HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

Health Risk Assessment (HRA)

CNA Required for Items in **BLUE**

Member's Name (First, Middle, Last)	Member's Medicaid ID	Date

Has Member Given Permission for Another Person to Complete this form?	Name of Person Completing/Assisting with the Completion of This Assessment and Their Relationship to Member
☐ Yes ☐ No	

Member's Address	City	State	Zip

Home Phone	Cell Phone	Other Phone

Emergency Contact Name/Phone	Date of Birth

Assessment Method	Demographics Verified?
☐ Telephonic ☐ In-person ☐ Other	☐ Yes ☐ No

Assessment Type

☐ Initial assessment ☐ Reassessment ☐ Change in health status

	Question	Response
1.	Do you have a language need other than English? Do you need translation services? Please describe:	☐ Yes ☐ No ☐ Yes ☐ No _____
2.	Do you have any special preferences we should be aware of?	☐ Cultural preference ☐ Hearing Impairment ☐ Literacy ☐ Religion/Spiritual needs or preferences ☐ Visual Impairment ☐ None ☐ Other (describe):_____
3.	What is your main health concern right now?	_____
4.	Do you have any current or past physical and/or behavioral health conditions or diagnoses?	☐ Behavioral health diagnosis (CNA required) ☐ Comorbid conditions (CNA required) ☐ ICF/MR/DD (CNA required) ☐ High risk pregnancy (CNA required) ☐ Transplant patient (CNA required) ☐ Medically Fragile Waiver Program (CNA required) ☐ Medically frail (CNA required) ☐ Traumatic brain injury (CNA required) ☐ Other acute or terminal disease: _____ (CNA required)
5.	(*Adult only question*) Compared to others your age, would you say your health is…..?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
6.	Do you have any pending physical health procedures or behavioral health appointments? Date of most recent physical examination or medical appointment:	☐ Yes ☐ No (if yes, CNA required) _____
7.	Have you visited the Emergency Room in the past 6 months? If yes, how many visits? Date(s) of ER visit(s): Reason for ER visit(s):	☐ Yes ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 or more (if 2 or more, CNA required) _____ _____

	Question	Response
8.	Have you stayed overnight in the hospital in the past 6 months? If yes, how many times? If yes, were you readmitted within 30 days of discharge?	☐Yes ☐No ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 or more (if 2 or more, CNA required) ☐Yes ☐No (if yes, CNA required)
9.	How many medicications are you currently taking?	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more (if 6 or more, CNA required)
10.	What is your current living situation?	☐ Homeless (CNA req.) ☐ Living alone ☐ Living in group home ☐ Living in shelter (CNA req.) ☐ Living with other family ☐ Living with others unrelated ☐ Living with spouse ☐ Living in assisted living facility ☐ Lives in out of state facility (CNA required) ☐ Lives in out of home placement ☐ Dependent child in out of home placement (CNA req.) ☐ Living in a nursing facility ☐ Other (describe): _____
11.	Do you need assistance with 2 or more of the following? Is your need for assistance being met today?	☐ Yes ☐ No (If yes, CNA required) ☐ Dressing ☐ Bathing/grooming ☐ Eating ☐ Meal acquisition/preparation ☐ Transfer ☐ Mobility ☐ Toileting ☐ Bowel/bladder ☐ Daily medication ☐ Other: _____ ☐ Yes ☐ No
12.	Do you need or are you interested in Long-Term Care services?	☐ Yes ☐ No
13.	An advance directive is a form that lets your loved ones know your health care choices if you are too sick to make them yourself. Do you have a living will or an advance directive in place? Could I send you more information?	☐ Living will ☐ Advance directive (for medical care) ☐ Advance directive (for psychiatric care) ☐ No living will or advance directive in place ☐ Declined discussion ☐ Requested further information
14.	Are you interested in receiving Care Coordination Services?	☐ Yes ☐ No

The MCO shall provide the following information to every Member during his or her HRA:

1. Information about the services available through Care Coordination
2. Information about the Care Coordination Levels (CCLS)
3. Notification of the Member's right to request a higher Care Coordination Level
4. Requirement for an in-person Comprehensive Needs Assessment for the purpose of providing services associated with Care Coordination level 2 or level 3
5. Information about specific next steps for the Member