Health Risk Assessment

Please fill out all required fields. We will use your information to refer you (member) to care management programs that may help you live a healthier life.

Helpful tips – If any of the information listed is incorrect, please contact Department of Children and Families at 850-300-4323, Monday through Friday, from 7 a.m. to 6 p.m., Eastern time.

A: About you

Today's date _____

Name of person completing form _____

I am filling out this form for:

- ☐ Myself
- ☐ Child
- ☐ Friend
- ☐ Parent
- ☐ Sibling
- ☐ Spouse
- ☐ Foster child

Do you agree to receive email and/or text communications (e.g., reminders, letters, educational materials, etc.) from Humana?

- ☐ Yes
- ☐ No

Please provide cellphone number _____

Please provide email address _____

Member name _____ Member ID _____

Parent/guardian name, if applicable _____

Date of birth _____

Home phone number _____ Cellphone number _____

Emergency contact name _____

Emergency contact phone number _____

Humana
Healthy Horizons®
in Florida

What language are you (member) most comfortable speaking?

☐ English ☐ Spanish ☐ Other ☐ I choose not to answer

B: Your medical history

Do you (member) know the name of your primary care physician (PCP) or obstetrician-gynecologist (OB-GYN)?

☐ Yes ☐ No

Name _____

Where do you (member) most often go for medical help?

☐ Clinic ☐ Urgent care center

☐ Emergency room ☐ Telehealth

☐ Doctor's office ☐ I choose not to answer

Do you (member) go to other doctors or healthcare providers in addition to, or instead of, your PCP?

☐ Yes ☐ No

Please tell us who you (member) see and the reason you see this doctor.

Doctor's name	Reason you see this doctor

How long has it been since your (member's) last checkup?

☐ Within the last 3 months

☐ Between 3 to 12 months ago

☐ More than 12 months ago

☐ I have never had a regular checkup

☐ I do not have a PCP

☐ I have a future checkup scheduled with my PCP on _____

Would you like help to make an appointment with your (member's) PCP or OB-GYN?

☐ Yes ☐ No

*If **yes**, please reach out to our care management team at **800-229-9880 (TTY: 711)** for assistance.

Member ID _____

Have you (member) had an annual dental visit in the past 12 months?

☐ Yes ☐ No

Did you (member) have a flu vaccination between August and March of this flu season?

☐ Yes ☐ No

Do you (member) plan on receiving or have received either the COVID vaccine or booster?
(For members 6 months and older)

☐ Yes, already received
☐ Yes, planning
☐ No
☐ Unsure
☐ Scheduled - I am scheduled to receive my vaccination in the home or at a site

☐ Refused
- ☐ I do not feel it is needed
- ☐ I am concerned about side effects
- ☐ I was advised by provider to not receive
- ☐ I am nervous about receiving
- ☐ I do not have transportation and do not want to use the transportation benefit
- ☐ Other

How easy is it for you (member) to get medical care when needed?

☐ Easy ☐ Somewhat difficult ☐ Very difficult ☐ Have not needed medical care

In the past 30 days, how many times have you (member) been to an emergency room (ER)?

☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11-20 ☐ 21-30

In the past 12 months, how many times have you (member) had an overnight hospitalization?

☐ 0 ☐ 1-3 ☐ 4-5 ☐ 6-10 ☐ 11+

Please check Yes, No or N/A

Condition name	Have you (member) been diagnosed with any of these conditions?	If yes, did your (member's) doctor diagnose the condition in the last 6 months?	If yes, are you (member) currently under the care of a doctor for this condition?	If yes, do you (member) need help managing these condition(s)? A nurse care manager can outreach to support.
AIDS	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Asthma	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Cancer	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

Member ID _____

Please check Yes, No or N/A				
Condition name	**Have you (member) been diagnosed with any of these conditions?**	**If yes, did your (member's) doctor diagnose the condition in the last 6 months?**	**If yes, are you (member) currently under the care of a doctor for this condition?**	**If yes, do you (member) need help managing these condition(s)? A nurse care manager can outreach to support.**
Chronic kidney disease	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Chronic Obstructive Pulmonary Disease (COPD)	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Cystic fibrosis	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Diabetes	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Heart failure	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
High blood pressure	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
HIV	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Sickle cell disease	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

Family history

Condition name	**Has any immediate family member (parents, grandparents, siblings, children) been diagnosed with any of these conditions?**		
AIDS	☐ Yes	☐ No	☐ N/A
Asthma	☐ Yes	☐ No	☐ N/A
Cancer	☐ Yes	☐ No	☐ N/A
Chronic kidney disease	☐ Yes	☐ No	☐ N/A

