AdvancedHealth
Bridging the Future of Healthcare
289 LaClair Street, Coos Bay, Oregon 97420 541-269-7400 * 1-800-264-0014 * TTY 1-877-769-7400

HEALTH RISK ASSESSMENT

INITIAL / ANNUAL / UPDATE

NAME:	ADDRESS:
PHONE:	MARITAL STATUS:
DOB:	EMAIL:
SEX: M / F	MEMBER ID#:
RACE: PLEASE CHECK ONE **American Indian / Alaska Native** ☐ **Asian** ☐ **Black / African American** ☐ **Hispanic / Latino** ☐ **Multiracial** ☐ **Native Hawaiian / Other Pacific Islander** ☐ **White** ☐ **Other:** **ETHNICITY: PLEASE CHECK ONE** **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐	**PLAN TYPE: PLEASE CHECK ONE** **CCOA – Medical, Dental, Behavioral Health, Transportation** ☐ **CCOB – Medical, Dental, Transportation** ☐ **CCOE – Behavioral Health, Transportation** ☐ **CCOG – Behavioral Health, Dental, Transportation** ☐

Is English your primary language? **YES** ☐ **NO** ☐

How well is your understanding of English? **Good** ☐ **Some** ☐ **None** ☐

What is your preferred language? ☐ **English** ☐ **Spanish** ☐ **Chinese** ☐ **Vietnamese** ☐ **Russian** ☐ **Hindi** ☐ **American Sign Language** ☐ **Other**

Do you need an interpreter? **YES** ☐ **NO** ☐

*Are you blind, deaf, or hard of hearing? **YES** ☐ **NO** ☐

Do you use any assistive devices to see or hear, such as glasses or hearing aids? YES ☐ NO ☐

Do you have any cultural needs? **YES** ☐ **NO** ☐ (Such as health beliefs and customs)

Please explain:

(Optional) What gender do you identify with?_____

Do you have someone you want us to talk to about your health? (Ex: spouse, relative, significant other, friend, caregiver, or case manager) **YES** ☐ **NO** ☐

Name: _____Relationship: _____Contact information: _____

Do we have permission to talk to this person about your health and healthcare needs today? **YES** ☐ **NO** ☐

- Verbal Authorization is only good for one day. A Release of Information will need to be on file. Our Customer Service team can send you a Release of Information if requested. –

Would you like us to send you a Release of Information? **YES** ☐ **NO** ☐

*Are you a Veteran? **YES** ☐ **NO** ☐

What is the highest grade of education you have completed? _____

Do you need assistance with transportation to your appointments? **YES** ☐ **NO** ☐

Would you like additional information about your transportation benefit? YES ☐ NO ☐

Who is your Primary Care Provider? _____

When was your last visit? ☐ **0-6 Months** ☐ **6-12 months** ☐ **1 year**

Who is your Dentist? _____

When was your last visit? ☐ **0-6 Months** ☐ **6-12 months** ☐ **1 year**

Do you know if you have Dental benefits? ☐ **YES** ☐ **NO**

Would you like additional information about your Dental Benefit? ☐ **YES** ☐ **NO**

In general, what would you say your health is? ☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Excellent**

(For Women only) *Are you currently pregnant? ☐ **YES** ☐ **NO**

*If yes, has your doctor told you that you are high risk? ☐ **YES** ☐ **NO**

When was your last PAP Test / Mammogram? _____

Have you had a colonoscopy? ☐ **YES** ☐ **NO** DATE:

*Have you been hospitalized over the last 6 months? ☐ YES ☐ NO

If so, why and when?

Have you visited the ED in the past year? ☐ YES ☐ NO

If so, why and when?

Do you need help getting or taking your medications? ☐ **YES** ☐ **NO**

How many medications do you take daily? _____

*Are you enrolled in a medication assistance program? ☐ **YES** ☐ **NO**

Do you have any allergies? (Food/Medication/Environmental)? ☐ **YES** ☐ **NO**

If yes, what allergies?_____

Do you usually eat a diet that includes, fruit, vegetables, and whole grains? ☐ **YES** ☐ **NO**

Height:_____Weight:_____Blood Pressure, if known:

Has your doctor recommended you gain/lose weight? ☐ **YES** ☐ **NO**

Have you had any significant weight gain/loss in the last 90 days? ☐ **YES** ☐ **NO**

In the past 7 days, how often did you exercise for at least 20 minutes in a day?

☐ Every day ☐ 3-6 days ☐ 1 to 2 days ☐ -0- days

In the past 7 days do you have pain and, if so, how much?

