Clever Care HEALTH PLAN

Health Risk Assessment

Member's first name:	Member's last name:	Middle initial:
Clever Care member ID number:	Date of birth:	HRA completion date:
Member phone number:	Primary Care Provider (PCP) name:	

How was the HRA completed:

☐ Telephone ☐ Face-to-Face ☐ Telehealth/Virtual ☐ Paper

If applicable, list all individuals who helped complete this form (i.e. provider, family member, friend, broker):

Name(s):	Relationship to member:
Broker Name:	Broker NPN:

Information About Me

1. **Please describe anything related to your culture, beliefs, religious practices, or anything else important to you that would help us serve you better.**

_____

_____

2. **a. What is your current housing situation?**

☐ I have a stable place to live

☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park). Explain: _____

b. Are you worried about losing your housing?

☐ No ☐ Yes, explain: _____

3. **Do you feel physically and emotionally safe where you currently live?**

☐ Yes ☐ No, explain: _____

4. **Who do you currently live with?**

☐ Living alone ☐ Living with spouse, family or friend ☐ Other: _____

5. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?**

☐ Yes, it has kept me from medical appointments.

☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things I need such as groceries.

☐ No

6. **In the past year, have you or any family members you live with been unable to get any of the following due to lack of money, access, or availability when needed? Select all that apply.**

- ☐ Food
- ☐ Utilities
- ☐ Phone
- ☐ Clothing
- ☐ Health care (medical, dental, mental health, vision)
- ☐ Other: _____
- ☐ None

7. **Do you have an Advance Directive or Living Will in place to ensure your medical wishes are followed if you are ever unable to speak for yourself (e.g., due to illness or injury)?**

- ☐ Yes, my wishes are documented in an Advance Directive or Living Will.
- ☐ No, I do not currently have written instructions or documentation in place.

Pain Screening

8. **Are you experiencing any pain now or in the last two weeks?**

- ☐ No
- ☐ Yes

At its worst, how severe is your pain (0 to 10 with 10 being the worst)?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Have you talked to your doctor or someone else about how to manage your pain?

- ☐ Yes, who? _____
- ☐ No

9. **Please select if you use any of the following equipment:**

- ☐ Don't have/use any equipment
- ☐ Dentures
- ☐ Medical alert device
- ☐ Lift chair
- ☐ Hearing aid
- ☐ Transfer equipment
- ☐ Glasses/contact lenses
- ☐ Bedside commode
- ☐ Incontinence supplies (pads, liners)
- ☐ Bathing equipment
- ☐ Walker/Cane
- ☐ Wheelchair (manual, electric)
- ☐ Other: _____
- ☐ **List equipment you need but do not have:** _____

Communication Connections

10. **How well do you feel you can communicate your health care needs or concerns to your providers (including in-home, medical, and mental health providers)?**

- ☐ Good, I can communicate all my needs and concerns
- ☐ Fair, I can communicate some but not all needs or concerns
- ☐ Poor, I usually have trouble understanding. Explain: _____

11. **How well do you understand health care providers' instructions regarding your health care?**

- ☐ Good, I have no trouble understanding
- ☐ Fair, I sometimes have trouble understanding
- ☐ Poor, I usually have trouble understanding. Explain: _____

12. What is the highest level of school that you have finished?

☐ More than high school degree ☐ High school diploma/GED ☐ Less than high school degree

My Health

13. Compared to other people your age, would you say your health is: (Please select one.)

☐  Excellent ☐  Good ☐  Fair ☐  Poor

14. Over the past two weeks, how often have you been bothered by any of the following problems?

	 Not at all	 Several days	 More than half of the days	 Nearly every day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐

15. How often do you feel lonely or isolated from those around you?

☐ Never ☐ Sometimes ☐ Often

16. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

☐ Not at all ☐ Somewhat ☐ Quite a bit

17. Do you have any of the following listed health problems? Select all that apply.

☐ Heart disease (heart attack, heart failure) ☐ High blood pressure
☐ Diabetes (high blood sugar) ☐ Lung disease (asthma, COPD)
☐ Mental health (depression, anxiety) ☐ High cholesterol
☐ Other (such as: stroke, arthritis, cancer): _____

18. Please list the medications, frequency, and dosage you are taking, including alternative therapy and herbal medicines.

Medication Name	Dosage/Strength	How often are you taking it?

19. Is there anything that prevents you from taking medications as prescribed (select all that apply)?

- ☐ Nothing
- ☐ Not sure how to take
- ☐ I don't believe in medications
- ☐ No system for managing
- ☐ Side Effects
- ☐ Cost
- ☐ Difficulty filling prescriptions
- ☐ Transportation/Access
- ☐ Visual Problems
- ☐ Forgetfulness
- ☐ Scheduling
- ☐ Other: _____

20. How many days a week do you exercise at least 30 minutes?

- ☐ None
- ☐ One or two
- ☐ Three or four
- ☐ Five or more

21. In the past year, did you go to an emergency room or stay overnight or longer in a hospital?

- ☐ No
- ☐ Yes, how many times? _____

22. How many times have you fallen to the ground in the last year?

- ☐ None
- ☐ One or two
- ☐ Three or more

My Everyday Life

23. Caregiver: Is there someone who regularly helps you care for your home or yourself, or regularly helps with errands or other things (such as family, friend, home care)?

- ☐ No
- ☐ Yes, caregiver name: _____

24. What is your ability to complete these tasks?

	 I don't need help	 I need some help or use equipment	 I always need help
Bathing	☐	☐	☐
Grooming	☐	☐	☐
Getting dressed	☐	☐	☐
Getting to and from the toilet	☐	☐	☐
Transferring in and out of chair or bed	☐	☐	☐
Walking, not climbing stairs	☐	☐	☐
Shopping	☐	☐	☐
Preparing meals	☐	☐	☐
Feeding yourself	☐	☐	☐
Using the telephone	☐	☐	☐
Housekeeping	☐	☐	☐
Laundry	☐	☐	☐

Alcohol/Tobacco

25. Do you drink alcohol?

☐ No ☐ Yes, are you interested in quitting or reducing your intake? ☐ Yes ☐ No

26. Do you currently use tobacco products (cigarettes, cigars, snuff, chew, vape, electronic cigarettes)?

☐ No ☐ Yes, are you interested in quitting or reducing your intake? ☐ Yes ☐ No

Health Goals

27. What are your health goals for everyday life? Please select at least one of the health goals listed below.

- ☐ Complete an annual wellness exam with my primary care provider (PCP)
- ☐ Volunteer for a local organization, such as the library, an animal shelter, or soup kitchen
- ☐ Work on maintaining or increasing my balance and strength to avoid falls
- ☐ Talk with my doctor to develop a regular exercise plan
- ☐ Follow a nutritious and healthy diet to maintain or improve my health
- ☐ Other personalized goal: _____

28. Are there any barriers that may keep you from accomplishing your goal(s)?

- ☐ No
- ☐ Yes – Select all that apply:
  - ☐ Transportation
  - ☐ Lack of time
  - ☐ Other _____
  - ☐ Lack of motivation
  - ☐ Lack of resources/equipment

F10004-A-EN (06/25)