Member ID _____

Condition name	Has any immediate family member (parents, grandparents, siblings, children) been diagnosed with any of these conditions?		
Chronic Obstructive Pulmonary Disease (COPD)	☐ Yes	☐ No	☐ N/A
Cystic fibrosis	☐ Yes	☐ No	☐ N/A
Diabetes	☐ Yes	☐ No	☐ N/A
Heart failure	☐ Yes	☐ No	☐ N/A
High blood pressure	☐ Yes	☐ No	☐ N/A
HIV	☐ Yes	☐ No	☐ N/A
Sickle cell disease	☐ Yes	☐ No	☐ N/A

Social determinants of health

Within the past 12 months, how often have you (member) worried that your food would run out before you got money to buy more?

☐ Often true ☐ Sometimes true

☐ Never true ☐ I choose not to answer

Within the past 12 months, how true is it that the food you (member) bought just didn't last and you didn't have money to get more.

☐ Often true ☐ Sometimes true

☐ Never true ☐ I choose not to answer

Have you (member) or any family members with whom you live been unable to get these items or services in the past year? (Check any of the following)

Item			
Child care	☐ Yes	☐ No	☐ N/A
Clothing	☐ Yes	☐ No	☐ N/A
Medicine or any health care (e.g., medical, dental, mental health, and/or vision)	☐ Yes	☐ No	☐ N/A
Phone	☐ Yes	☐ No	☐ N/A
Utilities	☐ Yes	☐ No	☐ N/A
Other:			

Member ID _____

What is your (member) living situation today?

- ☐ 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 choose not to answer

Where specifically are you (member) living?

- ☐ Temporarily staying with others
- ☐ In a hotel
- ☐ In a shelter
- ☐ Living outside on the street
- ☐ On a beach
- ☐ In a car
- ☐ In an abandoned building
- ☐ At a bus or train station
- ☐ In a park
- ☐ I choose not to answer

In the past 12 months, has a lack of reliable transportation kept you (member) from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes ☐ No ☐ I choose not to answer

C: Your healthy lifestyle

How tall are you (member)? _____ feet and _____ inches

How much do you (member) weigh? _____ pounds

How do you (member) feel about your current weight? (Select one)

- ☐ I am happy with my weight.
- ☐ I am not happy with my weight, but I am not ready to make a change.
- ☐ I would like to change my weight and would appreciate help doing so.

If you'd like assistance, please reach out to our wellness coaching team **855-330-8053 (TTY: 711)**.

Nutrition

On average, how many servings of fruits and vegetables do you (member) eat every day? (1 "serving" of fruit is 1 medium size fruit; 1 serving of vegetables is 1 cup of leafy or ½ cup fresh vegetables)

☐ 1-2 servings per day ☐ 2-4 servings per day ☐ 4+ servings per day ☐ None

On average, how many servings of dairy products do you (member) have every day? (1 "serving" of dairy is about a slice of cheese, a cup of yogurt, or a cup of milk or dairy substitute.)

☐ 1-2 servings per day ☐ 2-4 servings per day ☐ 4+ servings per day ☐ None

Physical activity

How many days a week do you (member) exercise in some way (e.g., walking, bicycling, swimming, yoga, strength training, household chores, raking the yard) inside or outside the home?

☐ 1-3 days ☐ 4 or more days ☐ I do not exercise

On average, how many total minutes do you (member) spend exercising, on days when you do exercise?

☐ Less than 30 minutes ☐ Greater than 30 minutes ☐ I do not exercise

How intensely do you (member) exercise?

☐ Low/Light-intensity (walking at leisurely pace, beginner yoga, cooking activities, light household chores)

☐ Medium/Moderate-intensity (bicycling, raking the yard, swimming, strength training, walking briskly)

☐ High/Vigorous-intensity (jogging, running, high-impact aerobics, carrying groceries upstairs, strenuous fitness class)

☐ I do not exercise

On average, how often do you (member) do strength-training exercises such as squats, push-ups, pull-ups, or weight training?

☐ 1-2 days per week ☐ 3-5 days per week ☐ 6 or 7 days per week ☐ Never

How many times in the past year have you (member) had:

• 5 or more drinks in a day (males) **• 4 or more drinks in a day (females)**

One drink is 12 ounces of beer (or 1 beer), 5 ounces of wine (or a glass of wine), or 1.5 ounces of 80-proof spirits (or 1 mixed drink).

