Sentara®
Health Plans

PO Box 66189
Virginia Beach, VA 23466

Broker-assisted Health Risk Assessment form

INSTRUCTIONS

Please fill out the attached Health Risk Assessment form completely and to the best of your ability.

Once we receive confirmation of your enrollment in Sentara Medicare, you may receive a call from your licensed broker to assist with completing this Health Risk Assessment. If your licensed broker is assisting you, please put their name and national producer number (NPN) on the last two lines of the form, on page 4, where it reads 'Broker' and 'Broker NPN.'

When you are finished filling out this form, please return it in the enclosed LIGHT BLUE* postage paid envelope.

Please note: Once you are enrolled, your care coordinator will call to complete your annual comprehensive health assessment needed to create your individualized care plan.

**Please do NOT send your enrollment application or any document other than the Health Risk Assessment form back in the LIGHT BLUE postage paid envelope. Your enrollment application will be delayed or could be lost if it is sent back in the LIGHT BLUE postage paid envelope.*

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Name:	Today's date:
Date of birth:	Telephone:
Sentara ID number (not required):	Assigned primary care provider (PCP):
Assessment type: ☐ Initial ☐ Reassessment ☐ Triggering—change in condition	How completed: ☐ Member completed with broker ☐ Member completed & mailed to SHP ☐ Member completed with CM/MO via phone ☐ Member completed with CM face to face ☐ Member/DR refused

1. Do you have any special communication needs (language, hearing, seeing, or talking)? **Check all that apply:**

☐ None
☐ Deaf
☐ Blind
☐ Speech
☐ Limited English proficiency—primary language is:
  ☐ English
  ☐ Chinese
  ☐ French
  ☐ German
  ☐ Italian
  ☐ Korean
  ☐ Portuguese
  ☐ Russian
  ☐ Spanish
  ☐ Tagalog
  ☐ Vietnamese
  ☐ N/A
  ☐ Member/DR refused
  ☐ Other: _____
☐ Non-reader
☐ Hard of hearing
☐ Visual impairment
☐ Member/DR refused

2. What is your preferred method of communication?

☐ Phone
☐ Text
☐ Email
☐ Letter
☐ Initial: Member/DR refused
☐ Reassessment: N/A, refused
☐ Other: _____

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3. What is your current weight? _____pounds

4. What is your current height? _____ feet _____ inches

5. Do you have a Living Will, durable power of attorney for healthcare and/or Advance Directive?
   ☐ Yes ☐ No ☐ Unsure If yes, date completed: _____

6. Do you have an appointment scheduled for an Annual Wellness Visit with your primary care provider (PCP)?
   ☐ Yes ☐ No If yes, when? _____

7. Have you been able to get all of the medications ordered by your doctor at the pharmacy?
   ☐ Yes ☐ No

8. Do you need help with any of the following activities? **Check all that apply:**
   - ☐ Using the bathroom
   - ☐ Walking
   - ☐ Eating
   - ☐ Taking a bath/shower
   - ☐ Getting in or out of bed/chair
   - ☐ Managing finances
   - ☐ Shopping
   - ☐ Taking medications
   - ☐ Bladder/bowel control
   - ☐ Climbing stairs
   - ☐ Preparing and/or cooking a meal
   - ☐ Getting dressed
   - ☐ Brushing hair, teeth, etc.
   - ☐ Washing dishes, doing laundry, or chores
   - ☐ Using a telephone
   - ☐ Currently does not need any help with ADL's or IADL's
   - ☐ Member/DR refused

9. Do you use any of the following medical supplies or equipment in your day to day tasks or for mobility?
   - ☐ Catheter
   - ☐ Diapers/incontinence supplies
   - ☐ Hospital bed
   - ☐ Oxygen
   - ☐ Walker/cane
   - ☐ Wheelchair
   - ☐ Other (please describe) _____
   - ☐ None of the above

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10. Have you been able to get all of the equipment that has been ordered by your provider or doctor?

☐ Yes ☐ No ☐ None needed ☐ N/A ☐ Member/DR refused

11. Has a doctor ever told you that you have any of the following conditions? **Check all that apply**.

☐ Alzheimer's or dementia
☐ Cancer
☐ Osteoporosis
☐ High cholesterol
☐ High blood pressure or hypertension
☐ End-stage renal disease (ESRD or kidney failure)
☐ Chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis
☐ Depression, anxiety, or other behavioral health diagnoses
☐ Heart disease (Coronary artery disease, angina, heart attack, atrial fibrillation)
☐ Arthritis
☐ Diabetes
☐ Stroke
☐ Heart failure (CHF)
☐ None of the above

12. Are you currently under a doctor's care for cancer?

☐ Yes ☐ No If yes, what type?_____

13. Have you been bothered by any of the following problems in the last two weeks?

Little interest or pleasure in doing things ☐ Yes ☐ No

Feeling down, depressed, or hopeless ☐ Yes ☐ No

14. Are you currently seeing a behavioral healthcare provider?

☐ Yes ☐ No

15. Do you have pain daily?

☐ Yes ☐ No

16. Are you currently seeing a doctor for your pain?

☐ Yes ☐ No ☐ N/A- no pain issues

If yes, who is your doctor?

