AmeriHealth Caritas Ohio

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Health Risk Assessment

Welcome to AmeriHealth Caritas Ohio. Now that you are a member, we ask that you please fill out this form. It will help us understand your needs and how to best support you with programs and services. If you need help completing this form, please call our Rapid Response and Outreach Team at **1-833-464-7768** and a health plan representative will help you.

If you are a parent or guardian completing this form for a child, please answer all questions on behalf of the name that you enter below.

Each enrolled member can also complete the Health Risk Assessment online through our member portal, available at **www.amerihealthcaritasoh.com**.

Your health, well-being, and safety are important to us. The Health Risk Assessment (HRA) is a valuable source of information to help you gain insight into your current health and lifestyle needs. Your responses help identify areas for improvement and ways to reduce potential risk. Understanding how lifestyle contributes to your health and risk factors can help you achieve better health.

While you may find some questions to be sensitive in nature, we know that awareness of everyday life situations influencing mental, social, and physical health can empower you. Please be assured that any information you provide will be kept strictly confidential and will be protected by federal and state laws. Any information provided in the HRA **cannot** be used to deny your health care coverage or benefits. Your doctor, care coordination team, and your health plan will only use this information to assist your health and wellness needs.

Please print in UPPERCASE letters.

Member information		
First name:	Middle initial:	Last name:
Address 1:		
Address 2:		
City:	State:	ZIP:
Date of birth: / /	Sex: ☑ Male ☑ Female	
Cell phone number:		
Email address:		

1. **Date HRA completed:** _____

2. **Complete the following statement. I am answering this survey about...**
   - ❑ Myself
   - ❑ A person I provide care for who is under 21
   - ❑ A person I provide care for who is 21 or over
   - ❑ Other: _____

3. **If you are answering on behalf of another person, what is your relationship to the person?**

   _____

For the rest of the survey, please think about the person you selected in question 2 when answering all questions. Please select the option that best describes him/her/them.

4. **Which one or more of the following would you say is your race? Choose all that apply.**
   - ❑ American Indian or Alaska Native
   - ❑ Asian
   - ❑ Black or African American
   - ❑ Native Hawaiian or Other Pacific Islander
   - ❑ White
   - ❑ Other Race:

   _____

5. **Do you have serious difficulty seeing, even when wearing glasses?**
   - ❑ Yes
   - ❑ No

6. **If you have difficulty seeing, do you use any of the following to help your sight? Choose all that apply.**
   - ❑ Qualified readers
   - ❑ Taped texts
   - ❑ Audio recordings
   - ❑ Braille materials and displays
   - ❑ Screen reader software
   - ❑ Magnification software
   - ❑ Optical readers
   - ❑ Secondary auditory programs (SAPs)
   - ❑ Large print materials
   - ❑ Other:

   _____

7. **Do you have difficulty hearing?**
   - ❑ Yes
   - ❑ No

8. **If you have difficulty hearing, do you use any of the following to help your hearing? Choose all that apply.**
   - ❑ Language interpreter
   - ❑ Assistive listening devices and systems
   - ❑ Telephone compatible with hearing aids
   - ❑ Closed caption decoders
   - ❑ Open and closed captioning, including real-time captioning
   - ❑ Voice, text, and video-based telecommunication products and systems, including text telephones
   - ❑ Teletypewriter (TTY), videophones, and captioned telephones or equally effective communication devices
   - ❑ Videotext displays
   - ❑ Other:

   _____

9. What is the highest level of school you have completed, or the highest degree received?

- ❑ Less than high school
- ❑ Some high school, but no diploma
- ❑ High school graduate or equivalent (GED/ vocational/trade school graduate)
- ❑ Some college, but no degree
- ❑ Associate degree (one- or two-year occupational, technical, or academic program)
- ❑ Four-year college graduate (bachelor's degree)
- ❑ Advanced degree (including master's, professional degree, or doctorate)

10. Describe your current living situation.

- ❑ I have a steady place to live.
- ❑ I have a place to live today, but I am worried about losing it in the future.
- ❑ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park).

11. Does your current living situation have any of the following problems? Choose all that apply.

- ❑ Pests such as bugs or rodents
- ❑ Mold
- ❑ Lead paint or pipes
- ❑ Lack of heat
- ❑ Oven or stove not working
- ❑ Smoke detectors missing or not working
- ❑ Water leaks
- ❑ None of the above

12. At any time in the past year, have you run out of food before you got money to buy more?

- ❑ Yes
- ❑ No

13. In the past year, have you had trouble getting to medical appointments or getting things you need because of transportation?

- ❑ Yes
- ❑ No

14. In the past year, have you been told that the electric, gas, oil, or water may be shut off in your home?

- ❑ Yes
- ❑ No

15. Do you currently have internet access?

- ❑ Yes
- ❑ No

16. How do you access the internet? Choose all that apply.

- ❑ Home
- ❑ Cell phone
- ❑ Borrowed device
- ❑ Work/school
- ❑ Public location
- ❑ Other: _____

17. Do you need help finding or keeping work?

- ❑ Yes
- ❑ No
- ❑ I am unable to work due to a disability.

18. Are you pregnant?

- ❑ Yes
- ❑ No
- ❑ N/A
- ❑ Declined to answer

19. In the last 30 days, have you (select all that apply):

- ❑ Felt down, depressed, or hopeless?
- ❑ Felt nervous, anxious, or on edge?
- ❑ Drank alcohol more than you wanted?
- ❑ Smoked cigarettes, used smokeless tobacco products, or vaped?
- ❑ Used recreational or street drugs?
- ❑ Taken your medications differently from how they are prescribed or used prescription drugs for non-medical reasons?

20. Would you like to speak to someone about mental health or substance use services?

- ❑ Yes
- ❑ No

21. If Yes, please select all that apply:

- ❑ Mental health
- ❑ Substance use
- ❑ Both mental health and substance use

22. Would you like a Care Manager to reach out to you to assist with your health concerns, community resources, or other questions or issues?

- ❑ Yes
- ❑ No
- ❑ N/A
- ❑ Declined to answer

23. How would you like us to contact you?

- ❑ Phone
- ❑ Mail
- ❑ Email
- ❑ Text
- ❑ Other: _____

Thank you for completing our care needs screening! This information will help us provide you the best possible care. We will keep your information private.

If you need help completing this form, please call our Rapid Response and Outreach Team at **1-833-464-7768** and a health plan representative will help you.

Please return this form in the postage-paid return envelope

You may also fax the completed form to **1-833-564-3290**.

www.amerihealthcaritasoh.com

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