

BRAND NEW DAY
ATTN: REWARDS PLUS PROGRAM
PO BOX 93122
LONG BEACH, CA 90809-3122

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>

3RD 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

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>	<input type="checkbox"/> M	<input type="checkbox"/> 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

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