



# Health Risk Assessment

## INSTRUCTIONS

The Healthy Michigan Plan is very interested in helping you get healthy and stay healthy. We want to ask you a few questions about your current health and encourage you to see your doctor for a check-up as soon as possible after you enroll with a health plan, and at least once a year after that. Take this form with you when you go. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan and your health plan can help you with a ride to and from this appointment. Your doctor and your health plan will use this information 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.

If you need assistance with completing this form, contact your health plan. You can also call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656 if you have questions.



Please contact HAP Midwest Health Plan  
Customer Service at (888) 654-2200 if you have any questions.

### Instructions for completing this Health Risk Assessment for Healthy Michigan Plan:

- Answer the questions in sections 1-3 as best you can. You are not required to answer all of the questions.
- Call your doctor's office to schedule an annual check-up appointment. Take this form with you to your appointment.
- Your doctor or other primary care provider will complete section 4. He or she will send your results to your health plan.

After your appointment, keep a copy or printout of this form that has your doctor's signature on it. This is your record that you completed your annual Health Risk Assessment.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

إذا كان لديكم أي سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

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

**SECTION 1 - Initial assessment questions (check one for each question)**

1. In general, how would you rate your health?  Excellent  Very Good  Good  Fair  Poor

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

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



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.

3. In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day?

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



Each time you ate a fruit or vegetable counts as one serving. It can be fresh, frozen, canned, cooked or mixed with other foods.

4. 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?  Never  Once a week  2-3 times a week  More than 3 times during the week



1 drink is 1 beer, 1 glass of wine, or 1 shot.

5. In the last 30 days have you smoked or used tobacco?  Yes  No

If YES, Do you want to quit smoking or using tobacco?

Yes  I am working on quitting or cutting back right now  No

6. In the last 30 days, how often have you felt tense, anxious or depressed?

Almost every day  Sometimes  Rarely  Never

7. Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax?  Almost every day  Sometimes  Rarely  Never



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.

8. The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year?  Yes  No

9. A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last checkup?  Within the last year  Between 1-3 years  More than 3 years

Take this form to your check-up and complete the rest of the form with your doctor at this appointment.

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## SECTION 2 - Annual appointment

A routine checkup is an important part of taking care of your health. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan and your health plan can help you with a ride to and from this appointment.

**What month did you first schedule this appointment?**

\_\_\_\_\_ (Month)

**Date of appointment:**

\_\_\_\_\_ (mm/dd/yyyy)

**At my appointment, I would most like to talk with my doctor about:**



*An annual appointment gives you a chance to talk to your doctor and ask any questions you may have about your health including questions about medications or tests you might need.*

## Section 3 - Readiness to change

### Your Healthy Behavior

Small everyday changes can have a big impact on your health. Think about the changes you would be most interested in making over the next year. Look at the list below and **CHOOSE ONE or MORE**:

- |  |  |
|--|--|
| <input type="checkbox"/> Exercise regularly, eat better, and/or lose weight  | <input type="checkbox"/> Cut back or quit drinking alcohol                           |
| <input type="checkbox"/> Cut back or quit smoking or using tobacco   | <input type="checkbox"/> Seek treatment for drug or substance abuse                  |
| <input type="checkbox"/> Get a flu shot  | <input type="checkbox"/> I will commit to keep up all of the healthy things I do now |
| <input type="checkbox"/> Return to the doctor to get tested for high blood pressure, high cholesterol and diabetes OR if I already have any of them, return to the doctor for check-ups for these conditions | <input type="checkbox"/> Other:  |



*Changes like drinking water rather than soda or walking every day can help you stay healthy or help you better control illnesses you may already have. You can learn new ways to handle stress or quit smoking. Remember, even small changes can be difficult and take a long time. It may be helpful to get support from your family, friends, community or your doctor. Your health plan may have programs that can help you.*

Now that you have selected your healthy behavior(s) above, answer questions 1 - 3. For each question, use the scale provided and pick a number from 0 through 5.

