

Champion Ally, Care and Choice Plans Health Risk Assessment (HRA) Form

This information will help us understand your health needs. Your answers WILL NOT affect your benefits. We may share your information with your primary care provider(s). Direct questions about this form to 1-800-885-8000 or 711 for TTY.

Today's date: _____

Personal Information

Name: _____

Address (City/State/ZIP): _____

Best Phone Number: _____

Date of Birth: _____

Medicare ID: _____

Medicaid (Medi-CAL) ID: _____

Champion Health Plan Member ID: _____

Person Completing this form: _____

Relationship to Member: _____

Right to Consent or Decline

I Accept/Opt In or Decline/Opt Out to participate in Champion Health Plan's Health Risk Assessment (HRA)

Physical Health Rating

1. What is your height _____(inches only)
2. What is your weight _____(pounds)
3. Are you concerned about your health? Yes No
4. Do you feel you get enough physical activity/exercise? Yes No
5. Do you feel that your diet supports a healthy lifestyle? Yes No

Champion Ally, Care and Choice Plans Health Risk Assessment (HRA) Form (Cont.)

Activities of Daily Living

6. How much help do you need with the following?

Activity	No Help Needed	Some Help Needed	Can't Do at All
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting out of bed or chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking your medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Where do you currently live?

- Private Home
 Assisted Living
 Nursing Home
 Group Home
 Apartment
 Condo
 Half-way House
 Trailer/Mobile Home Park
 Homeless
 Other

8. If you need help, do you have someone close by or a caregiver who helps you?

- Family
 Friend
 Neighbor
 Caregiver
 No help
 I prefer not to answer
 Other

9. Medical Equipment (check all that apply)

- Walker
 Wheelchair
 Hospital Bed
 Oxygen
 Nebulizer
 Portable Toilet
 Shower Chair
 C-pap/Bi-pap
 Other

Social Determinants of Health

10. Is there anything preventing you from taking steps to get the care you need?

- Yes
 No
 N/A

If yes, check all that apply

- Transportation
 Cost of Medical Services
 Cost of Medications
 Access to Services
 Care Giver Support
 Language differences
 Cultural differences
 Hard of hearing
 Visual difficulties
 Family objections
 Social issues: discrimination/distrust
 Mental health issues/distrust some people
 Domestic violence /abuse
 Elder abuse
 Other

Champion Ally, Care and Choice Plans Health Risk Assessment (HRA) Form (Cont.)

Clinical Health History & Treatment

11. What is the name of your Primary Care Physician (PCP)? _____

12. Do you need a PCP? I need a new PCP No
13. When did you last see your Primary Care Physician? Less than 6 mo.
 More than 6 mo. 12 mo. or greater
14. How many times were you admitted to the Hospital or Emergency Room in the past 12 months? 0 1 time 2 times 3 times More than 3 times
15. Have you been in a post-acute facility (skilled nursing, rehabilitation, or long-term care) in the past 12 months? 0 1 time 2 times 3 times
 More than 3 times
16. Please check Yes or No and include Treating Provider(s) for the following conditions:

Asthma or Chronic Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
COPD or Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Shortness of Breath or Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Frequent Falls	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Recent Fracture	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Parkinson's/ALS/MS/Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):

Champion Ally, Care and Choice Plans Health Risk Assessment (HRA) Form (Cont.)

Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Serious Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Eyes: Blindness or trouble seeing even when wearing glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Ears: Deafness or trouble hearing even when wearing a hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Stroke, Heart Attack, Chest Pain, or Blocked Arteries	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Congestive Heart Failure (CHF)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Circulation Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Swelling (ankle or leg)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Pre-Diabetes <input type="checkbox"/> Gestational	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Skin Ulcer, Non-Healing Wound, Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Memory Loss, Dementia, or Alzheimer's	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Urinary Incontinence or Bladder Control Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):

Champion Ally, Care and Choice Plans Health Risk Assessment (HRA) Form (Cont.)

Frequent Urinary Tract Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Kidney Failure or End Stage Renal Disease (ESRD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Bowel Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provider name(s):

Life Planning Activities

17. Do you have or need the following: Advance Health Care Directive such as a Living Will or Physician Orders for Life-Sustaining Treatment (POLST)?
 Yes No I need one

Preventive Health Maintenance

- 18. Do you get a flu vaccine/shot annually? Yes No
- 19. Have you received a Covid vaccine/shot in the year? Yes No
- 20. Have you had a colon cancer check /screening in the last 10 years? Yes No
- 21. Have you had a pap test in the past 2 years? Yes No N/A
- 22. Have you had a mammogram in the past 2 years? Yes No N/A
- 23. Do you use tobacco (smoke, chew, snuff, or in any other form)? Yes No
- 24. Does drinking alcohol interfere with your personal or work life? Yes No
- 25. Frequency of Pain in the past week?
 No pain Pain some days Pain every day
- 26. Pain Management medication or other therapies? Yes No

Champion Ally, Care and Choice Plans Health Risk Assessment (HRA) Form (Cont.)

Behavioral & Mental Health

27. Over the past 2 weeks, how often have you been bothered by any of the following feelings?

Feeling down, depressed, hopeless	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Little interest/pleasure in doing things	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Crying Spells	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Difficulty Sleeping	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Nervousness / Anxious / Worried	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Agitated / Irritable / Angry	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day
Thought of hurting myself or others	<input type="checkbox"/> Not at All <input type="checkbox"/> Several Days <input type="checkbox"/> More than Half the Days <input type="checkbox"/> Nearly Every Day

28. Do personal or family health issues result in loss of work or daily activities?

Yes No Unsure N/A

29. What stressors do you have at the moment (check all that apply)?

Relationships Family Children Lack of Social Support Occupation
 General Physical Health Financial Other N/A

Cultural and Linguistic Needs

30. Do you identify with a religion or spiritual tradition?

Atheism/Agnosticism Buddhism Catholicism Christianity
 Christian Science Hinduism Islam Jehovah's Witness Judaism
 Mormon Other None/Unaffiliated I prefer not to answer

31. What is your primary language?

English Spanish Chinese French Creole Korean Vietnamese
 Tagalog I prefer not to answer Other

Champion Ally, Care and Choice Plans Health Risk Assessment (HRA) Form (Cont.)

32. How do you describe your ethnicity?

- White or Caucasian Black or African American Hispanic /Latino
 Native American Indian/Alaskan Native Asian
 Pacific Islander/Native Hawaiian Unknown
 I prefer not to answer Other

Demographics

33. What gender do you identify?

- Male Female Intersex Trans Non-conforming Personal
 Eunuch I prefer not to answer Other _____

34. Who do you currently live with?

- Alone Child(ren) Extended Family Friend(s) Parent(s)
 Roommate(s) Sibling(s) Spouse/Partner Other _____

Housing

35. Do you have the following problems (check all that apply)?

- Bugs Rodents Lead/Asbestos Mold Electric Issues
 Heating Issues Water Issues House not safe
 No issues Other _____

36. Do you have internet access (check all that apply)?

- Computer Phone Tablet Other _____

Personal Goals

37. What is your main goal for your overall health? _____

38. As the caregiver, what is your main goal for your family member or client? _____

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