PASSPORT
BY MOLINA HEALTHCARE

Department for Medicaid Services of Kentucky- Health Risk Assessment

Kentucky Medicaid is committed to helping you stay healthy. Completing the Health Risk Assessment (HRA) helps us understand your health needs and support your health goals. Please take the time to answer each question in Sections 1 and 2. Submit your completed HRA to your Managed Care Organization (MCO) using the information listed in Section 3.

The information you share will remain private. If you have questions or need help filling out the HRA, contact your MCO member services at (800) 578-0603.

Your MCO may reach out to you if they need more information about your answers or your health needs. Based on your answers, you may be eligible to take part in a great program called care management. If you agree to care management, it can help you get the health care you need.

Member information

Name: _____ Address: _____

Date of birth: _____ Age: _____ Medicaid number: _____

Managed Care Organization: _____

Cell phone: _____ Text messaging allowed ☐ Yes / No ☐

Home phone: _____

Email: _____ Email contact allowed: ☐ Yes / No ☐

Health Risk Assessment: Please select all answers that apply to you.

1. What is your housing situation today?

- ☐ I have housing
- ☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car or in a park)
- ☐ I have a place to live today, but I am worried about losing it in the future
- ☐ I choose not to answer

2. In the past year, have you or your family members you live with been unable to get any of the following when it was really needed? Select yes or no for each answer.

Food ☐ Yes ☐ No Clothing ☐ Yes ☐ No Utilities ☐ Yes ☐ No
Childcare or adult care ☐ Yes ☐ No
Medicine or any health care (medical, dental, mental health, vision) ☐ Yes ☐ No
Internet or phone ☐ Yes ☐ No Social or community engagement ☐ Yes ☐ No
Other _____
☐ I choose not to answer

3. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Select all that apply.

☐ Yes, it has kept me from medical appointments or from getting my medications
☐ Yes, it has kept me from non-medical appointments, work, or from getting things that I need.
☐ No
☐ I choose not to answer

4. What is your current work situation?

☐ Unemployed ☐ Full-time employment ☐ Part-time, temporary, or community service (80+ hours per month) ☐ Part-time, temporary, or community service (Less than 80 hours per month) ☐ Student, retired, disabled, unpaid primary caregiver, caregiver for child age 13 or under, pregnant
☐ I choose not to answer

Note: To connect with community resources near you, contact the United Way by calling 2-1-1 or 1-800-543-7709 or https://www.kynect.ky.gov/resources

Health Information

5. Has a doctor ever told you that you have any of the following? Select all that apply.

☐ ADD/ADHD ☐ Allergies ☐ Asthma ☐ Austism/ASD
☐ Blind or Poor Vision ☐ Cancer (current active treatment)
☐ Chronic Obstructive Pulmonary Disease ☐ Chemical Dependency
☐ Cognitive Disability ☐ Deaf or Hard of Hearing ☐ Diabetes
☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure ☐ HIV/AIDS
☐ Intellectual Disability ☐ Learning Disability ☐ Kidney Disease
☐ Mental Health Condition ☐ Mobility-Related Disability ☐ Obesity
☐ Physical Disability ☐ Sickle Cell Disease ☐ Speech -Related Disability
☐ Traumatic Brain Injury ☐ Other _____
☐ I choose not to share ☐ I have not been diagnosed with any of the listed conditions
☐ I choose not to answer

6. Do you need help understanding health information from your doctor or pharmacy?

☐ Yes ☐ No ☐ I choose not to answer

7. Do you feel you understand your health condition(s) and how to take care of yourself?

☐ Yes ☐ No ☐ I choose not to answer

8. In the past 6 months, how would you rate your overall health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

☐ I choose not to answer

9. What type of health care appointments have you attended in the last 12 months? Select all that apply.

☐ Physical health/Medical ☐ Mental or Behavioral Health ☐ Dental

☐ Cancer Screenings ☐ Eye or Vision Exam ☐ Family Planning

☐ Did not attend any appointments ☐ None of these

☐ I choose not to answer ☐ Other _____

10. Have you visited the emergency room in the past 6 months? How many times and why?

☐ None ☐ Yes - 1 to 2 times ☐ Yes - 3 or more times

☐ I choose not to answer

If yes, why? _____

11. Have you stayed overnight in the hospital in the past 12 months?

☐ Yes ☐ No ☐ I choose not to answer

12. Are you up to date on your vaccinations?

☐ Yes ☐ No ☐ Unknown ☐ I choose not to answer

13. Are you currently pregnant?

☐ Yes ☐ No ☐ I choose not to answer

☐ Does not apply ☐ Not applicable

14. Do you need help performing daily activities? Select all that apply.

☐ Talking or listening in the language you know best

☐ Concentrating, remembering, or making decisions

☐ Cooking for yourself ☐ Doing errands alone (e.g., shopping, doctor visits)

☐ Dressing or bathing ☐ Feeding yourself ☐ Hearing

☐ Seeing, even when wearing glasses

☐ Understanding others speaking in your usual language
☐ Using the toilet ☐ Walking or climbing stairs ☐ Other difficulties with daily activities ☐ I don't know ☐ I do not have trouble performing daily activities
☐ I choose not to answer

15. How many prescriptions and over-the-counter medications do you take each day?
☐ None ☐ 1-3 ☐ 4-7
☐ 8 or more. ☐ I choose not to answer

Behavioral health information

16. How often do you exercise?
☐ 2-3 times per week ☐ Once per week ☐ Rarely ☐ Never
☐ I choose not to answer

17. How many times in the past year, have you had 4 or more drinks in a day?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily
☐ I choose not to answer

18. Do you vape or use tobacco products? Select all that apply.
☐ Yes - Vape ☐ Yes - cigarettes ☐ Yes - chewing tobacco ☐ Yes - Other
☐ No ☐ I would like help quitting ☐ I choose not to answer
Note: If you would like assistance with quitting, call 1-800-QUIT-NOW (784-8669).

