Health Risk Assessment

INSTRUCTIONS

The Healthy Michigan Plan is very interested in helping you get healthy and stay healthy. We want to ask you a few questions about your current health and encourage you to see your doctor for a check-up as soon as possible after you enroll with a health plan, and at least once a year after that. Take this form with you when you go. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan and your health plan can help you with a ride to and from this appointment. Your doctor and your health plan will use this information to better meet your health needs. The information you provide in this form is personal health information protected by federal and state law and will be kept confidential. It CANNOT be used to deny health care coverage.

If you need assistance with completing this form, contact your health plan. You can also call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656 if you have questions.

For assistance completing this form, please call Molina Healthcare at 1-866-408-9541 Monday through Friday between 9:00 am and 9:00 pm

Instructions for completing this Health Risk Assessment for Healthy Michigan Plan:

- Answer the questions in sections 1-3 as best you can. You are not required to answer all of the questions.
- Call your doctor’s office to schedule an annual check-up appointment. Take this form with you to your appointment.
- Your doctor or other primary care provider will complete section 4. He or she will send your results to your health plan.

After your appointment, keep a copy or printout of this form that has your doctor’s signature on it. This is your record that you completed your annual Health Risk Assessment.
**Health Risk Assessment**

<table>
<thead>
<tr>
<th>First Name, Middle Name, Last Name, and Suffix</th>
<th>Date of Birth (mm/dd/yyyy)</th>
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<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Apartment or Lot Number</th>
<th>mihealth Card Number</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Phone Number</th>
<th>Other Phone Number</th>
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**SECTION 1 - Initial assessment questions (check one for each question)**

1. In general, how would you rate your health?  
   - [ ] Excellent  
   - [ ] Very Good  
   - [ ] Good  
   - [ ] Fair  
   - [ ] Poor

2. In the last 7 days, how often did you exercise for at least 20 minutes in a day?  
   - [ ] Every day  
   - [ ] 3-6 days  
   - [ ] 1-2 days  
   - [ ] 0 days

   *Exercise includes walking, housekeeping, jogging, weights, a sport or playing with your kids. It can be done on the job, around the house, just for fun or as a work-out.*

3. In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day?  
   - [ ] Every day  
   - [ ] 3-6 days  
   - [ ] 1-2 days  
   - [ ] 0 days

   *Each time you ate a fruit or vegetable counts as one serving. It can be fresh, frozen, canned, cooked or mixed with other foods.*

4. In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?  
   - [ ] Never  
   - [ ] Once a week  
   - [ ] 2-3 times a week  
   - [ ] More than 3 times during the week

   *1 drink is 1 beer, 1 glass of wine, or 1 shot.*

5. In the last 30 days have you smoked or used tobacco?  
   - [ ] Yes  
   - [ ] No

   If YES, Do you want to quit smoking or using tobacco?  
   - [ ] Yes  
   - [ ] I am working on quitting or cutting back right now  
   - [ ] No

6. In the last 30 days, how often have you felt tense, anxious or depressed?  
   - [ ] Almost every day  
   - [ ] Sometimes  
   - [ ] Rarely  
   - [ ] Never

7. Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax?  
   - [ ] Almost every day  
   - [ ] Sometimes  
   - [ ] Rarely  
   - [ ] Never

   *This includes illegal or street drugs and medications from a doctor or drug store if you are taking them differently than exactly how your doctor told you to take them.*

8. The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year?  
   - [ ] Yes  
   - [ ] No

9. A checkup is a visit to a doctor’s office that is NOT for a specific problem. How long has it been since your last checkup?  
   - [ ] Within the last year  
   - [ ] Between 1-3 years  
   - [ ] More than 3 years

Take this form to your check-up and complete the rest of the form with your doctor at this appointment.
SECTION 2 - Annual appointment

A routine checkup is an important part of taking care of your health. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan and your health plan can help you with a ride to and from this appointment.

What month did you first schedule this appointment?  

Date of appointment:  

(Month) (mm/dd/yyyy)

At my appointment, I would most like to talk with my doctor about:

An annual appointment gives you a chance to talk to your doctor and ask any questions you may have about your health including questions about medications or tests you might need.

SECTION 3 - Readiness to change

Your Healthy Behavior

Small everyday changes can have a big impact on your health. Think about the changes you would be most interested in making over the next year. Look at the list below and CHOOSE ONE or MORE:

- Exercise regularly, eat better, and/or lose weight
- Cut back or quit drinking alcohol
- Cut back or quit smoking or using tobacco
- Seek treatment for drug or substance abuse
- Get a flu shot
- I will commit to keep up all of the healthy things I do now
- Return to the doctor to get tested for high blood pressure, high cholesterol and diabetes OR if I already have any of them, return to the doctor for check-ups for these conditions
- Other:

Changes like drinking water rather than soda or walking every day can help you stay healthy or help you better control illnesses you may already have. You can learn new ways to handle stress or quit smoking. Remember, even small changes can be difficult and take a long time. It may be helpful to get support from your family, friends, community or your doctor. Your health plan may have programs that can help you.

