HEALTH RISK ASSESSMENT

WELL SENSE HEALTH PLAN

IMPORTANT: Please fill out this form. To help us provide better health services and coordinate the care you receive, we would like some information about you. **This information will not affect your New Hampshire Medicaid benefits or eligibility and will only be shared with those authorized to see it.** If you need another form or have a question, call Member Services at **877-957-1300**.

SURVEY INSTRUCTIONS:

1. Complete one form for each Well Sense Health Plan member.
2. Answer each of the questions by checking off the box (yes, no) or filling in your response in the space provided.
3. Once completed, please return your survey using the enclosed postage-paid envelope, fax it to **617-897-0884**, or send it to:

   Well Sense Health Plan
   Attn: Central Processing
   Two Copley Place, Suite 600
   Boston, MA 02116

If completing on behalf of a member, please complete the following questions based on the member's information.

Member Information (Please print information clearly)

Member Last Name: _____

Member First Name: _____

Middle Initial: _____

Member ID#: _____

Date of Birth: _____

Gender ☐ MALE ☐ FEMALE

Do you (member) have other health insurance?
☐ YES ☐ NO

If YES, describe what other health insurance:

_____

Do you (member) have a healthcare proxy or durable power of attorney for healthcare decisions?
☐ YES ☐ NO

Do you (member) want to receive information about a healthcare proxy or durable power of attorney for healthcare decisions?
☐ YES ☐ NO

If YES, we will mail you the NH ADVANCE DIRECTIVE form. You can also print it from our website at **wellsense.org/members/important-documents**

Is there a guardian? ☐ YES ☐ NO

If YES, list guardian's first and last name:

_____

If YES, list guardian's phone number:

_____

If YES, list guardian's relationship to member:

_____

Primary Care Provider (Personal Doctor) Name:

_____

Last visit with Primary Care Provider:

☐ WITHIN LAST 3 MONTHS
☐ 3-6 MONTHS
☐ 6-12 MONTHS
☐ 12-24 MONTHS
☐ MORE THAN 2 YEARS
☐ HAVE NOT SEEN YET
☐ DO NOT HAVE PRIMARY CARE PROVIDER

Remember: You have a non-emergency medical transportation benefit. If you need transportation to a scheduled medical appointment, call **855-739-4775**.

Best Contact Information

Cell phone: _____

Home phone: _____

Work phone: _____

Email address: _____

Best time to call: _____

Current Medical Conditions

Asthma	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Kidney Disease	☐ YES	☐ NO
Sickle Cell Anemia	☐ YES	☐ NO
Chronic Pain	☐ YES	☐ NO
High Cholesterol	☐ YES	☐ NO
Chest Pain/Heart Condition	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
HIV/AIDS	☐ YES	☐ NO
Breathing Problems	☐ YES	☐ NO
Obesity/Weight Problems	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Other:	☐ YES	☐ NO

Past or Current Diagnoses

Intellectual Disability	☐ YES	☐ NO
Autism Spectrum	☐ YES	☐ NO
Down Syndrome	☐ YES	☐ NO
Chromosomal Abnormalities	☐ YES	☐ NO
Cerebral Palsy	☐ YES	☐ NO
Multiple Sclerosis	☐ YES	☐ NO
Muscular Dystrophy	☐ YES	☐ NO
Epilepsy/Seizure Disorder	☐ YES	☐ NO
Traumatic Brain Injury	☐ YES	☐ NO
Anoxic Brain Injury	☐ YES	☐ NO

Needs that require ongoing care or services such as physical, occupational or speech therapies, private duty nursing, or a personal care assistant?

☐ YES ☐ NO

Number of different types of specialists currently seeing

☐ 0-2 ☐ 3-4 ☐ 5+

Height

_____ feet _____ inches

Weight

_____ lbs.

Has there been a weight loss or gain of more than 10 lbs. in the last 6 months without trying?

☐ YES ☐ NO

Current living situation

☐ PERMANENT
☐ TEMPORARY (FAMILY/FRIENDS)
☐ SHELTER
☐ HOMELESS
☐ NURSING HOME
☐ ASSISTED LIVING
☐ GROUP HOME/RESIDENTIAL
☐ OTHER: _____

Currently experiencing any of the following?

