MedCare Partners
Health Plan of Texas

Member First Name: _____
Member Last Name: _____

Address (City/State/Zip): _____
_____
Phone Number: _____
Date of Birth (mmddyy): _____
Plan Type: CSNP
MedCare Partners Member ID: _____
Medicare Number (MBI #): _____
Person Completing this form: _____
Relationship to Member: _____

Health Risk Assessment (HRA) Tool

This information will help us understand your health needs.

Your answers WILL NOT affect your benefits. We may share your information with your primary care provider(s).

Direct questions about this form to 1 (866) 627-8901 (TTY: 711)).

Today's date is: _____, 202___

1. Right to Consent or Decline

I ☐ **Accept/Opt In** or ☐ **Decline/Opt Out** to participate in MedCare Partners Health Plan of Texas' Health Risk Assessment Tool (HRAT)

2. Physical Health Rating

2.1. What is your height _____(inches only) **2.2. What is your weight** _____(pounds)

2.2.	**Are you concerned about your health**	☐ Yes ☐ No
2.3.	**Do you feel you get enough physical activity/exercise**	☐ Yes ☐ No
2.4.	**Do you feel that your diet supports a healthy lifestyle**	☐ Yes ☐ No

3. Activities of Daily Living

3.1. How much help do you need with the following?

Activity	No Help Needed	Some Help Needed	Can't Do at All
3.1.1. Bathing	☐	☐	☐
3.1.2. Dressing	☐	☐	☐
3.1.3. Eating	☐	☐	☐
3.1.4. Getting out of bed or chair	☐	☐	☐
3.1.5. Preparing meals	☐	☐	☐
3.1.6. Taking your medicine	☐	☐	☐
3.1.7. Using the bathroom	☐	☐	☐
3.1.8. Walking	☐	☐	☐
3.1.9. Transportation	☐	☐	☐

3.2. Where do you currently live ☐Private Home ☐Assisted Living ☐Nursing Home ☐Group Home ☐Apartment ☐Condo ☐Half-way House ☐Trailer/Mobile Home Park ☐Homeless ☐Other

3.3. If you need help, do you have someone close by or a caregiver who helps you
☐Family ☐Friend ☐Neighbor ☐Caregiver ☐No help ☐I prefer not to answer ☐Other

3.4. Medical Equipment (check all that apply) ☐Walker ☐Wheelchair ☐Hospital Bed ☐Oxygen ☐Nebulizer ☐Portable Toilet ☐Shower Chair ☐C-pap/Bi-pap ☐Other

4. Social Determinants of Health

4.1. Is there anything preventing you from taking steps to get the care you need? ☐ Yes ☐ No ☐ N/A

If yes, check all that apply ☐Transportation ☐Cost of Medical Services ☐Cost of Medications ☐Access to Services ☐Care Giver Support ☐Language differences ☐Cultural differences ☐Hard of hearing ☐Visual difficulties ☐Family objections ☐Social issues: discrimination/distrust ☐Mental health issues/ distrust some people ☐Domestic violence /abuse ☐Elder abuse ☐Other

5. Clinical Health History & Treatment

5.1. What is the name of your Primary Care Physician (PCP)? _____

5.2. Do you need a PCP? ☐I need a new PCP ☐No

5.3. When did you last see your Primary Care Physician? ☐Less than 6 mo. ☐More than 6 mo. ☐12 mo. or greater

5.4. How many times were you admitted to the Hospital or Emergency Room in the past 12 months?
☐ 0 ☐ 1 time ☐ 2 times ☐ 3 times ☐ More than 3 times

5.7. Have you been in a post-acute facility (skilled nursing, rehabilitation, or long-term care) in the past 12 months? ☐ 0 ☐ 1 time ☐ 2 times ☐ 3 times ☐ More than 3 times

