



Health Risk Assessment

INSTRUCTIONS

Upper Peninsula Health Plan (UPHP) is interested in helping you get healthy and stay healthy. We want to ask you a few questions about your current health. This information will be used to better meet your health needs. The information you provide in this form is personal health information protected by federal and state law and will be kept confidential. It CANNOT be used to deny health care coverage.

We also encourage you to see your primary care provider for a checkup as soon as possible after you enroll with UPHP, and at least once a year after that. An annual checkup appointment is a covered benefit. Contact UPHP if you need transportation assistance to get to and from this appointment.

If you need assistance with completing this form, contact our UPHP Community Health Workers at 906-225-5964, Monday through Friday from 8 a.m. to 5 p.m. Eastern Time.

Instructions for completing the UPHP Health Risk Assessment (HRA):

- Answer the questions as best you can. You are not required to answer all of the questions.
- Don't forget to complete a new HRA with UPHP each year.

Keep a copy or printout of this form. This is your record that you completed your annual HRA.

First Name, Middle Name, Last Name			Date of Birth (mm/dd/yyyy)
Mailing Address		Apartment or Lot Number	Medicaid Number
City	State	Zip Code	Phone Number

Section 1 – Initial assessment questions (select one answer for each question)

1.	<p>Member agrees to complete the assessment. All questions are voluntary within this assessment and do not affect your coverage with UPHP. Information on how we protect, use, and share your data is provided via UPHP’s Notice of Privacy Practices which is available on our website at www.uphp.com or you may contact UPHP Customer Service for a copy.</p> <p><input type="radio"/> Next</p>
2.	<p>In general, how would you rate your health?</p> <p><input type="radio"/> Excellent <input type="radio"/> Very Good <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor</p>
3.	<p>Has a provider told you that you have hearing loss or are deaf?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
4.	<p>Skip questions 5-8 if member is under 18 years of age or assessment is being completed by someone other than the member.</p> <p><input type="radio"/> Acknowledge</p>
5.	<p>What is your sex assigned at birth?</p> <p><input type="radio"/> Male <input type="radio"/> Unknown</p> <p><input type="radio"/> Female <input type="radio"/> Declined to answer</p> <p><input type="radio"/> Intersex <input type="radio"/> Information is not available</p>
6.	<p>What is your gender identity? Check one:</p> <p><input type="radio"/> Male</p> <p><input type="radio"/> Female</p> <p><input type="radio"/> Transgender male/transman/female to male (FTM)</p> <p><input type="radio"/> Transgender female/transwoman/male to female (MTF)</p> <p><input type="radio"/> Genderqueer (neither exclusively male or female)</p> <p><input type="radio"/> Other: Please Specify _____</p> <p><input type="radio"/> Declined to answer</p> <p><input type="radio"/> Information is not available</p>

First Name, Middle Name, Last Name	Medicaid Number
7.	What are your preferred personal pronouns? Check all that apply: <input type="radio"/> He/him/his <input type="radio"/> Other: Please Specify: _____ <input type="radio"/> She/her/hers <input type="radio"/> Declined to answer <input type="radio"/> They/them/theirs <input type="radio"/> Information is not available
8.	What is your sexual orientation? <input type="radio"/> Lesbian, gay, or homosexual <input type="radio"/> Don't know <input type="radio"/> Straight or heterosexual <input type="radio"/> Declined to answer <input type="radio"/> Bisexual <input type="radio"/> Information is not available <input type="radio"/> Something else, please describe: _____
9.	Please describe your ethnicity <input type="radio"/> Hispanic <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Declined
10.	Please describe your racial identity, check all that apply: <input type="radio"/> Black or African American <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Native Hawaiian or Pacific Islander <input type="radio"/> Some other race, please describe: _____ <input type="radio"/> White <input type="radio"/> Asian <input type="radio"/> Declined
11.	What language do you want myself and health care providers to communicate with you in? <input type="radio"/> English <input type="radio"/> American Sign Language <input type="radio"/> Spanish <input type="radio"/> Other, please describe: _____ <input type="radio"/> Arabic <input type="radio"/> Declined to answer
12.	(For women only) Are you currently pregnant? <input type="radio"/> Yes <input type="radio"/> No
13.	In the last 7 days, how often did you exercise for at least 20 minutes in a day? <input type="radio"/> Every Day <input type="radio"/> 3 - 6 Days <input type="radio"/> 1 - 2 Days <input type="radio"/> 0 Days <i>Exercise includes walking, housekeeping, jogging, weights, a sport or playing with your kids. It can be done on the job, around the house, just for fun or as a work-out.</i>
14.	In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day? <input type="radio"/> Every Day <input type="radio"/> 3 - 6 Days <input type="radio"/> 1 - 2 Days <input type="radio"/> 0 Days <i>Each time you ate a fruit or vegetable counts as one serving. It can be fresh, frozen, canned, cooked or mixed with other foods.</i>

