input type="checkbox"/> Decline

Household Questions:

5. What best describes your current living arrangements? <input type="checkbox"/> Live Alone <input type="checkbox"/> Live with other family <input type="checkbox"/> Live with others, not family <input type="checkbox"/> Live with significant other <input type="checkbox"/> Live with child <input type="checkbox"/> Decline	7. Do you sometimes run out of money to pay for food, rent, bills, and medicine? <input type="checkbox"/> Yes, but I can manage <input type="checkbox"/> Yes, I have difficulty <input type="checkbox"/> No <input type="checkbox"/> Decline
6. Are you worried about losing your housing? <input type="checkbox"/> I have stable housing <input type="checkbox"/> I do not have housing <input type="checkbox"/> I have unstable housing <input type="checkbox"/> Decline <input type="checkbox"/> I have concerns about the stability of my housing	8. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? <input type="checkbox"/> Yes <input type="checkbox"/> No

Health Questions:																												
9. Compared to other people your age, would you say your health is: <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	20. Have you had any changes in thinking, remembering, or making decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No																											
10. How many days a week do you exercise at least 30 minutes? <input type="checkbox"/> None <input type="checkbox"/> One or Two <input type="checkbox"/> Three or four <input type="checkbox"/> Five or more	22. Over the last two weeks, how often have you been bothered by any of the following problems:																											
11. During the past 4 weeks, how much did pain interfere with your normal activities or work? <input type="checkbox"/> Extremely <input type="checkbox"/> Quite a bit <input type="checkbox"/> Moderately <input type="checkbox"/> Not at all <input type="checkbox"/> A little bit	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%;">Not at all</th> <th style="width: 10%;">Several days</th> <th style="width: 10%;">More than half the days</th> <th style="width: 10%;">Nearly every day</th> </tr> </thead> <tbody> <tr> <td>a. Little interest or pleasure in doing things?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Feeling down, depressed, or hopeless?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>					Not at all	Several days	More than half the days	Nearly every day	a. Little interest or pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Feeling down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
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12. Rate the level of your pain on a 1–10 scale, with “1” meaning “no pain” and “10” meaning “extreme pain.” Enter Number: _____	22. Do you need help with any of these actions/activities?																											
13. Where is your pain (list body parts)?	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 15%;">Unable to do this activity</th> <th style="width: 15%;">Yes, I need assistance</th> <th style="width: 10%;">No, I do this myself</th> </tr> </thead> <tbody> <tr> <td>a. Walking:</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Taking a bath or shower:</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Using the toilet:</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. Eating (able to feed yourself)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. Dressing</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>					Unable to do this activity	Yes, I need assistance	No, I do this myself	a. Walking:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Taking a bath or shower:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Using the toilet:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Eating (able to feed yourself)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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14. How are you managing your pain (select all that apply)? <input type="checkbox"/> Prescription <input type="checkbox"/> Over the Counter Medication <input type="checkbox"/> Exercise <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Alternative Therapy <input type="checkbox"/> Rest <input type="checkbox"/> No Treatment <input type="checkbox"/> Other	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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know																											
15. How many times have you fallen to the ground in the last <input type="checkbox"/> None <input type="checkbox"/> One or Two <input type="checkbox"/> Three or more	24. Are you afraid of anyone or is anyone hurting you? <input type="checkbox"/> No <input type="checkbox"/> Yes* - Please explain _____ _____																											
16. In the past year how many times have you gone into an emergency room? <input type="checkbox"/> None <input type="checkbox"/> One or Two <input type="checkbox"/> Three or more	* Note to Broker: If yes, follow established protocol for reporting and escalation.																											
17. Do you need help taking medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	25. What is the best phone number to reach you at? _____																											
18. Is there anything that prevents you from taking medications as prescribed (select all that apply)? <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Scheduling </div> <div style="width: 50%;"> <input type="checkbox"/> I dont believe in medications </div> <div style="width: 50%;"> <input type="checkbox"/> Side Effects </div> <div style="width: 50%;"> <input type="checkbox"/> Difficulty filling prescriptions </div> <div style="width: 50%;"> <input type="checkbox"/> Transportation/Access </div> <div style="width: 50%;"> <input type="checkbox"/> Forgetfulness </div> <div style="width: 50%;"> <input type="checkbox"/> Not sure how to take </div> <div style="width: 50%;"> <input type="checkbox"/> No system for managing </div> <div style="width: 50%;"> <input type="checkbox"/> Cost </div> <div style="width: 50%;"> <input type="checkbox"/> Other </div> <div style="width: 50%;"> <input type="checkbox"/> Visual Problems </div> <div style="width: 50%;"> <input type="checkbox"/> Nothing </div> </div>	26. What is your email address? _____																											
19. Have you seen your primary care doctor in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No																												