☐ AFRAID OF PARTNER
☐ AFRAID OF NEIGHBORHOOD
☐ AFRAID OF ANYTHING ELSE THAT IMPACTS ABILITY TO FUNCTION

If yes to any of the above, would you like to speak to someone at Well Sense Health Plan about support that may be available to you?

☐ YES ☐ NO

Tobacco use

☐ CHEW TOBACCO
☐ SMOKE CIGARETTES
☐ SMOKE CIGARS
☐ SMOKE A PIPE

Do you want to receive education materials about quitting tobacco?

☐ YES ☐ NO

Difficulty with any of the following activities

☐ BATHING
☐ DRESSING
☐ GETTING OUT OF BED
☐ GETTING OUT OF A CHAIR
☐ WALKING AROUND THE HOUSE
☐ EATING
☐ USING THE TOILET
☐ USING THE PHONE
☐ WALKING UP A FLIGHT OF STAIRS
☐ SHOPPING
☐ LIGHT HOUSEKEEPING
☐ DOING LAUNDRY
☐ PREPARING MEALS
☐ PAYING BILLS
☐ TAKING MEDICATIONS
☐ USING TRANSPORTATION
☐ ATTENDING WORK OR SCHOOL

Number of Emergency Room visits in the past 4 months

☐ 0-1 ☐ 2-4 ☐ 5+

Number of overnight stays in the hospital in the past 12 months

☐ 0 ☐ 1-2 ☐ 3+

Current number of medications being taken. Include prescriptions, over-the-counter drugs, herbals and any other.

☐ 0-3 ☐ 4-7 ☐ 7+

Use of any of the following equipment

☐ OXYGEN
☐ CPAP
☐ NEBULIZER
☐ CANE
☐ WALKER
☐ WHEELCHAIR
☐ HOSPITAL BED
☐ OTHER: _____

Difficulty with hearing?

☐ YES ☐ NO

Difficulty with vision/eyesight?

☐ YES ☐ NO

Rating of general health status

☐ VERY GOOD
☐ GOOD
☐ FAIR
☐ POOR

Confident in managing medical conditions?

☐ YES ☐ NO

Remember: you can contact our Nurse Advice Line at **866-763-4829** 24 hours a day for any questions regarding your medical conditions. If you are interested in participating in our Care Management program, call **855-833-8119**.

FEMALE MEMBERS: Currently pregnant?

☐ YES ☐ NO

If pregnant, when is the due date? _____

Is there an OB/GYN provider, regular doctor, nurse, or midwife who is providing care during the pregnancy?

☐ YES ☐ NO

Who? _____

Where? _____

Current treatment for any of the following mental health conditions?

☐ Depression/Extreme sadness
☐ Bipolar disorder
☐ Anxiety/Nervousness
☐ Eating disorder
☐ ADD/ADHD

In the last two weeks, have you (member) been bothered by any of the following problems?

Little interest or pleasure in doing things:

☐ (0) Not at all
☐ (1) Several days
☐ (2) More than half the days
☐ (3) Nearly every day

Feeling down, depressed or hopeless:

☐ (0) Not at all
☐ (1) Several days
☐ (2) More than half the days
☐ (3) Nearly every day

In the last three months, have you (member) been bothered by any of the following problems?

Change of appetite:

☐ (0) Not at all
☐ (1) Several days
☐ (2) More than half the days
☐ (3) Nearly every day

Change in sleep:

☐ (0) Not at all
☐ (1) Several days
☐ (2) More than half the days
☐ (3) Nearly every day

Are four or more alcoholic drinks consumed over the course of one day?

☐ YES ☐ NO

Use of any of the following

Recreational drugs (like marijuana or cocaine)

☐ YES ☐ NO

Prescription drugs differently than they are prescribed for you?

☐ YES ☐ NO

Prescription drugs intended for someone else?

☐ YES ☐ NO

Would you like to work with someone from Well Sense Health Plan regarding mental health or substance abuse?

☐ YES ☐ NO

Please describe race. Choose up to two options.

☐ Alaskan Native
☐ American Indian
☐ Asian
☐ Black/African American
☐ Hispanic/Latino – Black
☐ Hispanic/Latino – White
☐ Hispanic/Latino – Other
☐ Native Hawaiian or other Pacific Islander
☐ White/Caucasian
☐ Other: _____

Please describe ethnic background

1. _____

2. _____

Preferred spoken language for communication from Well Sense Health Plan

1. _____

Preferred written language for communication from Well Sense Health Plan

1. _____