ATRIO™
HEALTH PLANS

Health Risk Assessment

This assessment helps ATRIO Health Plans coordinate care specific to your needs. We encourage you to make copies for your personal health record and take to your healthcare provider to discuss further. Any information provided does not affect your enrollment.

Member name: _____

Date of birth: _____ **Gender:** Male ☐ Female ☐

Cell phone number: _____ **Home phone number:** _____

Mailing address: _____

Email address: _____

Preferred language: _____ **Race/ethnicity:** _____

This questionnaire is being completed by: Self ☐ Spouse/Partner ☐ Caretaker ☐ Other ☐

Primary Care Provider name: _____

Primary Care Provider city of practice: _____

Member height: _____(feet) _____(inches) **Member weight in pounds:** _____

1. Have you been to your regular doctor in the last 12 months? Yes
   If no, why not? _____
2. Have you been to a dentist in the last 12 months? Yes
   If no, why not? _____
3. Do you have prescription medications? Yes
   If no, skip to question 4.
   If yes,
   a. Do you take your medications as prescribed? Yes
   b. Are you aware that you can get your medications as a 90-day supply and/or by mail? Yes
   c. Are there any barriers preventing you from taking your medications? Yes
      If yes, please explain: _____
   d. Which pharmacy do you use? _____
4. Have you been to the emergency room in the past 12 months? Yes
   If no, skip to question 5.
   If yes,
   a. Did you follow up with your primary care provider? Yes
   b. How many times did you go to the ER in the past three (3) months?
      ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more
5. Have you had an unplanned overnight stay as a patient in a hospital the past 12 months? Yes
   If no, skip to question 6.

If yes,

a. Did you follow up with your primary care provider? Yes
b. How many times did you stay overnight in a hospital in the past three (3) months?
☐ 0 ☐ 1 ☐ 2 ◼ 3 or more

6. Have you fallen down in the past 12 months? Yes
If yes, how often do you fall down or feel unsteady? _____

7. Has your doctor recommended you exercise more or lose weight? Yes

8. Do you live in an adult foster home or assisted living facility? Yes
If yes, which one? _____

9. Do you have any challenges or need help with activities of daily living? Circle 'yes' or 'no' for each activity below.
a. Shopping and meal preparation Yes
b. Cleaning your house Yes
c. Showering or dressing yourself Yes
d. Getting up/down or in/out of chairs and bed Yes
e. Eating and/or drinking Yes
f. Driving or getting places Yes
g. Using the toilet Yes

10. Do you have family or friends to help with your medical needs? Yes

11. Do you have any challenges accessing food? Yes

12. Would you like more information on nutrition and why it is important to your health? Yes

13. Have you noticed confusion or memory loss that is getting worse? Yes
If yes, please provide an example. _____

14. Do you smoke or use tobacco products? Yes
If yes, would you like help with quitting? Yes

15. Do you drink more than three (3) alcoholic drinks per day? Yes

16. Do you use medications or other drugs for recreational purposes that are not prescribed by a medical provider? Yes

17. Have you completed an advanced directive for end-of-life decision making? Yes
If no, are you interested in learning more about this? Yes

18. Have you received any vaccinations in the past 12 months? Circle 'yes' or 'no' for each activity below.
a. Annual flu vaccine Yes
b. Pneumonia vaccine Yes
c. Covid vaccine Yes

19. Have you had a mammogram in the last two (2) years? Yes
If yes, Year _____ Location _____
If no, are you interested in scheduling a mammogram? Yes

20. Have you had a colonoscopy in the past ten (10) years? No
    If yes, Year _____ Location _____
    If no,
    a. Have you had any other type of colon cancer screening in the last two (2) years? No
    b. Are you interested in scheduling a colonoscopy or other type of colon cancer screening? No

21. What chronic health conditions has your doctor diagnosed you with? Circle 'yes' or 'no' for each condition below:

    a. Alzheimer's or Dementia No
    b. Arthritis No
    c. Asthma No
    d. Blindness No
    e. Cancer No
       If yes, Type _____ Year _____
    f. COPD (lung disease) No
    g. Diabetes No
       If no, skip to h
       If yes,
          a. Type _____ Provider _____
          b. Do you test your blood sugar daily? No
          c. Do you take insulin? No
          d. Have you had an A1C test within the last six (6) months? No
          e. Have you had a Diabetic eye exam in the last twelve (12) months? No
          f. Have you had a urine test in the last twelve (12) months to see if your kidneys are healthy? No
    h. Hearing impairments No
       If yes, do you use any devices to support communications? No
    i. Heart disease (example: CHF, AFib, history of heart attack) No
    j. High blood pressure No
    k. High cholesterol No
    l. Kidney disease or renal failure No
       If yes, are you on dialysis? No
    m. Mental health condition or developmental disability No
       If yes, Type _____ Provider _____
    n. Stroke No
    o. Vision loss No
       If yes, do you use any corrective lenses (glasses or contacts)? No

22. If you have a chronic health condition, are there any barriers preventing you from managing the condition? No
    If yes, please explain: _____
    _____
    _____
    _____

23. Do you use any medical equipment or devices to assist you daily?
    a. Commode No
    b. CPAP No
    c. Hospital bed No

d. Oxygen No
e. Shower chair or rails No
f. Test strips No
g. Walker or cane No
h. Wheelchair No
i. Other equipment? _____ No

24. Do you need to have someone help you read instructions, pamphlets, or other written material from your doctor, pharmacy or ATRIO? No

25. Are you able to get urgent care, routine care, tests, treatment, or medications when you need it? No
If no, please explain: _____

26. In the past two (2) weeks, have you felt blue, down, or anxious more than usual? No

27. How is your overall physical health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

28. Compared to a year ago, how would you rate your health now?
☐ Better ☐ Same ☐ Worse ☐ Unsure

29. In the past two (2) weeks, how much body pain have you had?
☐ None ☐ Mild ☐ Moderate ☐ Severe

30. How much does body pain interfere with your normal activities?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

31. On average, how many hours of sleep do you get at night?
☐ 0-3 ☐ 4-6 ☐ 7-10 ☐ 10+

32. Are you satisfied with your Primary Care Doctor/Provider?
☐ YES ☐ NO ☐ I don't know who my provider is

33. What are the three (3) most important things to address that could make you feel your most healthy?
a. _____
b. _____
c. _____

34. Would you like a Nurse Case Manager to call and discuss your health goals? No

Thank you for completing your annual health risk assessment. Do you have any other comments about your health care or future health needs?

_____
_____

Please use the self-addressed, stamped envelope provided to return this form by mail. You may also complete this over the phone by calling Customer Service at **1-877-672-8620**, daily 8am - 8pm. TTY Users can call 711.

You will receive a care plan in the mail from your ATRIO Nurse Case Manager within the next 2 months and another Health Risk Assessment within the next 12 months (per Centers of Medicare and Medicaid Services, D-SNP regulation).