☐ Once or Twice ☐ Daily or almost daily ☐ Weekly

☐ Monthly ☐ N/A

Have you (member) ever felt you should cut down on your drinking?

☐ Yes ☐ No ☐ N/A

How many times in the past year have you (member) smoked, vaped, or chewed tobacco?

☐ Once or Twice ☐ Daily or almost daily ☐ Weekly

☐ Monthly ☐ N/A

Member ID _____

How do you (member) feel about your current smoking, vaping, or chewing tobacco habits?

- ☐ I already quit smoking, vaping, or chewing tobacco
- ☐ I have no plans to quit smoking, vaping, or chewing tobacco
- ☐ I plan to stop smoking, vaping, or chewing tobacco in the future
- ☐ I would like to know how to begin to stop smoking, vaping, or chewing tobacco now
- ☐ N/A

If you'd like assistance, please reach out to our wellness coaching team **855-330-8053 (TTY: 711)**.

How many times in the past year have you (member) used prescription drugs for non-medical reasons?

☐ Never ☐ Once or Twice ☐ Daily or almost daily

☐ Weekly ☐ Monthly ☐ N/A

How many times in the past year have you (member) used illegal drugs?

☐ Never ☐ Once or Twice ☐ Daily or almost daily

☐ Weekly ☐ Monthly ☐ N/A

Please answer the following question about any medications you (member) take:

How many different medications do you take per day?

☐ 0 ☐ 1-5 ☐ 6-10 ☐ 11-20+ ☐ N/A

D: Your social and mental wellness

Please check Yes, No or N/A				
Condition name	**Have you (member) been diagnosed with any of these conditions?**	**If yes, did your (member's) doctor diagnose the condition in the last 6 months?**	**If yes, are you (member) currently under the care of a doctor for this condition?**	**If yes, do you (member) need help managing these condition(s)? A nurse care manager can outreach to support.**
Anxiety	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Attention Deficit Hyperactivity Disorder (ADHD)	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Autism	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

Member ID _____

Please check Yes, No or N/A				
Condition name	**Have you (member) been diagnosed with any of these conditions?**	**If yes, did your (member's) doctor diagnose the condition in the last 6 months?**	**If yes, are you (member) currently under the care of a doctor for this condition?**	**If yes, do you (member) need help managing these condition(s)? A nurse care manager can outreach to support.**
Bipolar	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Depression	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Eating Disorder, such as anorexia or bulimia	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Oppositional Defiant Disorder (ODD)	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Post-Traumatic Stress Disorder (PTSD)	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Schizophrenia	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A

How often do you (member) see or talk to people that you care about and/or to whom you feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

☐ Less than once a week ☐ 1 to 2 times a week ☐ 3 to 5 times a week

☐ 5 or more times a week ☐ I choose not to answer

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you (member)?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

☐ I choose not to answer

Do you (member) need help with activities of daily living, such as bathing, preparing meals, shopping, and/or managing finances?

☐ Yes ☐ No, I don't need help

If you (member) need help with activities of daily living, how much help do you need?

☐ I get the help I need. ☐ I need a lot more help. ☐ I need a little more help.

Member ID _____

Signs of domestic violence

We like to ask all our members the following questions because we understand how domestic violence can affect your overall health. You have the option of not answering any of the questions if it makes you feel uncomfortable. These questions are confidential and cannot be shared with anyone without your written permission. However, under required mandatory reporting laws information shared pertaining to child abuse, abuse of a disabled person, abuse of an elderly adult, gunshot wounds or life-threating injuries may be reported. **The questions below are for the member.**

Have you ever been hit, kicked, punched, slapped, or shoved by your partner or family member?

☐ Yes ☐ No ☐ I decline to answer

Does your relationship make you feel threatened, ashamed or unsafe at home?

☐ Yes ☐ No ☐ I decline to answer

If you answered yes to any of the above and feel comfortable sharing.
Has the relationship gotten worse, or is it getting scarier?

☐ Yes ☐ No ☐ I decline to answer

Does your partner or family member ever watch you closely, follow you or stalk you?

☐ Yes ☐ No ☐ I decline to answer

If your partner or family member is here with you today, are you afraid to leave with him/her?

☐ Yes ☐ No ☐ I decline to answer

Does your partner or family member ever force you to have sex when you don't want to?

☐ Yes ☐ No ☐ I decline to answer

Are there children in the home?