Name: _____ Phone: (_____)_____

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17. Do you currently smoke or use any tobacco products?

☐ Yes ☐ No ☐ Member/DR refused

18. Do you drink alcohol, use recreational drugs, or use prescription drugs other than as prescribed by your provider?

☐ Yes ☐ No ☐ Member/DR refused

19. Describe your general overall health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

20. How does your health compare to a year ago?

☐ Much better ☐ Better ☐ Same ☐ Worse

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Emergency room/urgent care center:

21. How many times have you been to the emergency room (ER) or urgent care center in the past 3 months? ____

22. Have you had an unplanned admission to the hospital in the past 12 months?

    ☐ Yes ☐ No

    If yes, why?

23. Have you had any surgery in the past year?

    ☐ Yes ☐ No

    If yes, please describe:

24. Have you had any complications from surgery in the past year or needed to be readmitted to the hospital within 30 days of discharge?

    ☐ Yes ☐ No

    If yes, please describe:

25. Do you have any surgeries or procedures planned?

    ☐ Yes ☐ No

    If yes, what is the surgery or procedure for?_____

26. How many times have you had a fall in the last 90 days and needed to visit a doctor, emergency room, urgent care center, or hospital because of the fall? ____

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27. Do you have a caregiver that helps you with your personal care (bathing, dressing, cooking, or mobility needs)?

☐ Yes ☐ No ☐ Member/DR refused

28. Does your health prevent you from leaving your home?

☐ Yes ☐ No ☐ Member/DR refused

29. Do you have any other healthcare concerns that you would like assistance addressing?

☐ Yes ☐ No

30. What goals do you have for your health? _____

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Immunizations and preventive health:

31. Have you ever had the flu shot?

☐ Yes ☐ No ☐ Unsure If yes, date received: _____

32. Have you ever had the pneumonia shot?

☐ Yes ☐ No ☐ Unsure If yes, date received: _____

33. For members over 45: Have you had a colonoscopy in the last 10 years?

☐ Yes ☐ No ☐ Unsure ☐ N/A Date of last exam: _____

34. For female members age 40 or older: Have you had a mammogram in the last year?

☐ Yes ☐ No ☐ Unsure ☐ N/A Date of last exam: _____

35. For female members: Have you had a pelvic exam & PAP smear in the last two years?

☐ Yes ☐ No ☐ Unsure ☐ N/A Date of last exam: _____

36. For male members age 50 and older: Have you had a prostate check (exam or blood test) in the last year?

☐ Yes ☐ No ☐ Unsure ☐ N/A Date of last exam: _____

37. For members with diabetes: Have you had a diabetic eye exam in the last year?

☐ Yes ☐ No ☐ Unsure ☐ N/A Date of last exam: _____

38. For members with diabetes: Have you had a diabetic foot exam in the last year?

☐ Yes ☐ No ☐ Unsure ☐ N/A Date of last exam: _____

39. For diabetic members: What was your last A1C?

☐ Unsure ☐ 8.9 or less ☐ 9.0 or greater ☐ N/A

40. For members with hypertension: Have you had your blood pressure checked at your PCP or specialist in the last year?

☐ Yes ☐ No ☐ Unsure ☐ N/A Date checked: _____

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Social determinants of health and health risk assessment:

41. What is the highest level of school that you have finished? **Check all that apply:**
    - ☐ Completed or some elementary school grades K-5
    - ☐ Completed or some junior high school grades 6-8
    - ☐ Some high school but no diploma
    - ☐ High school diploma or equivalency (GED)
    - ☐ Some college but no degree
    - ☐ Workforce credential or industry certification after high school
    - ☐ Associate degree
    - ☐ Bachelor degree or higher
    - ☐ I would like help in completing education or obtaining education
    - ☐ I choose not to answer this question

42. What is your housing situation, today? Do you have a place to live?
    - ☐ I have housing/a place to live
        - ☐ Yes
        - ☐ No
        - ☐ I am worried about losing my housing
    - ☐ I do not have housing. **Check all that apply:**
        - ☐ Staying with others, ie. apartment with family/house with friend
        - ☐ Living in a hotel
        - ☐ Living in a shelter
        - ☐ Living outside (on the street, on a beach, in a car, or in a park)
    - ☐ I choose not to answer this question

43. In the past 12 months, did you worry whether your food would run out before you got money to buy more?
    - ☐ Yes ☐ No ☐ Sometimes

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44. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? **Check all that apply:**

- ☐ Yes, it has kept me from medical appointments or from getting my medications
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- ☐ No

45. Do you have other important health issues or needs that you would like to discuss with someone?

☐ Yes ☐ No

46. How soon do you want to be contacted by someone to discuss your health issues or needs?

- ☐ 1–30 days
- ☐ 31–60 days
- ☐ 61–90 days
- ☐ 91–120 days
- ☐ Do not contact me

Name of person completing this survey: _____

Relationship: _____

Broker: _____

Broker NPN: _____