19. Do you use any substances or prescription medications not prescribed to you?
☐ Yes ☐ No ☐ I choose not to answer
Note: Misuse of substances or prescriptions that are not prescribed for you could cause serious injury or death. Call 1-800-662-HELP (4357) 24/7 to help find treatment near you.

20. Stress is when someone feels tense, nervous, anxious, or cannot sleep at night because their mind is troubled. How stressed are you?
☐ Not at all ☐ Somewhat ☐ Very much
☐ I choose not to answer

21. Do you feel safe, both physically and emotionally where you currently live?

☐ Yes ☐ No ☐ Not sure ☐ I choose not to answer

22. In the past year, have you been afraid of your partner, ex-partner or a friend?

☐ Yes ☐ No ☐ Not sure ☐ I have not had a partner in the last year
☐ I choose not to answer

23. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

☐ Yes ☐ No ☐ I choose not to answer

Note: For safety assistance, call 1-800-799-SAFE to get help if someone close to you makes you feel unsafe.

Over the past two weeks, how often have you been bothered by the following problems?

24. Having little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Almost every day
☐ Every day ☐ I choose not to answer

25. Feeling down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Almost every day
☐ Every day ☐ I choose not to answer

26. Had thoughts about harming yourself or others?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Almost every day
☐ Every day ☐ I choose not to answer

Note: Call or text 988 for help if you have thoughts of hurting yourself or visit https://findhelpnow.org/ky.

General information

27. What was your sex at birth?

☐ I choose not to answer ☐ Male ☐ Female ☐ Unavailable

28. What gender do you currently identify with? Select all that apply.

- ☐ I choose not to answer
- ☐ Female
- ☐ Male
- ☐ Female-to-male/Transgender Male/Trans Man
- ☐ Male-to-female/Transgender Female/Trans Woman
- ☐ Genderqueer/Non-binary, neither exclusively male nor female
- ☐ Other

29. What is your sexual orientation? Select all that apply.

☐ I choose not to answer ☐ Straight or heterosexual
☐ Lesbian, gay, or homosexual ☐ Bisexual ☐ Something else
☐ Do not know

30. What are your pronouns? Select all that apply.

☐ I choose not to answer ☐ He/Him/His ☐ She/Her/Hers
☐ They/Them/Theirs ☐ Other

31. What is your race? Select all that apply.

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander
☐ White ☐ Some other race ☐ I choose not to answer ☐ Unknown

32. What is your ethnicity? Select all that apply.

☐ I choose not to answer ☐ African ☐ African American
☐ American ☐ Asian ☐ Brazilian ☐ Cambodian ☐ Caribbean Islander
☐ Central American ☐ Chinese ☐ Colombian ☐ Cuban ☐ Dominican
☐ East African ☐ Eastern European ☐ English ☐ Egyptian
☐ Ethiopian ☐ European ☐ Filipino ☐ French ☐ German
☐ Guatemalan ☐ Haitian ☐ Hispanic ☐ Honduran ☐ Iranian ☐ Irish
☐ Italian ☐ Israeli ☐ Jamaican ☐ Japanese ☐ Korean
☐ Laotian/Lao ☐ Latino ☐ Lebanese ☐ Mexican ☐ Mexican American
☐ Middle Eastern African ☐ Moroccan ☐ Native American ☐ Nigerian
☐ North African ☐ Polish ☐ Portuguese ☐ Puerto Rican ☐ Russian
☐ Salvadoran ☐ South African ☐ South American ☐ Syrian
☐ Vietnamese ☐ West African ☐ Ethnicity not listed (please list)
☐ Unknown _____

33. Do you speak a language other than English at home?

☐ I choose not to answer ☐ Yes ☐ No

If yes, what language: _____

34. Do you write a language other than English at home?

☐ I choose not to answer ☐ Yes ☐ No

If yes, what language: _____

35. Do you have cultural or other beliefs that may affect your health care? For example, the gender of your health care provider or the treatments you get.

☐ Yes ☐ No ☐ I choose not to answer

36. What is your highest completed level of education?

☐ Elementary ☐ Middle/Junior HIgh

☐ High School ☐ College and above

☐ I choose not to answer

How to submit your completed Health Risk Assessment

After you've finished the assessment, please return this document using the information in the chart below.

Managed Care Organization	Contact number	Email
Passport by Molina Healthcare	(833) 959-2398	KYCareManagement@MolinaHealthcare.com
Fax	**Mail**	**Website**
(800) 983-9160	2028 W. Broadway Louisville, KY 40203	PassportHealthPlan.com

Managed Care Organization completes the section below when the HRA is received.

Date returned or completed by member: _____

Who completed the HRA: _____

Method of completion:

☐ Phone ☐ Online ☐ Mail ☐ In person ☐ Mobile app ☐ Other

Reason for the HRA:

☐ Initial ☐ Annual ☐ Care plan ☐ Care needs ☐ Members request

Risk score: _____ Health risks identified: _____

Chronic/Complex condition(s) identified: _____

Care Management offered: ☐ Yes ☐ No Date: Enrolled: ☐ Yes ☐ No

MCO services offered: _____

Community or resource referrals: _____