5.8. Please check Yes or No and include Treating Provider(s) for the following conditions:

5.8.1. Asthma or Chronic Bronchitis ☐ Yes ☐ No	**5.8.15. Stroke, Heart Attack, Chest Pain, or Blocked Arteries** ☐ Yes ☐ No
5.8.2. COPD or Emphysema ☐ Yes ☐ No	**5.8.16. Congestive Heart Failure (CHF)** ☐ Yes ☐ No
5.8.3. Shortness of Breath or Breathing Problems ☐ Yes ☐ No	**5.8.17. Circulation Problems** ☐ Yes ☐ No
5.8.4. Frequent Falls ☐ Yes ☐ No	**5.8.18. High Blood Pressure** ☐ Yes ☐ No
5.8.5. Osteoporosis ☐ Yes ☐ No	**5.8.19. Swelling (ankle or leg)** ☐ Yes ☐ No
5.8.6. Osteoarthritis ☐ Yes ☐ No	**5.8.20. Diabetes** ☐ Yes ☐ No ☐Type 1 ☐Type 2 ☐Pre-Diabetes ☐Gestational
5.8.7. Recent Fracture ☐ Yes ☐ No	**5.8.21. Skin Ulcer, Non-Healing Wound, Sores** ☐ Yes ☐ No
5.8.8. Parkinson's/ALS/MS/Lupus ☐ Yes ☐ No	**5.8.22. Organ Transplant** ☐ Yes ☐ No
5.8.9. Cancer ☐ Yes ☐ No	**5.8.23. Memory Loss, Dementia, or Alzheimer's** ☐Yes ☐ No
5.8.10. HIV/AIDS ☐ Yes ☐ No	**5.8.24. Urinary Incontinence or Bladder Control Problems** ☐ Yes ☐ No
5.8.11. Depression ☐ Yes ☐ No	**5.8.25. Frequent Urinary Track Infections** ☐ Yes ☐ No
5.8.12. Serious Mental Illness ☐ Yes ☐ No	**5.8.26. Kidney Failure or End Stage Renal Disease (ESRD)** ☐ Yes ☐ No
5.8.13. Eyes: Blindness or trouble seeing even when wearing glasses ☐ Yes ☐ No	**5.8.27. Bowel Problems** ☐ Yes ☐ No
5.8.14. Ears: Deafness or trouble hearing even when wearing a hearing aid? ☐ Yes ☐ No	**5.8.28. Other** ☐ Yes ☐ No

6. Life Planning Activities

6.1. Do you have or need the following: Advance Health Care Directive such as a Living Will or Physician Orders for Life-Sustaining Treatment (POLST)? ☐Yes ☐No ☐I need one

7. Preventative Health Maintenance

HEALTH RISK ASSESSMENT TOOL

7.1.	**Do you get a flu vaccine/shot annually?**	☐ Yes ☐ No
7.2.	**Have you received a Covid vaccine/shot in the year?**	☐ Yes ☐ No
7.3.	**Have you had a colon cancer check /screening in the last 10 years?**	☐ Yes ☐ No
7.4.	**Have you had a pap test in the past 2 years?**	☐ Yes ☐ No ☐ N/A
7.5.	**Have you had a mammogram in the past 2 years?**	☐ Yes ☐ No ☐ N/A
7.6.	**Do you use tobacco (smoke, chew, snuff, or in any other form)?**	☐ Yes ☐ No
7.7.	**Does drinking alcohol interfere with your personal or work life?**	☐ Yes ☐ No
7.8.	**Frequency of Pain in the past week?**	☐No pain ☐Pain some days ☐Pain every day
7.9.	**Pain Management medication or other therapies?**	☐ Yes ☐ No

8. Behavioral & Mental Health

8.1. Over the past 2 weeks, how often have you been bothered by any of the following feelings?

8.1.1.	Feeling down, depressed, hopeless	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.2.	Little interest/pleasure in doing things	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.3.	Crying Spells	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.4.	Difficulty Sleeping	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.5.	Nervousness / Anxious / Worried	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.6.	Agitated / Irritable / Angry	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day
8.1.7.	Thought of hurting myself or others	☐ Not at All	☐ Several Days	☐ More than Half the Days	☐ Nearly Every Day

8.2. Do personal or family health issues result in loss of work or daily activities? ☐ Yes ☐ No ☐Unsure ☐ N/A

8.3. What stressors do you have at the moment (check all that apply)? ☐Relationships ☐Family ☐Children ☐Lack of Social Support ☐Occupation ☐General Physical Health ☐Financial ☐Other ☐N/A

9. Cultural and Linguistic Needs

9.1. Do you identify with a religion or spiritual tradition? ☐ Atheism/Agnosticism ☐ Buddhism ☐ Catholicism ☐ Christianity ☐ Christian Science ☐ Hinduism ☐ Islam ☐ Jehovah's Witness ☐ Judaism ☐ Mormon ☐ Other ☐ None / Unaffiliated ☐ I prefer not to answer

9.2. What is your primary language? ☐ English ☐ Spanish ☐ French Creole ☐ Vietnamese ☐ Tagalog ☐ I prefer not to answer ☐ Other

9.3. How do you describe your ethnicity? ☐White or Caucasian ☐Black or African American ☐Hispanic /Latino ☐Native American Indian /Alaskan Native ☐Asian ☐Pacific Islander /Native Hawaiian ☐Unknown ☐I prefer not to answer ☐Other

10. Demographics

10.1. What gender do you identify? ☐Male ☐Female ☐Intersex ☐Trans ☐Non-conforming ☐Personal ☐Eunuch ☐ I prefer not to answer ☐Other _____

10.2. Who do you currently live with? ☐Alone ☐Child(ren) ☐Extended Family ☐Friend(s) ☐Parent(s) ☐Roommate(s) ☐Sibling(s) ☐ Spouse/Partner ☐Other _____

11. Housing

11.1. Do you have the following problems (check all that apply)? ☐Bugs ☐Rodents ☐Lead/Asbestos ☐Mold ☐Electric Issues ☐Heating Issues ☐Water Issues ☐ House not safe ☐No issues ☐Other _____

11.2. Do you have internet access (check all that apply)? ☐Computer ☐Phone ☐Tablet ☐Other _____