Now that you have selected your healthy behavior(s) above, answer questions 1 - 3. For each question, use the scale provided and pick a number from 0 through 5.

1. Thinking about your healthy behavior(s), do you want to make some small lifestyle changes in this area to improve your health?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t want to make changes now</td>
<td>I want to learn more about changes I can make</td>
<td>Yes, I know the changes I want to start making</td>
<td></td>
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</tbody>
</table>

2. How much support do you think you would get from family or friends if they knew you were trying to make some changes?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t think family or friends would help me</td>
<td>I think I have some support</td>
<td>Yes, I think family or friends would help me</td>
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</table>

3. How much support would you like from your doctor or your health plan to make these changes?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not want to be contacted</td>
<td>I want to learn more about programs that can help me</td>
<td>Yes, I am interested in signing up for programs that can help me</td>
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Section 4 – To be completed by your primary care provider

Primary care providers should fill out this form for Healthy Michigan Plan beneficiaries enrolled in Managed Care Plans only. Fill in the Member Results, select a Healthy Behavior statement in discussion with the member, and sign the Primary Care Provider Attestation. Blood pressure, BMI and tobacco use status will be known from the appointment. For all other Member Results, marking the result as unknown and indicating whether the screening or immunization is recommended satisfies the requirements for a complete Health Risk Assessment. All three parts of Section 4 must be filled in for the attestation to be considered complete.

**Member Results**

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>(xxx/xxx mmHg)</th>
<th>Patient diagnosed with hypertension?</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>BMI</td>
<td>Ht Wt.</td>
<td>In the context of all relevant clinical factors, does this BMI indicate need for weight management?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tobacco Use Status</td>
<td>Never used tobacco</td>
<td>Previous tobacco user</td>
<td>Current tobacco cessation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Starting tobacco cessation</td>
<td>Tobacco user</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol</td>
<td>Cholesterol known?</td>
<td>Yes</td>
<td>No</td>
<td>Patient diagnosed with high cholesterol?</td>
</tr>
<tr>
<td>If cholesterol known is Yes:</td>
<td>Total cholesterol:</td>
<td>LDL:</td>
<td>HDL:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Date of most recent test results:</td>
<td>Triglycerides:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If cholesterol known is No:</td>
<td>Screening not recommended</td>
<td>Screening Ordered</td>
<td></td>
<td></td>
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<tr>
<td>Blood Sugar</td>
<td>Blood sugar known?</td>
<td>Yes</td>
<td>No</td>
<td>Patient diagnosed with diabetes?</td>
</tr>
<tr>
<td>If blood sugar known is Yes:</td>
<td>FBS (xxx mg/dl):</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Date of most recent test results:</td>
<td>A1C (xx.x%):</td>
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<tr>
<td>If blood sugar known is No:</td>
<td>Screening not recommended</td>
<td>Screening Ordered</td>
<td></td>
<td></td>
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<tr>
<td>Influenza Vaccine</td>
<td>Annual Influenza Vaccination?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If Influenza vaccination is Yes:</td>
<td>Date of most recent vaccination:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Influenza vaccination is No:</td>
<td>Vaccination not recommended</td>
<td>Vaccination recommended</td>
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</table>
Healthy Behaviors - Choose one of the following statements (1 - 4)

☐ 1. Patient does not have health risk behaviors that need to be addressed at this time.

☐ 2. Patient has identified at least one behavior to address over the next year to improve their health (choose one or more below):
   - Increase physical activity, learn more about nutrition and improve diet, and/or weight loss
   - Reduce/quit tobacco use
   - Annual influenza vaccine
   - Agrees to follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes
   - Reduce/quit alcohol consumption
   - Treatment for Substance Use Disorder
   - Other: explain

☐ 3. Patient has a serious medical, behavioral or social condition(s) which precludes addressing unhealthy behaviors at this time.

☐ 4. Unhealthy behaviors have been identified, patient’s readiness to change has been assessed, and patient is not ready to make changes at this time.

Primary Care Provider Attestation
I certify that I have examined the patient named above and the information is complete and accurate to the best of my knowledge. I have provided a copy of this Health Risk Assessment to the member listed above.

<table>
<thead>
<tr>
<th>Print Name (First Name, Last Name)</th>
<th>National Provider Identifier (NPI)</th>
</tr>
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<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
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</table>

Submission Instructions:
- Submit completed forms in the secure manner specified by the member's Managed Care Plan.

Please submit completed forms via secure fax to:
Molina Healthcare of Michigan at (855) 671-1283.