First Name, Middle Name, Last Name	Medicaid Number
15.	<p>In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?</p> <p><input type="radio"/> Never <input type="radio"/> Once a week <input type="radio"/> 2-3 times a week <input type="radio"/> More than 3 times a week</p> <p><i>I drink is 1 beer, 1 glass of wine, or 1 shot.</i></p>
16.	<p>In the last 30 days have you smoked or used tobacco?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><i>If yes, do you want to quit smoking or using tobacco?</i></p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I am working on quitting or cutting back right now</p>
17.	<p>How often is stress a problem for you in handling everyday things such as your health, money, work, or relationships with family and friends?</p> <p><input type="radio"/> Almost Every Day <input type="radio"/> Sometimes <input type="radio"/> Rarely <input type="radio"/> Never</p>
18.	<p>Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you relax?</p> <p><input type="radio"/> Almost Every Day <input type="radio"/> Sometimes <input type="radio"/> Rarely <input type="radio"/> Never</p> <p><i>This includes illegal or street drugs and medications from a doctor or drug store if you are taking them differently than exactly how your doctor told you to take them.</i></p>
19.	<p>Have you had a flu shot in the last year?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
20.	<p>How long has it been since you last visited a dentist or dental clinic for any reason?</p> <p><input type="radio"/> Within the last year <input type="radio"/> More than 5 years</p> <p><input type="radio"/> Between 1-2 years <input type="radio"/> Never</p> <p><input type="radio"/> Between 3-5 years</p>
21.	<p>Do you have access to transportation for medical appointments?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes, but it is not reliable</p> <p><i>Transportation could be your own car, a friend who drives you, a bus pass, or taxi. UPHP can help you with transportation to and from covered medical appointments.</i></p>
22.	<p>Do you need help with food, clothing, utilities, or housing?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><i>This could be trouble paying your heating bill, no working refrigerator, or no permanent place to live.</i></p>

First Name, Middle Name, Last Name	Medicaid Number
23.	<p>A checkup is a visit to a primary care provider's office that is NOT for a specific problem. How long has it been since your last checkup?</p> <p><input type="radio"/> Within the last year <input type="radio"/> Between 1-3 Years <input type="radio"/> More than 3 years</p>
24.	<p>Referral Source (Non applicable-for internal use only)</p> <p>HMP/Medicaid HRA</p>
25.	<p>In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school or a hobby?</p> <p><input type="radio"/> Yes, Clarify _____</p> <p><input type="radio"/> No</p>
26.	<p>In the past year, was there a time when you needed to see a doctor but could not because it cost too much?</p> <p><input type="radio"/> Yes, Clarify _____</p> <p><input type="radio"/> No</p>
27.	<p>In the past 12 months did you ever eat less than you feel you should because there was not enough money for food?</p> <p><input type="radio"/> Yes, Clarify _____</p> <p><input type="radio"/> No</p>
28.	<p>Do you have a job or other steady source of income?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, Clarify _____</p>
29.	<p>Are you worried that in the next two months, you may not have stable housing?</p> <p><input type="radio"/> Yes, Clarify _____</p> <p><input type="radio"/> No</p>
30.	<p>In the past 12 months has any utility company threatened to shut off services to your home?</p> <p><input type="radio"/> Yes, Clarify _____</p> <p><input type="radio"/> No</p>
31.	<p>Does getting childcare make it hard for you to work, go to school or study?</p> <p><input type="radio"/> Yes, Clarify _____</p> <p><input type="radio"/> No</p>

First Name, Middle Name, Last Name	Medicaid Number
32.	<p>Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?</p> <p><input type="radio"/> Yes, Clarify _____</p> <p><input type="radio"/> No</p>
33.	<p>In the past 12 months have you ever had to go without health care because you didn't have a way to get there?</p> <p><input type="radio"/> Yes, Clarify _____</p> <p><input type="radio"/> No</p>
34.	<p>Do you have enough household supplies? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo.</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No, Clarify _____</p>
35.	<p>How often is stress a problem for you in handling everyday things such as your health, money, work, or relationships with family and friends?</p> <p><input type="radio"/> Depression <input type="radio"/> Anxiety <input type="radio"/> Stress <input type="radio"/> No</p>
36.	<p>Would you like to receive assistance with any of these needs?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A - No needs</p>
37.	<p>Describe intervention or assistance given (for internal use only)</p> <p><input type="radio"/> Health Care Assistance <input type="radio"/> Educational Assistance</p> <p><input type="radio"/> Benefit Assistance <input type="radio"/> Transportation Assistance</p> <p><input type="radio"/> Food Assistance <input type="radio"/> Household Supply Assistance</p> <p><input type="radio"/> Financial Assistance <input type="radio"/> Other, clarify _____</p> <p><input type="radio"/> Housing Assistance <input type="radio"/> Depression Resources</p> <p><input type="radio"/> Utility Assistance <input type="radio"/> Stress Resources</p> <p><input type="radio"/> Child Care Assistance <input type="radio"/> Anxiety Resources</p>
38.	<p>Outcome (for internal use only)</p> <p><input type="radio"/> Rapid Resource Referral - direct connection to the resources</p> <p><input type="radio"/> Equipped - member provided resources but declined follow up</p> <p><input type="radio"/> Follow up wanted and member agreeable, schedule activity to follow up: Follow up date:</p> <p><input type="radio"/> Failure - no resources that exist to meet the need</p>

First Name, Middle Name, Last Name	Medicaid Number
------------------------------------	-----------------

39.	Screening Summary (for internal use only) <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
-----	--

Section 2 – Annual Appointment

A routine checkup is an important part of taking care of your health. An annual checkup is a covered benefit and UPHP can help you with a ride to and from this appointment.

Date of Appointment: _____

At my appointment I would most like to talk with my provider about: _____

Take a COPY of this form to your checkup and review your answers with your provider at this appointment.