

Champion Advantage, Connect and Select Plans Health Risk Assessment (HRA) Form

Thank you for participating in the Health Risk Assessment (HRA). 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.

Today's date: _____

PERSONAL INFORMATION:

1. Full name: _____

2. Best phone number: _____

3. Date of birth: _____

4. Gender: Female; Male; Other

5. Medicare ID: _____

6. Medicaid (Medi-CAL) ID: _____

7. Preferred language: English; Spanish; Vietnamese; Chinese; Korean

Tagalog; Other: _____

8. 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.

9. Height: _____ (Feet) _____ (Inches)

10. Weight: _____ (Lbs.)

ESRD STATUS:

Please only complete questions 10 through 20 if you have been diagnosed with ESRD.

11. ESRD diagnosis date: _____

12. Have you had a transplant? Yes No If yes, date of transplant: _____

13. Are you on a waiting list for a kidney transplant? Yes No

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14. Are you currently receiving dialysis treatments? Yes No

• If yes, what type of dialysis treatment are you receiving?

o Hemodialysis

In-center

Home Hemodialysis

o Peritoneal Dialysis

CCPD (Continuous Cycling Peritoneal Dialysis)

CAPD (Continuous Ambulatory Peritoneal Dialysis)

o Other: _____

15. Dialysis center name and address: _____

16. Dialysis treatment frequency: 3 times per week; Other: _____

17. Access type

Catheter Fistula Graft

18. Have you had any problems getting to your dialysis treatments?
(e.g., transportation?)

Yes No If yes, details: _____

19. Are you having trouble following your recommended kidney diet?

Yes No If yes, detail: _____

OTHER MEDICAL HISTORY / INFORMATION:

20. How many times were you hospitalized in the past year?

None One Two Times Three Times More

21. How many times did you visit the Emergency Room in the past year?

None One Two Times Three Times More

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22. List any other medical conditions you have (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Asthma or Chronic Bronchitis | <input type="checkbox"/> Congestive Heart Failure (CHF) |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> COPD or Emphysema |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Circulation Problems | |
| <input type="checkbox"/> Diabetes:
<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2
<input type="checkbox"/> Pre-Diabetes <input type="checkbox"/> Gestational | |
| <input type="checkbox"/> Ears: Deafness or trouble hearing even when wearing a hearing aid | <input type="checkbox"/> Eyes: Blindness or trouble seeing even when wearing glasses? |
| <input type="checkbox"/> Frequent Falls | <input type="checkbox"/> Frequent Urinary Tract Infections |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Kidney Failure or End Stage Renal Disease (ESRD) | <input type="checkbox"/> Memory Loss, Dementia, or Alzheimer's |
| <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Parkinson's/ALS/MS/Lupus |
| <input type="checkbox"/> Recent Fracture | <input type="checkbox"/> Serious Mental Illness |
| <input type="checkbox"/> Shortness of Breath or Breathing Problems | <input type="checkbox"/> Skin Ulcer, Non-Healing Wound, Sores |
| <input type="checkbox"/> Stroke, Heart Attack, Chest Pain, or Blocked Arteries | <input type="checkbox"/> Swelling (ankle or leg) |
| <input type="checkbox"/> Urinary Incontinence or Bladder Control Problems | Other:

_____ |

23. Do you have any pain? Yes No

24. Where is your pain? _____

25. Is the pain:

- Sharp Dull Achy Tingling Burning

26. What is your pain score:

- Mild (1-3) Moderate (4-7) Severe (8-10)

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27. How severe is the pain:

- Comes and goes
 Constant Low
 Constant Medium
 Constant High
 Very High
 Prevents sleep

27. How is your hearing?

- Excellent
 Very Good
 Good
 Fair
 Poor

29. 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: _____

30. If you drive yourself, or someone you know drives you, Champion will reimburse money for gas (per IRS standards).

31. How is your eyesight?

- Excellent
 Very Good
 Good
 Fair
 Poor

32. Do you need information in large print? Yes No Other: _____

33. Are you getting injections for your eyes? Yes No

34. Have you been to the dentist in the past year? Yes No

FRAILITY INDICATORS:

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

35. Recent unintentional weight loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
36. Regular feelings of exhaustion or fatigue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
37. Decline in grip strength?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
38. Trouble in walking or ascending stairs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
39. Slower walking speed or reduced physical activity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
40. Any falls in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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BEHAVIOR:

			Frequency
41. Physical activity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Times per week:
42. Smoke or use tobacco	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Times per week:
43. Alcohol use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Times per week:
44. Unprotected sex	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Times per month:
45. Use a seat belt in cars	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Always; <input type="checkbox"/> Sometimes; <input type="checkbox"/> Never
46. Home Safety Evaluation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	We can provide one for you

EMOTIONAL / PSYCHOLOGICAL FEELINGS:

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

47. Reduced interest/pleasure in usual activities in the past two weeks? Yes No
48. Feelings of sadness or hopelessness in the past two weeks? Yes No
49. Feelings of significant anger or rage in the past two weeks? Yes No
50. Feelings of significant stress in the past two weeks? Yes No
51. Feelings of loneliness or social isolation in the past two weeks? Yes No

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LIVING SITUATION AND COMMUNITY SUPPORT:

What is your housing situation today?

