CHAMPION HEALTH PLAN

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, TTY 711. Your answers will be used to help update your individualized care plan and connect you with your care team, providers, benefits, and community resources when appropriate.

Today's date: _____

Preferred spoken language: _____

Preferred written language: _____

Do you need an interpreter, large print, braille, or another format?

☐ No ☐ Yes (specify): _____

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. Blood pressure (if taken by provider or known): _____

4. Are you concerned about your health?

☐ Yes ☐ No

5. How would you rate your health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Health Risk Assessment (HRA) Form (Cont.)

6. Do you feel you get enough physical activity/exercise?

☐ Yes ☐ No

7. During the past 30 days, how many days per week did you engage in moderate exercise (for example, a brisk walk that makes you breathe a little harder)?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

8. Have you fallen in the last 12 months?

☐ Yes ☐ No

9. Do you feel unsteady when walking?

☐ Yes ☐ No

10. Are you worried about falling?

☐ Yes ☐ No

Activities of Daily Living

11. 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 in/out of bed or chair	☐	☐	☐
Walking	☐	☐	☐
Taking your medicine	☐	☐	☐
Preparing meals	☐	☐	☐
Managing finances	☐	☐	☐
Transportation to appointments	☐	☐	☐

12. Do you have someone who helps you with these activities?

☐ No ☐ Family ☐ Friend ☐ Paid Caregiver ☐ Other _____

Living Situation / Caregiver / Home Safety

Health Risk Assessment (HRA) Form (Cont.)

13. Where do you currently live?

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

14. Who do you currently live with?

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

15. 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 _____

16. If you have a caregiver, you can share their information here:

Name: _____

Relationship to you: _____ Phone: _____

17. Does your caregiver need support or respite resources (a break from caregiving)?

☐ No ☐ Yes ☐ Not applicable ☐ I prefer not to answer

Medical Equipment

18. Do you currently use any of the following medical equipment at home? (Check all that apply.)

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

Social Determinants of Health

19. Housing Stability
What is your current living situation?

☐ I have stable housing ☐ I am worried about losing my housing
☐ I do not have stable housing

20. Food Security
In the past 12 months, were you ever worried that your food would run out before you had money to buy more?

☐ Often ☐ Sometimes ☐ Never

21. Transportation
In the past 12 months, has lack of transportation made it difficult for you to get

medical care, medications, or other necessities?

☐ Yes ☐ No

General Barriers to Care

22. Do you have any barriers that make it difficult to get the care you need? (Check all that apply.)

☐ Transportation ☐ Cost of medications or medical services

☐ Language or communication needs ☐ Need for caregiver support

☐ Mental health concerns ☐ No barriers ☐ Other: _____

Resource Assistance

23. Would you like help connecting with community resources or plan benefits?

☐ Yes ☐ No ☐ Maybe later

Clinical Health History and Treatment

24. How many times were you admitted to the Hospital or Emergency Room in the past 24 months?

☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ More than 3 times

25. Do you currently have any of the following health conditions? (Check all that apply.)

☐ Arthritis, osteoporosis, or other bone/joint disorder

☐ Cancer (current or treated within the last 5 years)

☐ Chronic pain condition

☐ Diabetes

☐ Hearing impairment

☐ Heart disease (heart attack, heart failure, coronary artery disease, irregular heartbeat)

☐ High blood pressure (hypertension)

☐ Kidney disease or dialysis

☐ Lung disease (COPD, emphysema, asthma, chronic breathing problems)

☐ Memory problems, dementia, or Alzheimer's disease

☐ Mental health condition (depression, anxiety, bipolar disorder, schizophrenia, PTSD, or other behavioral health condition): (specify) _____

☐ Organ transplant (speciy organ) _____

☐ Stroke or neurological disorder (stroke, Parkinson's disease, multiple sclerosis,

seizure disorder)

☐ Vision impairment

☐ Other significant health condition: _____

☐ None of the above

26. Do you have trouble getting, taking, understanding, or paying for medications?

☐ No ☐ Yes (describe): _____

27. Primary care provider (PCP) name/phone: _____

Date of last PCP visit: _____

Life Planning Activities

28. Do you have an Advance Health Care Directive, Living Will, or Physician Orders for Life-Sustaining Treatment (POLST)?

☐ Yes ☐ No ☐ Not sure ☐ I would like information

Preventive Health Maintenance

29. Are you up to date with your recommended vaccines and preventive screenings, or would you like assistance scheduling them?

☐ Yes, I am up to date (Check all that apply.)

Vaccines: ☐ Flu ☐ COVID-19 ☐ Pneumonia ☐ Shingles

☐ Td/Tdap ☐ RSV ☐ Other _____

Preventive Screenings: ☐ Colon cancer ☐ Breast cancer ☐ Cervical cancer

☐ Diabetic eye exam ☐ A1c ☐ Kidney health ☐ Dental ☐ Vision

☐ Hearing ☐ Other _____

☐ No, I may be due for vaccines or screenings

☐ Not sure

☐ I would like assistance

Pain Assessment

30. In the past week, how often did pain interfere with your daily activities or sleep?

☐ Never ☐ Some days ☐ Every day

31. If you have pain, where is it located? _____

Behavioral and Mental Health

Health Risk Assessment (HRA) Form (Cont.)

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

Feeling	Not at All	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐

33. Are you currently having thoughts of hurting yourself or others?

☐ No ☐ Yes

Substance Use

34. Do you currently use any of the following substances? (Check all that apply.)

- ☐ Tobacco products (cigarettes, cigars, vaping, chewing tobacco)
- ☐ Alcohol (beer, wine, liquor)
- ☐ Marijuana/Cannabis
- ☐ Prescription medications not prescribed to you
- ☐ Illegal or street drugs
- ☐ Other: _____
- ☐ None of the above
- ☐ Prefer not to answer

35. Would you like help reducing or stopping your use of any substance?

☐ Yes ☐ No ☐ Not at this time ☐ Not applicable ☐ Prefer not to answer

Personal Goals

36. What is your main goal for your overall health?

_____

For Caregivers Only

37. 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
5000 Airport Plaza Dr., Ste. 100
Long Beach, CA 90815-1273