brand new day
A Bright HealthCare Company

Health Risk Assessment (HRA)

Dear Member,

Answering the questions below helps us to find ways to help you continue to feel good and improve your health. Please answer as many questions as you can and return this form in the attached pre-paid envelope.

MBI# | **Member ID#** | **Effective Date** | **Home Phone** | **Plan**

First Name | **Last Name** | **Date of Birth** | **Gender** ☐ **M** ☐ **F**

Address | **City** | **State** | **Zip Code**

Cell Phone Number | **Email Address**

What is your preferred method of communication? ☐ Cell Phone ☐ Email

Do you use any of the following at home?

☐ Tablet or Smartphone ☐ Laptop or Desktop Computer ☐ Cable TV ☐ None

Do you have access to internet at home? ☐ Yes ☐ No ☐ Unsure

Are you open to a virtual / telehealth visit with your provider? ☐ Yes ☐ No ☐ Unsure

Do you want to participate in Interdisciplinary Care Team (ICT) review? ☐ Yes ☐ No ☐ Unsure

I authorize Brand New Day to send me information about my plan ☐ Yes ☐ No

Primary Care Doctor

Sales Agent Information

If someone helped you fill out this application he/she must complete the information below and sign:

Name of Staff/Agent/Broker (Print Name)

Signature | **Date**

Relationship to Enrollee | **Agent NPN**

Agent Phone Number | **Agent License Number** | **FMO**

MBI# _____

Section A: Medical

A1: In general how would you rate your health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

A2: In the last 12 months, have you stayed overnight as a patient in the hospital?

☐ No ☐ 1-2 times ☐ 3-5 times ☐ >6 months

A3: How often do you exercise per week?

☐ >5 days ☐ 4-3 days ☐ 2-1 days ☐ Seldom ☐ Never

A4: What is your height? _____ **A5:** What is your weight _____ lbs

A6: Without wanting to, I have lost or gained 10 lbs in the last six months? ☐ Yes ☐ No

A7: Have you received a Flu Shot this year? ☐ Yes ☐ No

A8: Have you had a Pneumonia Vaccine? ☐ Yes ☐ No

If yes, when? _____

A9: Have you had a Colonoscopy? ☐ Yes ☐ No

If yes, when? _____ Where: _____

A10: Are you using home health services? ☐ Yes ☐ No

A11: Have you fallen in the past month? ☐ Yes ☐ No

A12: Has your doctor told you that you have:

☐ Cancer ☐ Dementia ☐ Diabetes/High Blood Sugar ☐ Mental Health Problems ☐ None

A13: Do you have a mother, father, sister, or brother with Diabetes? ☐ Yes ☐ No

A14: Do you currently smoke cigarettes? ☐ Yes ☐ No

A15: On average how many cigarettes did you smoke per day? _____

A16: How many years have you smoked? _____

A17: Are you currently using Durable Medical Equipment or medical devices? ☐ Yes ☐ No

A18: If yes to A17, please specify which equipment or medical devices below:

☐ Wheelchair ☐ Walker ☐ Cane ☐ Commode

☐ Pressure Mattress ☐ Hospital Bed ☐ Toilet Seats ☐ Diapers

☐ CPAP machine/Sleep Apnea ☐ Oxygen ☐ Bath Chair ☐ Catheters

☐ Other: _____

Section A: Medical

A19: What medication allergies do you have? _____

A20: Do you sometimes forget to take your medicine? ☐ Yes ☐ No

A21: What medications do you take? _____

_____

A22: Have you received a COVID vaccine? ☐ Yes ☐ No

Circle name of vaccine: Moderna / Pfizer / Johnson & Johnson (Janssen) / Covidencia / Other: _____

If Yes: Date of first dose: _____ Date of second dose: _____

Section B: Behavioral Health

For **B1** *&* **B2**, *over the last 2 weeks, how often have you been bothered by any of the following problems?*

B1: Little interest or pleasure in doing things:

☐ Not at all ☐ More than half the days ☐ Several days ☐ Nearly everyday

B2: Feeling down, depressed, or hopeless:

☐ Not at all ☐ More than half the days ☐ Several days ☐ Nearly everyday

B3: Do your family / friends have concerns about your memory? ☐ Yes ☐ No

B4: Have you ever attended an Alcoholics Anonymous or Narcotics Anonymous meeting? ☐ Yes ☐ No

B5: Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

Alcohol:

One drink =  12 oz. Beer  5 oz. Wine  1.5 oz. liquor (one shot)

	None	1 or more
B6: Men: How many times in the past year have you had 5 or more drinks in a day?	☐	☐
B7: Women: How many times in the past year have you had 4 or more drinks in a day?	☐	☐
B8: How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	☐	☐

Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

Section B: Behavioral Health

B9: How often do you feel that you lack companionship?

☐ Hardly ever ☐ Some of the time ☐ Often ☐ Nearly everyday

B10: How often do you feel left out?

☐ Hardly ever ☐ Some of the time ☐ Often ☐ Nearly everyday

B11: How often do you feel isolated from others?

☐ Hardly ever ☐ Some of the time ☐ Often ☐ Nearly everyday

Section C: Activities Of Daily Living

C1: Do you: ☐ Snore ☐ Stop breathing while sleeping ☐ N/A

C2: Has your sleepiness ever: ☐ Resulted in a car crash ☐ Led to a near-miss while driving ☐ N/A

C3: At night do you:

- ☐ Wake up gasping or choking
- ☐ Have frequent awakenings
- ☐ Wake up to go to the bathroom
- ☐ N/A

C4: During the day, do you:

- ☐ Feel sleepy or "doze off" without meaning to?
- ☐ Have headaches in the morning?
- ☐ Have difficulty with memory or concentrating?
- ☐ N/A

C5: Do you live in:

- ☐ An independent house, apartment, condo, or mobile home
- ☐ An assisted living apartment or board and care home
- ☐ A nursing home
- ☐ N/A

C6: Who do you live with? _____

C7: Is there a friend, relative, or neighbor who would take care of you for a few days if necessary?

☐ Yes ☐ No Name: _____ Phone: _____

C8: Do you have transportation to and from your doctor's appointments? ☐ Yes ☐ No

C9: Do you have an Advance Directive? ☐ Yes ☐ No

C10: Do you have a POLST – Physician Orders for Life Sustaining Treatment? ☐ Yes ☐ No

MBI# _____

Section D: The Barthel Index

For each section, please check a box that describes you the most:

FEEDING	
Unable	0 ❑
Needs help cutting, spreading butter, etc., or requires modified diet	5 ❑
Independent	10 ❑
BATHING	
Dependent	0 ❑
Independent (or in shower)	5 ❑
GROOMING	
Needs help with personal care	0 ❑
Independent face/hair/teeth/shaving (implements provided)	5 ❑
DRESSING	
Dependent	0 ❑
Needs help but can do about half unaided	5 ❑
Independent (including buttons, zips, laces, etc.)	10 ❑
BOWELS	
Incontinent (or needs to be given enemas)	0 ❑
Occasional accident	5 ❑
Continent	10 ❑
BLADDER	
Incontinent, or catheterized and unable to manage alone	0 ❑
Occasional accident	5 ❑
Continent	10 ❑
TOILET USE	
Dependent	0 ❑
Needs some help, but can do something alone	5 ❑
Independent (on and off, dressing, wiping)	10 ❑
TRANSFERS (BED TO CHAIR AND BACK)	
Unable, no sitting balance	0 ❑
Major help (one or two people, physical), can sit	5 ❑
Minor help (verbal or physical)	10 ❑
Independent	15 ❑
MOBILITY (ON LEVEL SURFACES)	
Immobile or < 50 yards	0 ❑
Wheelchair independent, including corners, > 50 yards	5 ❑
Walks with help of one person (verbal or physical) > 50 yards	10 ❑
Independent (but may use any aid; for example, stick) > 50 yards	15 ❑
STAIRS	
Unable	0 ❑
Needs help (verbal, physical, carrying aid)	5 ❑
Independent	10 ❑

TOTAL SCORE (0–100): _____