BRAND NEW DAY
ATTN: REWARDS PLUS PROGRAM
PO BOX 93122
LONG BEACH, CA 90809-9871

brand new day
HEALTHCARE YOU CAN FEEL GOOD ABOUT

IMPORTANT PLAN INFORMATION
<MEM_FIRST_NAME> <MEM_LAST_NAME>
<MEM_ADDR1>
<MEM_ADDR2>
<MEM_CITY>, <MEM_STATE> <MEM_ZIP>

<PROCESS_DATE>

2ND ATTEMPT

Dear <MEM_FIRST_NAME> <MEM_LAST_NAME>,

Medicare asks all Medicare health plans to collect medical information from our members each year. Enclosed please find a Health Risk Assessment (HRA) questionnaire. An HRA will ask you many questions about your health. By providing the HRA back to Brand New Day it will help us assess your health and see how it is today. We do this so that we can better serve you in your overall health care needs.

Get $10 in your Rewards Plus Card when you mail us your completed HRA! HRA's are completed yearly. Please mail us your HRA in the enclosed postage paid envelope at your earliest.

If you need assistance completing this form, we can help. Please call Brand New Day Member Services at 1-866-255-4795, TTY 711, Monday – Friday from 8 am to 8 pm between April 1 and September 30 and 7 days a week from October 1 to March 31 from 8 am to 8 pm.

Sincerely,

Brand New Day

Enclosed:

1. Health Risk Assessment (HRA) Survey
2. Postage Paid Envelope

brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

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!**

MBI#	MEMBER ID#	EFFECTIVE DATE	HOME PHONE	PLAN
<HEALTH_ID>	<MEM_ID>	<EFF_DT>	<PHONE>	<MEDICARE_PBP>

FIRST NAME	LAST NAME	DATE OF BIRTH	GENDER
<MEM_FIRST_NAME>	<MEM_LAST_NAME>	<DOB>	☐ M ☐ F

ADDRESS	CITY	STATE	ZIP CODE
<ADDR1>	<CITY>	<STATE>	<ZIP>

CELL PHONE NUMBER	EMAIL ADDRESS

☐ 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

Member ID#: _____

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?

Member ID#: _____

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**

Member ID#: _____

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
- ☐ An assisted living apartment or board and care home
- ☐ A nursing 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

Member ID#: _____

SECTION D: FUNCTIONAL ASSESMENT

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