brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

Health Risk Assessment (HRA)

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.

MEDICARE ID# | **MEMBER ID#** | **EFFECTIVE DATE** | **HOME PHONE** | **PLAN**

FIRST NAME | **LAST NAME** | **DATE OF BIRTH** | **GENDER** ☐ M ☐ F

ADDRESS | **CITY** | **STATE** | **ZIP CODE**

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 Colonoscopy? ☐ Yes ☐ No

When: _____ **Where:** _____

A9: Are you using home health services? ☐ Yes ☐ No

A10: Have you fallen in the past month? ☐ Yes ☐ No

A11: Has your doctor told you that you have:

☐ Cancer ☐ Dementia ☐ Diabetes/High Blood Sugar ☐ Mental Health Problems

A12: Do you have a mother, father, sister, or brother with Diabetes? ☐ Yes ☐ No

A13: On average how many cigarettes did you smoke per day? _____

A14: How many years have you smoked? _____

A15: Are you currently using Durable Medical Equipment or medical devices? ☐ Yes ☐ No

A16: If yes to A15, 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: _____

A17: What medication allergies do you have? _____

A18: Do you sometimes forget to take your medicine? ☐ Yes ☐ No

A19: 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**

SECTION C: ACTIVITIES OF DAILY LIVING

C1: Do you: ☐ **Snore** ☐ **Stop breathing while sleeping**

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

C3: At night do you:

☐ **Wake up gasping or choking**
☐ **Have frequent awakenings**
☐ **Wake up to go to the bathroom**

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?**

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**

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 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 ☐