☐ Yes ☐ No ☐ I decline to answer

If yes, have there been threats or direct abuse of the children?

☐ Yes ☐ No ☐ I decline to answer

Resources:

State Abuse Hotline number: **800-962-2873 (800-96-ABUSE)**
State Domestic Violence Hotline number: **800-500-1119**
State Rape Crisis Hotline number: **888-956-7273 (888-956-RAPE)**
Humana Care Managers are also available: **800-229-9880**

Member ID _____

E: Women's health. If not applicable, please skip.

In the past year, have you (member) had a pap test for cervical cancer?

☐ Yes ☐ No ☐ N/A

Are you (member) pregnant?

☐ Yes ☐ No ☐ N/A

E1: If you (member) are pregnant: If not applicable, please skip to section E2.

a. When are you due? _____

b. Has the Florida Department of Children and Families (DCF) been notified of the pregnancy?

☐ Yes ☐ No

If **no,** please contact DCF to inform them of the pregnancy.

c. Have you (member) been diagnosed with high blood pressure during this pregnancy?

☐ Yes ☐ No

d. Do you (member) currently have diabetes, or have you been diagnosed with diabetes during this pregnancy?

☐ Yes ☐ No

e. Have you (member) been referred to see a high-risk obstetrics (OB) doctor during this pregnancy?

☐ Yes ☐ No

f. If referred to a high-risk OB doctor, what was the reason for the referral?

_____

_____

E2: Have you (member) ever been pregnant before?

☐ Yes ☐ No ☐ Yes, but never delivered live birth ☐ N/A

If you (member) have been pregnant before, have you:

a. Delivered a baby before 37 weeks of pregnancy?

☐ Yes ☐ No

b. Delivered a baby in the last 6 months?

☐ Yes ☐ No

c. Had a Cesarean section?

☐ Yes ☐ No

Pregnancy prevention

What method do you (member) currently use to prevent a pregnancy, if applicable?

- ☐ Condoms
- ☐ Oral contraceptives
- ☐ Foam, spermicides, film, or suppositories
- ☐ Depo Provera shot, IUDs or implants
- ☐ Rhythm method or withdrawal
- ☐ Tubal ligation
- ☐ Vasectomy
- ☐ Hysterectomy
- ☐ Nothing
- ☐ I/my partner and I are trying to get pregnant
- ☐ N/A

Discuss your sexual health with your provider at your next visit to see if you require any testing and/or prevention tips for sexually transmitted diseases in addition to pregnancy prevention.

F: Members 3 years old and younger. If not applicable, please skip to section G.

Was the child (member) born more than five weeks before their expected delivery date?

☐ Yes ☐ No

Did the child (member) have any complications, such as vision, respiratory, or feeding and growth development?

☐ Yes ☐ No

Is the child (member) meeting their developmental milestones? (e.g., at 2 months holds head up when on tummy; at 6 months rolls from tummy to back; at 12 months pulls up to standing position; at 18 months able to drink from a cup)

☐ Yes ☐ No

G: Members 20 years old and younger. If not applicable, please skip, answer the final question, sign, and send to us.

Do you (parent/caregiver) have any concerns about the child's (member's) development or behavior at home or in school?

☐ Yes ☐ No ☐ N/A

Is the child (member) up to date on all immunizations?

☐ Yes ☐ No

If no, why not?

☐ Just late ☐ Barrier (such as transportation, childcare, or choice)

☐ Religious or personal preference

Member ID _____

Is the child (member) exposed to secondhand smoke, such as from cigarettes or vaping?

☐ Yes ☐ No

Does the child (member) smoke e-cigarettes, vape, or use smokeless tobacco?

☐ Yes ☐ No

Does the child (member) often worry about or fear something that significantly affects their daily health and activities?

☐ Yes ☐ No

In the past 6 months, has the use of alcohol or drugs had an impact on the child's (member's) life?

☐ Yes ☐ No

Do you (member) need assistance and would like to speak with a nurse care manager, behavioral health professional or someone for assistance with resources? (Check all that apply)

☐ Yes, I would like to speak with a nurse care manager for assistance with my medical health and disease management

☐ Yes, I would like to speak with a behavioral health professional for assistance with my mental health

☐ Yes, I would like to speak with someone for assistance with community-based resources

☐ No, I am not in need of assistance at this time

In general, how would you (member) rate your health?

☐ Very good ☐ Good ☐ Fair ☐ Poor

☐ Other: _____

Additional comments

_____

_____

_____

_____ _____

Signature Date