

## HEALTH RISK ASSESSMENT (HRA)

**ATTENTION: IF YOU HAVE COMPLETED AND SUBMITTED THIS FORM TO US, YOU DON'T NEED TO COMPLETE IT AGAIN.**

Dear Member,

Answering the questions below helps us to find ways to help you continue to feel good and improve your health. Please answer as many questions as you can and return this form in the attached pre-paid envelope. **Get \$10 in your Rewards Plus Card when you mail us your completed HRA!**

<b>MBI#</b>	<b>MEMBER ID#</b>	<b>EFFECTIVE DATE</b>	<b>HOME PHONE</b>	<b>PLAN</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>FIRST NAME</b>	<b>LAST NAME</b>	<b>DATE OF BIRTH</b>	<b>GENDER</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	
<b>ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>CELL PHONE NUMBER</b>	<b>EMAIL ADDRESS</b>			
<input type="text"/>	<input type="text"/>			

I authorize Brand New Day to send me information about my plan

What is your preferred method of communication?  CELL PHONE  EMAIL

**PRIMARY CARE DOCTOR**

## SALES AGENT INFORMATION

If someone helped you fill out this application he/she must complete the information below and sign:

**NAME OF STAFF/AGENT/BROKER (print name)**

**SIGNATURE**

**DATE**

**RELATIONSHIP TO ENROLLEE**

**DATE**

**AGENT PHONE NUMBER**

**AGENT LICENSE NUMBER**

**FMO**

## SECTION A: MEDICAL

A1: In general how would you rate your health?  Excellent  Very Good  Good  Fair  Poor

A2: In the last 12 months, have you stayed overnight as a patient in the hospital?

No  1-2 times  3-5 times  >6 months

A3: How often do you exercise per week?  >5 days  4-3 days  2-1 days  Seldom  Never

A4: What is your height?  A5: What is your weight?  lbs

A6: Without wanting to, I have lost or gained 10 lbs in the last six months?  Yes  No

A7: Have you received a Flu Shot this year?  Yes  No

A8: Have you had a Pneumonia Vaccine?  Yes  No

If Yes, when

A9: Have you had a Colonoscopy?  Yes  No

When:  Where:

A10: Are you using home health services?  Yes  No

A11: Have you fallen in the past month?  Yes  No

A12: Has your doctor told you that you have:

Cancer  Dementia  Diabetes/High Blood Sugar  Mental Health Problems

A13: Do you have a mother, father, sister, or brother with Diabetes?  Yes  No

A14: On average how many cigarettes did you smoke per day?

A15: How many years have you smoked?

A16: Are you currently using Durable Medical Equipment or medical devices?  Yes  No

A17: If yes to A16, please specify which equipment or medical devices below:

Wheelchair  Walker  Cane  Commode

Pressure Mattress  Hospital Bed  Toilet Seats  Diapers

CPAP machine/Sleep Apnea  Oxygen  Bath Chair  Catheters

Other:

A18: What medication allergies do you have?

A19: Do you sometimes forget to take your medicine?  Yes  No

A20: What medications do you take?

## SECTION B: BEHAVIORAL HEALTH

For **B1** & **B2**, over the last 2 weeks, how often have you been bothered by any of the following problems?

**B1:** Little interest or pleasure in doing things:

Not at all     More than half the days     Several days     Nearly everyday

**B2:** Feeling down, depressed, or hopeless:

Not at all     More than half the days     Several days     Nearly everyday

**B3:** Do your family / friends have concerns about your memory?

Yes     No

**B4:** Have you ever attended an Alcoholics Anonymous or Narcotics Anonymous meeting?

Yes     No

**B5:** Are you currently in recovery for alcohol or substance use?

Yes     No

**Alcohol:**

One drink =



12 oz.  
Beer



5 oz.  
Wine



1.5 oz.  
liquor  
(one shot)

None    1 or more

**B6: Men:** How many times in the past year have you had 5 or more drinks in a day?

  

**B7: Women:** How many times in the past year have you had 4 or more?

  

Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

None    1 or more

**B8:** How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?

  

**B9:** How often do you feel that you lack companionship?

Hardly ever     Some of the time     Often

**B10:** How often do you feel left out?

Hardly ever     Some of the time     Often

**B11:** How often do you feel isolated from others?

Hardly ever     Some of the time     Often

## SECTION C: ACTIVITIES OF DAILY LIVING

**C1:** Do you:  Snore  Stop breathing while sleeping  N/A

**C2:** Has your sleepiness ever:  Resulted in a car crash  Led to a near-miss while driving  N/A

**C3:** At night do you:

Wake up gasping or choking

Have frequent awakenings

Wake up to go to the bathroom

N/A

**C4:** During the day, do you:

Feel sleepy or "doze off" without meaning to?

Have headaches in the morning?

Have difficulty with memory or concentrating?

N/A

**C5:** Do you live in:

An independent house, apartment, condo, or mobile home

A nursing home

An assisted living apartment or board and care home

N/A

**C6:** Who do you live with? \_\_\_\_\_

**C7:** Is there a friend, relative, or neighbor who would take care of you for a few days if necessary?

Yes  No **NAME:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**C8:** Do you have transportation to and from your doctor's appointments?

Yes  No

**C9:** Do you have an Advance Directive?

Yes  No

**C10:** Do you have a POLST - Physician Orders for Life Sustaining Treatment?

Yes  No

**SECTION D: FUNCTIONAL ASSESSMENT****D1: BATHING**

- Bathes self completely or needs help in bathing single part of body  1
- Needs help with bathing more than one part of the body, getting in/out of the tub  0

**D2: DRESSING**

- Gets clothes from closet, drawers and puts on clothes with fasteners; may have help tying shoes  1
- Needs help with dressing self or needs to be completely dressed  0

**D3: TOILETING**

- Goes to toilet, gets on and off, arranges clothes, cleans the genital area without help  1
- Needs help transferring to the toilet, cleaning self or uses bedpan or commode  0

**D4: TRANSFERRING**

- Moves in and out of bed or chair unassisted (mechanical transferring aides are acceptable)  1
- Needs help in moving from bed to chair or requires a complete transfer  0

**D5: CONTINENCE**

- Exercises complete self-control over urination and defecation  1
- Is partially or totally incontinent of bowel or bladder  0

**D6: FEEDING**

- Gets food from plate into mouth without help (Preparation of food may be done by another)  1
- Needs partial or total help with feeding or requires parenteral feeding  0

**TOTAL POINTS**

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