Member Health Risk Assessment

Member Information

Member Name*		Member Date of Birth*	Age
Member Address			
Member Phone #	Member ID #	Emergency Contact Name & Phone #	
Date Completed:	Who is Completing This Form for You?		

Health Assessment **All Required*

1. What is your gender?
   ☐ Male ☐ Female

2. What is your race or ethnicity?
   ☐ African American ☐ American Indian or Alaskan Native
   ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ White Non-Hispanic
   ☐ Hispanic or Latino ☐ Multiracial ☐ Other

3. What is your highest level of education?
   ☐ Elementary School (K-5) ☐ Middle School (6-8) ☐ High School (9-12)
   ☐ High School graduate ☐ Some College ☐ College Graduate
   ☐ Graduate School ☐ N/A

4. What is your preferred language to speak at home?
   ☐ English ☐ Spanish ☐ Other

5. What is your living situation?
   ☐ Own ☐ Live with family ☐ Rent ☐ Homeless ☐ Live with friends
   ☐ Other

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6. Are you currently pregnant?
   ☐ Yes ☐ No

7. Has a doctor ever told you that you have the following?
   ☐ Diabetes ☐ High blood pressure ☐ Heart disease ☐ Kidney disease ☐ Cancer
   ☐ Asthma ☐ COPD ☐ Allergies ☐ HIV/AIDS ☐ Hepatitis
   ☐ Schizophrenia ☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ N/A

8. Do you currently take prescription medicine?
   ☐ Yes ☐ No

9. Do you currently use any of the following?
   ☐ Hearing aids ☐ Glasses ☐ Wheelchair or walker ☐ Other assistive devices ☐ N/A

10. How often do you exercise?
    ☐ 2-3 times per week ☐ Once per week ☐ Rarely ☐ Never

11. How often do you use alcohol?
    ☐ Every day ☐ Two or more days per week ☐ Rarely ☐ Never

12. Do you use tobacco or tobacco products?
    ☐ Yes ☐ No ☐ I would like help quitting

13. In general, how would you rate your overall health?
    ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

14. Stress is when you feel tense, nervous or anxious, or you can't sleep at night because your mind is troubled. How stressed would you say you are?
    ☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much
    ☐ I choose not to answer this question

15. How often do you see or talk to people you care about? ***(For Example: Talking to friends on the phone, visiting friends or family, going to church or club meetings)***
    ☐ Less than once per week ☐ 1-2 times per week ☐ 3-5 Times per week
    ☐ 5 or more times per week ☐ I choose not to answer this question

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16. Do you need help with any of the following? ***(Mark all that apply)***

☐ Food ☐ Clothing ☐ Housing ☐ Employment ☐ Mobility
☐ Getting to medical appointments ☐ Safety ☐ N/A

17. Do you need help with performing any of the following daily activities?

☐ Accessing medication ☐ Bathing ☐ Eating ☐ Dressing ☐ Shopping
☐ Managing finances ☐ N/A

18. Compared to one year ago, my health is worse.

☐ Yes ☐ No

19. Have you received dental care in the past year?

☐ Yes ☐ No

20. Have you been to the emergency room in the last three months?

☐ Yes ☐ No

21. Would you like your health plan to contact you about any other health concerns?

☐ Yes ☐ No

Send us your completed Health Risk Assessment Form (HRA):

Email: CareManagement_KY@passporthealthplan.com

Mail to:
Passport Health Plan by Molina Healthcare
Attn: Care Management Dept.
5100 Commerce Crossing Drive Louisville, KY 40229

If you need help filling out your HRA, call us at 1-833-959-2398.

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