52. I have housing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
53. I am staying with others in a hotel	<input type="checkbox"/> Yes	<input type="checkbox"/> No
54. I am staying in a shelter	<input type="checkbox"/> Yes	<input type="checkbox"/> No
55. I am living outside on the street, on a beach, in a car or in a park	<input type="checkbox"/> Yes	<input type="checkbox"/> No
56. Do you live in an independent house, apartment, condo, or mobile home? <input type="checkbox"/> Alone; <input type="checkbox"/> Friend; <input type="checkbox"/> Spouse; <input type="checkbox"/> Child <input type="checkbox"/> Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No
57. Do you live in an assisted living facility/apartment, or board and care home, or nursing home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
58. I choose not to answer these questions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

59. List any community support or resources that help with your ESRD care or wellness:

ACTIVITIES OF DAILY LIVING (ADLS):

Tell us how much help you need with each of the following:

60. Bathing

Can do this myself Need a little help Can't do this I need significant help

61. Dressing

Can do this myself Need a little help Can't do this I need significant help

62. Eating

Can do this myself Need a little help Can't do this I need significant help

63. Toileting

Can do this myself Need a little help Can't do this I need significant help

64. Grooming

Can do this myself Need a little help Can't do this I need significant help

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Can do this myself Need a little help Can't do this I need significant help

66. Transferring (from bed to chair for example)

Can do this myself Need a little help Can't do this I need significant help

67. Do you have someone to help you with the above if you need help? Yes No

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS):

Tell us how much help you need with each of the following:

68. Shopping

Can do this myself Need a little help Can't do this I need significant help

69. Food Preparation

Can do this myself Need a little help Can't do this I need significant help

70. Using the telephone

Can do this myself Need a little help Can't do this I need significant help

71. Housekeeping

Can do this myself Need a little help Can't do this I need significant help

72. Laundry

Can do this myself Need a little help Can't do this I need significant help

73. Taking medications

Can do this myself Need a little help Can't do this I need significant help

74. Handling my finances

Can do this myself Need a little help Can't do this I need significant help

75. Do you have someone to help you with the above if you need help? Yes No

76. Do you have any difficulties in affording medical care or medications? Yes No

77. Do you sometimes run out of money to pay for food/rent/bills/medicine?

Yes No

78. Who helps you at home with daily tasks, treatments, and appointments, and how do they help? _____

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79. Do you have someone who is paid to help take care of you at home, like a caregiver through In-Home Supportive Services (IHSS)? Yes No

80. Do you regularly exercise?

Yes, how often: _____

No, reason: _____

81. Do you use your doctor's patient portal? Yes No

Why not? _____

82. Do you have an advance care plan?

Yes

Living Will

Durable Power of Attorney for Healthcare

Do Not Resuscitate (DNR) Order

Physician Orders for Life-Sustaining Treatment (POLST)

Do Not Intubate (DNI)

No

MEDICATION & DIETARY GUIDANCE

83. How many different prescription medicines do you take:

1 - 3; 4 - 6; 7 - 10; more than 10 different medications

84. Challenges with understanding or adhering to medications prescribed?

Yes No If yes, detail: _____

85. Do you have difficulty picking up your medications?

Yes No If yes, detail: _____

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NECESSITIES:

In the past year, did you or anyone you live with have trouble getting any of the following when really needed? Check all that apply:

86. Food	<input type="checkbox"/> Yes	<input type="checkbox"/> No
87. Utilities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
88. Clothing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
89. Childcare	<input type="checkbox"/> Yes	<input type="checkbox"/> No
90. Medicine or any health care that you needed (medical, dental, mental health care, vision, hearing, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
91. Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
92. Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No
93. I choose not to answer these questions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

94. Medical appointments	<input type="checkbox"/> Yes	<input type="checkbox"/> No
95. Non-medical appointments, meetings, work, or getting things I need	<input type="checkbox"/> Yes	<input type="checkbox"/> No
96. I choose not to answer these questions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

VACCINATIONS / IMMUNIZATIONS:

Have you had this in the past 12 months?

97. Flu Shot	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not yet but want it
98. Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not yet but want it
99. COVID	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not yet but want it

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100. What are your main personal goals for your kidney care and overall health?

101. Do you have any wishes for your treatment, how your care is managed, or end-of-life care?

102. As the caregiver, what is your main goal for your family member/client?

ADDITIONAL FEEDBACK:

103. 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 **1-800-885-8000** or **711 for TTY**. Ask for the Care Management Team.