CHAMPION HEALTH PLAN

HRA Short Form

Dear Member,
Thank you for participating in the Health Risk Assessment (HRA) for ESRD. Your insights will enable our MAPD health plan case manager to customize your care plan. We assure confidentiality and urge you to be as precise as possible.

PERSONAL INFORMATION: **Today's Date:**

Full name:	
Best phone number:	
Date of birth:	Gender: ☐ Female ☐ Male ☐ Other
Medicare ID:	
Medicaid (Medi-Cal) ID:	
Preferred Language:	☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Korean ☐ Tagalog ☐ Other:______________________
Race or ethnicity: (check all that apply)	☐ White ☐ Black ☐ Asian ☐ American Indian/Alaska Native ☐ Hawaiian or other Pacific Islander ☐ Hispanic ☐ Other:______________________ ☐ I choose not to answer

ESRD STATUS:

ESRD diagnosis date:	
Have you had a transplant?	☐ Yes ☐ No If yes, date of transplant:
Are you on a waiting list for a kidney?	☐ Yes ☐ No
Are you currently receiving dialysis treatments?	☐ Yes ☐ No If yes, what type of dialysis treatment are you receiving? ☐ Hemodialysis ☐ Peritoneal Dialysis ☐ Other:______________________
Dialysis center name and address:	
Dialysis treatment frequency:	☐ 3 times per week ☐ Other:______________________
Have you encountered challenges accessing dialysis treatment (e.g., transportation?)	☐ Yes ☐ No If yes, details:______________________
Difficulties in maintaining the recommended ESRD diet?	☐ Yes ☐ No If yes, details:______________________

OTHER MEDICAL HISTORY / INFORMATION:

Question	Response
How many times in the past year have you been admitted into the hospital?	☐ None ☐ 1 Time ☐ 2 Times ☐ 3 Times ☐ More
How many times in the past year did you go to an Emergency Room?	☐ None ☐ 1 Time ☐ 2 Times ☐ 3 Times ☐ More
List any other medical conditions you have (e.g., hypertension, diabetes):	
Do you have any pain?	☐ Yes ☐ No Where is your pain?________________
How severe is the pain?	☐ Comes and goes ☐ Constant low ☐ Constant medium ☐ Constant high ☐ Very high prevents sleep
How is your hearing?	☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
If you are deaf, do you have a personal sign-language interpreter?	☐ Yes ☐ No
Do you need Champion Insurance to schedule a sign-language interpreter to be present at your doctor appointments?	☐ Yes ☐ No Other:________________ If you drive yourself, or someone you know drives you, Champion will reimburse money for gas (per IRS standards).
How is your eyesight?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Do you need information in large print?	☐ Yes ☐ No Other:________________
Have you been to the dentist in the past year?	☐ Yes ☐ No

FRAILTY INDICATORS:

Have you experienced or are experiencing any of the following in the past year?

Question	Response
Recent unintentional weight loss?	☐ Yes ☐ No
Regular feelings of exhaustion or fatigue?	☐ Yes ☐ No
Decline in grip strength?	☐ Yes ☐ No
Trouble in walking or ascending stairs?	☐ Yes ☐ No
Slower walking speed or reduced physical activity?	☐ Yes ☐ No
Any falls in the past year?	☐ Yes ☐ No

CHAMPION HEALTH PLAN

BEHAVIOR:

		Frequency
Physical activity	☐ Yes ☐ No	Times per week:______
Smoke or use tobacco	☐ Yes ☐ No	Times per week:______
Alcohol use	☐ Yes ☐ No	Times per week:______
Unprotected sex	☐ Yes ☐ No	Times per week:______
Use a seat belt in cars	☐ Yes ☐ No	☐ Always ☐ Sometimes ☐ Never
Home Safety Evaluation	☐ Yes ☐ No	We can provide one for you

EMOTIONAL / PSYCHOLOGICAL FEELINGS:

Indicate your response to each of the following. Have you had...

