

Member Health Risk Assessment

Kentucky Medicaid

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*

- What is your legal gender?
 Male Female
- What is your gender identity?
 Female Male Transgender Non-Binary
 Agender Gender fluid Other _____
- What is your race?
 Black or African American American Indian or Alaska Native
 Asian Native Hawaiian
 Pacific Islander White
 I choose not to answer Other _____
- Are you Hispanic or Latino?
 Yes No I choose not to answer
- What is your preferred language to use at home?
 English Spanish Other _____

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6. 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

Vocational/Trade School

GED

N/A

7. What is your work status?

Work full time

Work part time

Retired

I'm currently looking for work

I'm unable to work
due to a disability

I'm not looking for
work for another reason

N/A

Other _____

8. Do you feel physically and emotionally safe where you currently work?

Yes

No

I choose not to answer

N/A

Note: contact OSHA at 1-800-321-6742 to discuss a health and safety issue at work. If you are being forced to work against your will, call the National Human Trafficking hotline at 1-888-373-7888 or text 233733.

9. How hard is it for you to pay for the very basics like food, housing, and heating?
Would you say it is:

Very hard

Somewhat hard

Not hard at all

10. What is your living situation?

Own

Live with family

Rent

Homeless/unsheltered

Shelter

Live with friends

Other _____

11. Do you feel physically and emotionally safe where you currently live?

Yes

No

I choose not to answer

Note: Call 1-800-799-SAFE to get help if someone close to you makes you feel unsafe.

12. Does the environment where you live feel healthy (clean air, clean drinking water, healthcare nearby, etc.)?

Yes

No

I choose not to answer

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13. Are you currently pregnant?

- Yes No

14. Has a doctor ever told you that you have the following?

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Allergies | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> ADHD | <input type="checkbox"/> Autism Spectrum Disorder | |
| <input type="checkbox"/> Developmental Delay | | <input type="checkbox"/> Substance Use Disorder | |
| <input type="checkbox"/> Cancer (current active treatment) | <input type="checkbox"/> N/A | | <input type="checkbox"/> Other |

15. Do you understand your health condition(s) and how to care for yourself to stay healthy?

- Yes, I understand my conditions and what to do to stay healthy
 No, I need information or help understanding my health conditions and how to stay healthy

16. Over the last two weeks, how often have you had little interest or pleasure in doing things?

- Not at all Several Days More than half the days Nearly every day

17. Over the last two weeks, how often have you been feeling down, depressed or hopeless?

- Not at all Several Days More than half the days Nearly every day

18. In the last two weeks, have you thought about harming yourself?

- Yes No

Note: Call or text 988 for help if you have thoughts about hurting yourself.

19. Do you use illegal substances or prescription medications not prescribed for you?

- Yes No

Note: If you are, you could be at risk for serious injury or death. Call 1-800-662-HELP (4357) for 24/7 help finding treatment near you.

20. How often do you use alcohol?

- Every day Two or more days per week Rarely Never Other

If you use alcohol or drugs:

Have you ever felt that you ought to cut down on your drink or drug use?

- Yes No

Have people annoyed you by criticizing your drinking or drug use?

- Yes No

Have you ever felt bad or guilty about your drinking or drug use?

- Yes No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?

- Yes No

21. Do you use cigarettes or nicotine products such as e-cigarettes/vape or dip/chew?

- Yes No I would like help quitting

22. 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

23. 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

24. Are you or any of your family members unable to get any of the following when it is really needed? (Mark all that apply)

- Food Clothing Housing Training/Employment
 Utilities Medicine or any healthcare Childcare
 N/A Other _____

25. Have you had at least one well visit with your primary care provider in the last year?

- Yes No I don't have a primary care provider

26. For children/youth ages birth through 18 years of age, do you understand what vaccines (shots) are needed and are you up to date on shots?
- I'd like information I am up to date on shots Other _____ N/A
27. Have you received dental care as recommended in the past year? <(At least one visit to the dentist for adults 21 and over and at least every 6 months for children ages 1-20.)>
- Yes No
28. In the past 3 months, how often have you visited the emergency room and/or stayed overnight in the hospital?
- One time or not at all 2 to 5 times 6 or more times
29. 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: KYCareManagement@MolinaHealthcare.com

Mail to:

Passport 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.