CHAMPION HEALTH PLAN

Champion Plus 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 HEALTH PLAN

Champion Plus 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	☐	☐	☐
Dressing	☐	☐	☐
Eating	☐	☐	☐
Getting out of bed or chair	☐	☐	☐
Preparing meals	☐	☐	☐
Taking your medicine	☐	☐	☐
Using the bathroom	☐	☐	☐
Walking	☐	☐	☐
Transportation	☐	☐	☐

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 HEALTH PLAN

Champion Plus 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? ☐ Yes ☐ No

13. When did you last see your Primary Care Physician? ☐ Less than 6 mo. ☐ More than 6 mo. ☐ 12 mo. or greater

14. Do you need a psychiatrist? ☐ Yes ☐ No

15. When did you last see your psychiatrist? ☐ Less than 6 mo. ☐ More than 6 mo. ☐ 12 mo. or greater

16. 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

17. 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

18. Please check **Yes** or **No** and include Treating Provider(s) for the following conditions:

Asthma or Chronic Bronchitis	☐ Yes ☐ No	If Yes, Provider name(s):
COPD or Emphysema	☐ Yes ☐ No	If Yes, Provider name(s):
Shortness of Breath or Breathing Problems	☐ Yes ☐ No	If Yes, Provider name(s):
Frequent Falls	☐ Yes ☐ No	If Yes, Provider name(s):
Osteoporosis	☐ Yes ☐ No	If Yes, Provider name(s):
Osteoarthritis	☐ Yes ☐ No	If Yes, Provider name(s):
Recent Fracture	☐ Yes ☐ No	If Yes, Provider name(s):
Parkinson's/ALS/MS/Lupus	☐ Yes ☐ No	If Yes, Provider name(s):
Cancer	☐ Yes ☐ No	If Yes, Provider name(s):

CHAMPION HEALTH PLAN

Champion Plus Health Risk Assessment (HRA) Form (Cont.)

HIV/AIDS	☐ Yes ☐ No	If Yes, Provider name(s):
Depression	☐ Yes ☐ No	If Yes, Provider name(s):
Mental Illness: (Check all that apply) ☐ Bipolar Disorder ☐ Paranoid Disorder ☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Major Depressive Disorder	☐ Yes ☐ No	If Yes, Provider name(s):
Eyes: Blindness or trouble seeing even when wearing glasses	☐ Yes ☐ No	If Yes, Provider name(s):
Ears: Deafness or trouble hearing even when wearing a hearing aid?	☐ Yes ☐ No	If Yes, Provider name(s):
Stroke, Heart Attack, Chest Pain, or Blocked Arteries	☐ Yes ☐ No	If Yes, Provider name(s):
Congestive Heart Failure (CHF)	☐ Yes ☐ No	If Yes, Provider name(s):
Circulation Problems	☐ Yes ☐ No	If Yes, Provider name(s):
High Blood Pressure	☐ Yes ☐ No	If Yes, Provider name(s):
Swelling (ankle or leg)	☐ Yes ☐ No	If Yes, Provider name(s):
Diabetes ☐ Type 1 ☐ Type 2 ☐ Pre-Diabetes ☐ Gestational	☐ Yes ☐ No	If Yes, Provider name(s):
Skin Ulcer, Non-Healing Wound, Sores	☐ Yes ☐ No	If Yes, Provider name(s):
Organ Transplant	☐ Yes ☐ No	If Yes, Provider name(s):

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Memory Loss, Dementia, or Alzheimer's	☐ Yes ☐ No	If Yes, Provider name(s):
Urinary Incontinence or Bladder Control Problems	☐ Yes ☐ No	If Yes, Provider name(s):
Frequent Urinary Tract Infections	☐ Yes ☐ No	If Yes, Provider name(s):
Kidney Failure or End Stage Renal Disease (ESRD)	☐ Yes ☐ No	If Yes, Provider name(s):
Bowel Problems	☐ Yes ☐ No	If Yes, Provider name(s):
Other	☐ Yes ☐ No	If Yes, Provider name(s):

Life Planning Activities

19. 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

20. Do you get a flu vaccine/shot annually? ☐ Yes ☐ No

21. Have you received a Covid vaccine/shot in the last year? ☐ Yes ☐ No

22. Have you had a colon cancer check/screening in the last 10 years? ☐ Yes ☐ No

23. Have you had a pap test in the past 2 years? ☐ Yes ☐ No ☐ N/A

24. Have you had a mammogram in the past 2 years? ☐ Yes ☐ No ☐ N/A

25. Do you use tobacco (smoke, chew, snuff, or in any other form)? ☐ Yes ☐ No

26. Does drinking alcohol interfere with your personal or work life? ☐ Yes ☐ No

27. Frequency of Pain in the past week?
☐ No pain ☐ Pain some days ☐ Pain every day

28. Pain Management medication or other therapies? ☐ Yes ☐ No

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Behavioral & Mental Health

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

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

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

☐ Yes ☐ No ☐ Unsure ☐ N/A

31. 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

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Substance Use

32. Do you currently use any substance? ☐ None ☐ Yes (If the answer is YES, check all that apply below)

Substance	0 times	1–2 times	Monthly	Weekly	Daily or almost daily
Tobacco (cigarettes, vaping, chew)	☐	☐	☐	☐	☐
Alcohol (beer, wine, liquor)	☐	☐	☐	☐	☐
Marijuana (smoke, vape, edibles)	☐	☐	☐	☐	☐
Prescription medications not prescribed to you (pain pills, stimulants, sedatives)	☐	☐	☐	☐	☐
Illegal drugs (cocaine, meth, heroin, ecstasy, etc.)	☐	☐	☐	☐	☐
Inhalants (sniffed or huffed substances)	☐	☐	☐	☐	☐
Other substances: _____	☐	☐	☐	☐	☐

Safety and Risk

33. Do you have thoughts of harming yourself? ☐ Never ☐ Sometimes ☐ Frequently

34. Do you have thoughts of harming others? ☐ Never ☐ Sometimes ☐ Frequently

35. Do you take your medication as prescribed by your physician?

☐ Yes, all the time ☐ Misses occasionally ☐ Misses frequently

Cultural and Linguistic Needs

36. 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

37. What is your primary language?

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

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38. 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

39. What gender do you identify?

☐ Male ☐ Female ☐ Intersex ☐ Trans ☐ Non-conforming ☐ Personal
☐ Eunuch ☐ I prefer not to answer ☐ Other_____

40. Who do you currently live with?

☐ Alone ☐ Child(ren) ☐ Extended Family ☐ Friend(s) ☐ Parent(s)
☐ Roommate(s) ☐ Sibling(s) ☐ Spouse/Partner ☐ Other_____

Housing

41. 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 _____

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

☐ Computer ☐ Phone ☐ Tablet ☐ Other _____

Personal Goals

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

_____

44. 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