- |   |                                      |                                      |                                      |                                      |                                      |                                      |  |
|---|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--|
| <p><b>1. Thinking about your healthy behavior(s), do you want to make some small lifestyle changes in this area to improve your health?</b></p> | <input type="checkbox"/><br><b>0</b> | <input type="checkbox"/><br><b>1</b> | <input type="checkbox"/><br><b>2</b> | <input type="checkbox"/><br><b>3</b> | <input type="checkbox"/><br><b>4</b> | <input type="checkbox"/><br><b>5</b> | <p>I don't want to make changes now</p> <p>I want to learn more about changes I can make</p> <p>Yes, I know the changes I want to start making</p>                       |
| <p><b>2. How much support do you think you would get from family or friends if they knew you were trying to make some changes?</b></p>          | <input type="checkbox"/><br><b>0</b> | <input type="checkbox"/><br><b>1</b> | <input type="checkbox"/><br><b>2</b> | <input type="checkbox"/><br><b>3</b> | <input type="checkbox"/><br><b>4</b> | <input type="checkbox"/><br><b>5</b> | <p>I don't think family or friends would help me</p> <p>I think I have some support</p> <p>Yes, I think family or friends would help me</p>                              |
| <p><b>3. How much support would you like from your doctor or your health plan to make these changes?</b></p>                                    | <input type="checkbox"/><br><b>0</b> | <input type="checkbox"/><br><b>1</b> | <input type="checkbox"/><br><b>2</b> | <input type="checkbox"/><br><b>3</b> | <input type="checkbox"/><br><b>4</b> | <input type="checkbox"/><br><b>5</b> | <p>I do not want to be contacted</p> <p>I want to learn more about programs that can help me</p> <p>Yes, I am interested in signing up for programs that can help me</p> |

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**Section 4 – To be completed by your primary care provider**

Primary care providers should fill out this form for Healthy Michigan Plan beneficiaries enrolled in Managed Care Plans only. Fill in the Member Results, select a Healthy Behavior statement in discussion with the member, and sign the Primary Care Provider Attestation. Blood pressure, BMI and tobacco use status will be known from the appointment. For all other Member Results, marking the result as unknown and indicating whether the screening or immunization is recommended satisfies the requirements for a complete Health Risk Assessment. All three parts of Section 4 must be filled in for the attestation to be considered complete.

**Member Results**

<b>Blood Pressure</b>	(xxx/xxx mmHg)	Patient diagnosed with hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>BMI</b>	_____ Ht _____ Wt. BMI _____ (xx.x)	In the context of all relevant clinical factors, does this BMI indicate need for weight management? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco Use Status</b>	<input type="checkbox"/> Never used tobacco <input type="checkbox"/> Previous tobacco user <input type="checkbox"/> Current tobacco cessation <input type="checkbox"/> Starting tobacco cessation <input type="checkbox"/> Tobacco user	
<b>Cholesterol</b>	Cholesterol known? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient diagnosed with high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If cholesterol known is <b>Yes</b> :      Total cholesterol: _____      LDL: _____	
	Date of most recent test results:      HDL: _____	
	Triglycerides: _____	
	If cholesterol known is <b>No</b> : <input type="checkbox"/> Screening not recommended <input type="checkbox"/> Screening Ordered	
<b>Blood Sugar</b>	Blood sugar known? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient diagnosed with diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If blood sugar known is <b>Yes</b> :      FBS (xxx mg/dl): _____	
	Date of most recent test results:      A1C (xx.x%): _____	
	If blood sugar known is <b>No</b> : <input type="checkbox"/> Screening not recommended <input type="checkbox"/> Screening Ordered	
<b>Influenza Vaccine</b>	Annual Influenza Vaccination? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If Influenza vaccination is <b>Yes</b> :      Date of most recent vaccination: _____	
	If Influenza vaccination is <b>No</b> : <input type="checkbox"/> Vaccination not recommended <input type="checkbox"/> Vaccination recommended	

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**Healthy Behaviors** - Choose one of the following statements (1 - 4)

- 1. Patient does not have health risk behaviors that need to be addressed at this time.
- 2. Patient has identified at least one behavior to address over the next year to improve their health (choose one or more below):
  - Increase physical activity, learn more about nutrition and improve diet, and/or weight loss
  - Reduce/quit tobacco use
  - Annual influenza vaccine
  - Agrees to follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes
  - Reduce/quit alcohol consumption
  - Treatment for Substance Use Disorder
  - Other: explain \_\_\_\_\_
- 3. Patient has a serious medical, behavioral or social condition(s) which precludes addressing unhealthy behaviors at this time.
- 4. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.

**Primary Care Provider Attestation**

I certify that I have examined the patient named above and the information is complete and accurate to the best of my knowledge. I have provided a copy of this Health Risk Assessment to the member listed above.

Print Name (First Name, Last Name)	National Provider Identifier (NPI)
Signature	Date

**Submission Instructions:**

- Submit completed forms in the secure manner specified by the member's Managed Care Plan.

**Please fax completed Health Risk Assessment within 7 days of exam to HAP Midwest Health Plan at (248) 663-3775**

Authority: MCL 400.105(d)(1)(e)  
 Completion: Of this form provides information to better meet the health needs of Healthy Michigan Plan beneficiaries in Managed Care Plans.

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