Health Risk Assessment (HRA)

Member Name

Address

City State Zip

Phone Number

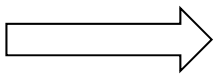
State ID Number:

Thank you for choosing the Integrated Community Health Partners (ICHP) as your health plan.

We would like to ask you some questions to help us understand your healthcare needs and to better serve you. Your answers are confidential and will not change your current coverage. Please complete this questionnaire. After you finish it, please mail it back to us in the postage paid envelope that we have provided (you do not need to put a stamp on it).

You can also call us and give your answers to a care manager. Please call toll free (855) 959-7340.

Please turn this page to view your questionnaire.



Do you have general questions for us?
Do you need help reading this document or need it in another language?
Please call ICHP Customer Service at (855) 959-7340

Este documento puede estar disponible en un formato diferente o idioma. Para obtener información adicional, llame al servicio al cliente en el número de teléfono que aparece arriba.

1	Do you need help, such as an interpreter, to speak and understand English?	☐Yes ☐No
2	Do you have any spiritual or cultural beliefs that need to be a part of your healthcare?	☐Yes ☐No
3	Is your child deaf? Does your child have serious difficulty hearing?	☐Yes ☐No
4	Is your child blind or have serious difficulty seeing, even when wearing glasses?	☐Yes ☐No
5	Would you say that your child's health and quality of life is worse than it was 1 year ago?	☐Yes ☐No
6	Would you currently say that your child's mental health is worse than it was 1 year ago?	☐Yes ☐No
7	Because of a physical, mental, or emotional condition, does your child have serious difficulty concentrating, remembering, or making decisions?	☐Yes ☐No
8	Do you feel your child is getting enough sleep?	☐Yes ☐No
9	Does your child need with self-care activities such as bathing, dressing, eating, and going to the bathroom?	☐Yes ☐No ☐N/A
10	Does your child need help with moving around -- like getting in and out of bed, walking, meal preparation, or eating?	☐Yes ☐No ☐N/A
11	In the past 6 months, has your child fallen or had problems with balance or walking?	☐Yes ☐No
12	Has your doctor ever told you that your child has any of the following diseases: Asthma? Diabetes or high blood sugar?	☐Yes ☐No
13	Has your doctor ever told you that your child is overweight or obese?	☐Yes ☐No
24	Do you have any concerns about violence or abuse, sexual issues, depression and suicide, exercise, nutrition and eating disorders?	☐Yes ☐No
15	If your child has prescriptions, what are they and how often do you give them to your child?	☐Yes ☐No
16	Overall, is your child getting the care he or she needs?	☐Yes ☐No
17	Does your child have friends? Where does your child usually play with them? _____	☐Yes ☐No
18	In the last thirty days, has your child talked about his or her problems, feelings, or opinions with someone in your family?	☐Yes ☐No
19	In the last thirty days, was someone there for you when you needed someone to listen or to help you?	☐Yes ☐No
20	Because of a physical, mental, or emotional condition, has your child missed time at school, at work, or with friends?	☐Yes ☐No
21	In the last thirty days, has your child been around people who smoke or chew tobacco or use marijuana?	☐Yes ☐No
22	In the last thirty days, has your child been around people who use illegal drugs or prescription drugs for non-medical purposes?	☐Yes ☐No
23	Do you put your child in a carrier/booster seat or seatbelt? Does your child wear a helmet with riding a bicycle, skateboard, etc.?	☐Yes ☐No
25	In the last thirty days, have there been times when there wasn't enough to eat at home?	☐Yes ☐No
26	In the last year, has your child seen a dentist, eye doctor, counselor, or other doctor? _____	☐Yes ☐No
27	How does your child get to school? _____ To appointments? _____	☐Yes ☐No
28	In the event you become unable to make medical decisions for yourself, do you have a power of attorney, living will or advance directive?	☐Yes ☐No