Reduced interest/pleasure in usual activities in the past two weeks?	☐ Yes ☐ No
Feelings of sadness or hopelessness in the past two weeks?	☐ Yes ☐ No
Feelings of significant anger or rage in the past two weeks?	☐ Yes ☐ No
Feelings of significant stress in the past two weeks?	☐ Yes ☐ No
Feelings of loneliness or social isolation in the past two weeks?	☐ Yes ☐ No

LIVING SITUATION AND COMMUNITY SUPPORT:

What is your housing situation today?

I have housing	☐ Yes ☐ No
I am staying with others in a hotel	☐ Yes ☐ No
I am staying in a shelter	☐ Yes ☐ No
I am living outside on the street, on a beach, in a car or in a park	☐ Yes ☐ No
Do you live in an independent house, apartment, condo, or mobile home? ☐ Alone ☐ Friend ☐ Spouse ☐ Child ☐ Other	☐ Yes ☐ No
Do you live in assisted living facility/apartment, or board and care home, or nursing home?	☐ Yes ☐ No
I choose not to answer these questions	☐ Yes ☐ No
List any community support or resources aiding your ESRD care or wellness: ____________________	

ACTIVITIES OF DAILY LIVING (ADLS):

Indicate your level of self-sufficiency for:

	Can do this myself	Need a little help	Can’t do this. I need significant help
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Eating	☐	☐	☐
Toileting	☐	☐	☐
Grooming	☐	☐	☐
Walking	☐	☐	☐
Transferring (from bed to chair for example)	☐	☐	☐
Do you have someone to help you with the above if you need help?			☐ Yes ☐ No

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS):

Indicate your level of self-sufficiency for each of the following:

	Can do this myself	Need a little help	Can’t do this. I need significant help
Shopping	☐	☐	☐
Food Preparation	☐	☐	☐
Using the telephone	☐	☐	☐
Housekeeping	☐	☐	☐
Laundry	☐	☐	☐
Taking medications	☐	☐	☐
Handling my finances	☐	☐	☐
Do you have someone to help you with the above if you need help?			☐ Yes ☐ No
Do you have any difficulties in affording medical care or medications?			☐ Yes ☐ No
Do you sometimes run out of money to pay for food/rent/bills/ medicine?			☐ Yes ☐ No

MEDICATION & DIETARY GUIDANCE:

How many different prescription medicines do you take:	☐ 1 - 3 ☐ 4 – 6 ☐ 7 - 10 ☐ more than 10 different medications
Challenges with understanding or adhering to medications prescribed?	☐ Yes ☐ No If yes, detail:____________________
Difficulty to pick up medication?	☐ Yes ☐ No If yes, detail:____________________

NECESSITIES:

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply:

Food ☐ Yes ☐ No	Utilities ☐ Yes ☐ No	Clothing ☐ Yes ☐ No
Childcare ☐ Yes ☐ No	Phone ☐ Yes ☐ No	
Medicine or any health care that you needed (medical, dental, mental health care, vision, hearing, etc.)? ☐ Yes ☐ No		
Other ☐ Yes ☐ No	I choose not to answer these questions ☐ Yes ☐ No	

In the past year, has lack of transportation caused you to miss any of the following:

Medical appointments ☐ Yes ☐ No
Non-medical appointments, meetings, work, or getting things I need ☐ Yes ☐ No
I choose not to answer these questions ☐ Yes ☐ No

VACCINATIONS / IMMUNIZATIONS:

Have you had this in the past 12 months?	**Yes**	**No**	**Not yet but want it**
Flu Shot	☐	☐	☐
Pneumonia	☐	☐	☐
COVID	☐	☐	☐

GOALS & PREFERENCES:

What are your personal primary objectives for ESRD care and general health:

____

Specify any treatment preferences, care coordination wishes, or end-of-life decisions:

____

Share any other vital information about your health or care necessities:

____

Thank you for your help. This information is crucial to deliver optimal care tailored to meet your requests and needs. Kindly send this completed form to:

Champion Health Plan
PO Box 15337
Long Beach, CA 90815-9995

If you have any questions or need assistance, please call and ask to have your personal Care Manager return a call to you. Please call **800-885-8000 or 711 for TTY**. Ask for the Care Management Team.