☐ None ☐ Some ☐ A lot ☐ N/A no pain

In the past 7 days have had any problems staying or falling asleep? ☐ **YES** ☐ **NO**

Are you currently working or have a source of income you receive regularly? ☐ **Yes** ☐ **No**

What kind of work do you do? _____

Do you have access to a smart phone/computer? ☐ **YES** ☐ **NO**

Do you need assistance with transportation to your medical appointments? **YES** ☐ **NO** ☐

Would you like additional information about your transportation benefit? YES ☐ NO ☐

Do you have a state ID Card? ☐ **Yes** ☐ **No**

Would you like information on getting one? ☐ **Yes** ☐ **No**

Do you run out of food before you are able to afford to buy more? ☐ **Yes** ☐ **No**

Are you currently receiving SNAP (Food Assistance) benefits? ☐ **Yes** ☐ **No**

Would you like information about applying for SNAP benefits? ☐ **Yes** ☐ **No**

Would you like a list of local food banks? ☐ **Yes** ☐ **No**

Do you have any clothing needs? ☐ **Yes** ☐ **No**

Do you feel safe in your neighborhood? ☐ **Yes** ☐ **No**

Do you feel safe in your home? ☐ **Yes** ☐ **No**

Have you missed any rent or mortgage payments in the last 6 months? ☐ **Yes** ☐ **No**

Have you received an eviction notice? ☐ **Yes** ☐ **No**

Have your utilities, such as water or electric, been shut off in the last 6 months? ☐ **YES** ☐ **NO**

What is your living arrangement now? (CHECK)

☐ Own or Rent Home/Apt ☐ Assisted Living ☐ Live with friend/relative ☐ Foster Home
☐ Retirement Home ☐ Nursing Home ☐ Other:

*Have you recently experienced homelessness or are at risk of becoming homeless? ☐ **YES** ☐ **NO**

Do you want help changing your living situation? ☐ **YES** ☐ **NO**

Do you need help with any of the following (please check any that may apply)?

☐ Washing/bathing ☐ Using toilet ☐ Swallowing/chewing ☐ Preparing meals ☐ Getting Dressed
☐ Getting in/out bed or chair ☐ Using the phone ☐ Housekeeping/Laundry ☐ Shopping

Do you use any Durable Medical Equipment such as a wheelchair or brace or walker? ☐ **YES** ☐ **NO**

What DME and how have your Durable Medical Equipment items been purchased previously?

*Has your doctor said you have a serious or chronic illness? ☐ **YES** ☐ **NO** If yes check illness:

☐ Heart ☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Lung or Breathing Problems ☐ Chronic
☐ Pain ☐ Stroke ☐ Hearing Problems ☐ Vision Problems ☐ Bladder or Kidney Problems ☐ Liver
☐ Problems ☐ Tuberculosis ☐ HIV/AIDS ☐ Allergies ☐ Asthma ☐ N/A ☐ Other:

Would you like additional educational materials about your health? ☐ **YES** ☐ **NO**

Krames online at https://schuyler.kramesonline.com/ is a free patient education resource with simple basic educational health sheets.

Do you have a family history of any of the following? ☐ **YES** ☐ **NO** If yes check illness:

☐ Heart ☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Lung or Breathing Problems ☐ Chronic
☐ Pain ☐ Stroke ☐ Hearing Problems ☐ Vision Problems ☐ Bladder or Kidney Problems ☐ Liver
☐ Problems ☐ Tuberculosis ☐ HIV/AIDS ☐ Allergies ☐ Asthma ☐ N/A ☐ Other:

*Are you experiencing any of the following (If yes check any that apply)?

Anxiety ☐ Depression ☐ Stress ☐ Lack of emotional/social support ☐ Abuse ☐ N/A ☐

*Have you been diagnosed with a behavioral or emotional illness? ☐ **YES** ☐ **NO** If yes Please list:

Would you like assistance getting connected to Behavioral Health services? ☐ **YES** ☐ **NO**

Would you like additional information about your Behavioral Health Benefit? ☐ **YES** ☐ **NO**

For immediate crisis assistance: **COOS CRISIS LINE (541) 266-6800** **CURRY CRISIS LINE (877) 519-9322**

Do you use tobacco (smoke, vape or chew)? ☐ **YES** ☐ **NO** ☐ **N/A**

Do you use alcohol? ☐ **YES** ☐ **NO** If yes, how often:_____

*Do you Use/Abuse any prescription, legal, or illegal substances? ☐ **YES** ☐ **NO** Opioid/IV ☐ **YES** ☐ **NO**

If yes, how often? _____

Would you like help with a referral for Drug and/or Alcohol Treatment? ☐ **YES** ☐ **NO** ☐ **N/A**

Have you completed Life Planning Activities or an Advanced Directive? ☐ **YES** ☐ **NO**

If yes, where is this located?_____

If no, would you like more information? ☐ **YES** ☐ **NO**

If yes, we will mail you an advance directive.

*Are you currently working with another program/case worker or another agency? ☐ **YES** ☐ **NO**

If yes, which agency:_____

Do you have another insurance? ☐ **YES** ☐ **NO**

If yes, which one?_____

What is your ID#? _____This will help us coordinate your benefits.

Have you recently been part of a different Coordinated Care Organization? ☐ **YES** ☐ **NO**

If yes, which one?_____ This will help us coordinate your benefits.

You may also qualify for extra help through our Intensive Care Coordination Program.

*Are you interested in participating in care coordination? ☐ **YES** ☐ **NO**

*Qualifies for Intensive Care Coordination Referral

If you are unsure if you fit in to any of the above groups, or think you need care coordination help, please call Member Services at 541-269-7400 *or* 1-800-264-0014 *or* TTY 1-877-769-7400.

You can get this letter in another language, large print, or another way that is best for you free of charge. You can also have a language interpreter free of charge. Call Advanced Health Member Services at:

541-269-7400 or 800-264-0014 (TTY:711)