Department for Medicaid Services of Kentucky-Health Risk Assessment

Kentucky Medicaid is committed to helping you stay healthy. Completing the Health Risk Assessment (HRA) will help us help you to reach or maintain your healthcare goals. Please take the time to answer each question as accurately as you can to complete sections 1 and 2. Once completed submit the HRA to your Managed Care Organization (MCO) using the information in section 3.

The information you share will remain private. If you have questions or need assistance with completing the HRA, contact your MCO Member Services at **800-444-9137**, Monday through Friday, from 7 a.m. to 7 p.m., Eastern time.

Member information

Name: _____ Address: _____

Date of birth: _____ Age: _____ Medicaid ID#: _____

Managed care organization: _____

Phone: _____ Text messaging allowed: ☐ Yes ☐ No

Email: _____ Email contact allowed: ☐ Yes ☐ No

Emergency contact name: _____ Phone: _____

Date completed: _____ Who completed the HRA? _____

Health Risk Assessment (Please select all answers which apply to you.)

Household information

1. What is your housing situation today?

☐ I have housing

☐ I choose not to answer this question

☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)

2. Are you worried about losing your housing?

☐ Yes ☐ No ☐ I choose not to answer this question

3. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Select all that apply.

☐ Food ☐ Clothing ☐ Utilities ☐ Childcare

☐ Medicine or any health care (medical, dental, mental health, or vision) ☐ Phone

☐ Other _____ ☐ I choose not to answer this question

Note: To connect with Community Resources near you, contact the United Way by calling **211** or **800-543-7709**.

Health Risk Assessment (Please select all answers which apply to you.)

Household information

4. Has lack of transportation kept you from attending medical appointments, meetings, work, or from getting things needed for daily living? Select all that apply.

- ☐ Yes, it has kept me from medical appointments
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- ☐ No
- ☐ I choose not to answer this question

5. What is your current work situation?

- ☐ Unemployed
- ☐ Part-time or temporary work
- ☐ Full-time work
- ☐ Otherwise, unemployed but not seeking work (e.g., student, retired, disabled, or unpaid primary caregiver.) Please write: _____
- ☐ I choose not to answer this question

Health information

6. Are you currently pregnant?

- ☐ Yes. If yes, due date: _____
- ☐ No
- ☐ I choose not to answer this question
- ☐ Does not apply

7. Has a doctor ever told you that you have any of the following? Select all that apply.

- ☐ ADHD
- ☐ Allergies
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism spectrum disorder
- ☐ Bipolar disorder
- ☐ Cancer (current active treatment)
- ☐ Chronic obstructive pulmonary disease
- ☐ Depression
- ☐ Developmental delay
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Obesity
- ☐ Schizophrenia
- ☐ Sickle cell disease
- ☐ Substance use disorder
- ☐ Do not have any
- ☐ Other _____
- ☐ I choose not to answer this question

8. Do you understand your health condition(s) and how to care for yourself to stay healthy?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

9. In the past 6 months, how would you rate your overall health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ I choose not to answer this question

10. What type of health care appointments have you attended in the last 12 months? Select all that apply.

- ☐ Physical health/medical
- ☐ Mental or behavioral health
- ☐ Dental
- ☐ Hospital overnight
- ☐ Did not attend any appointments
- ☐ I choose not to answer this question

Health Risk Assessment (Please select all answers which apply to you.)

Health information

11. Have you visited the Emergency Room in the past 6 months? How many times and why?

☐ No ☐ Yes-1 time ☐ Yes-2 times ☐ Yes-3 times

☐ Yes-5 times ☐ Yes-more than 5 times. If yes, why: _____

☐ I choose not to answer this question

12. Are you up to date on your vaccinations?

☐ Yes ☐ No ☐ Unknown

☐ I choose not to answer this question

13. Are you interested in learning more about healthy eating habits or how to lose weight?

☐ Yes ☐ No ☐ I choose not to answer this question

14. Are you deaf, have a problem hearing, or do you have serious difficulty hearing?

☐ Yes ☐ No ☐ I choose not to answer this question

15. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

☐ Yes ☐ No ☐ I choose not to answer this question

16. Do you need help performing daily activities? (e.g., accessing medication, managing medication, bathing and grooming, eating, dressing, meal preparation, managing finances, accessing healthcare, walking, climbing stairs, or completing errands alone)

☐ I do not need any help ☐ I receive all the help I need

☐ I could use more help ☐ I choose not to answer this question

17. How many prescriptions and over-the-counter medication do you take each day?

☐ None ☐ 1-3 ☐ 4-7 ☐ 8 or more

☐ I choose not to answer this question

Behavioral health information

18. How often do you exercise?

☐ 2-3 times per week ☐ Once per week ☐ Rarely ☐ Never

☐ I choose not to answer this question

19. Has alcohol or drug use made it hard for you to work, keep relationships or meet your daily needs?

☐ Yes ☐ No ☐ I choose not to answer this question

20. Do you use tobacco, tobacco products, nicotine products, E-cigs, or vapes? Select all that apply.

☐ Yes ☐ No ☐ I would like help quitting

☐ I choose not to answer this question

Note: If you would like assistance with quitting, call **800-QUIT-NOW (784-8669)**.

21. Do you use any substances or prescription medications not prescribed to you?

☐ Yes ☐ No ☐ I choose not to answer this question

Note: Misuse of substances could cause serious injury or death. Call **800-662-HELP (4357)** for 24/7 help finding treatment near you.

Health Risk Assessment (Please select all answers which apply to you.)

Behavioral health information

22. Do you have difficulty concentrating, remembering, or making decisions?

☐ Never ☐ Rarely ☐ Sometimes ☐ Always

☐ I choose not to answer this question

23. How often do you see or talk to people that you care about and feel close to? (e.g., talking to friends on the phone, visiting friends or family, going to church, or club meetings)

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

☐ I choose not to answer this question

24. Stress is when someone feels tense, nervous, anxious, or cannot sleep at night because their mind is troubled. How stressed are you?

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

☐ Very much ☐ I choose not to answer this question

25. Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No ☐ Not sure

☐ I choose not to answer this question

26. In the past year, have you been afraid of you partner or ex-partner?

☐ Yes ☐ No ☐ Not sure

☐ I have not had a partner in the last year ☐ I choose not to answer this question

27. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

☐ Yes ☐ No ☐ I choose not to answer this question

Note: For safety assistance, Call **800-799-SAFE** to get help if someone close to you makes you feel unsafe.

Over the past two weeks, how often have you been bothered by the following problems?

28. Having little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

☐ I choose not to answer this question

29. Feeling down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

☐ I choose not to answer this question

30. Had thoughts about harming yourself or others?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

☐ I choose not to answer this question

Note: Call or text **988** for help if you have thoughts of hurting yourself.

Health Risk Assessment (Please select all answers which apply to you.)

General information

31. What was your sex at birth?

- ☐ I choose not to answer this question
- ☐ Female
- ☐ Male
- ☐ Unavailable

32. What gender do you currently identify with? Select all that apply.

- ☐ I choose not to answer this question
- ☐ Female
- ☐ Male
- ☐ Female-to-male/transgender male/ trans man
- ☐ Male-to-female/transgender female/ trans woman
- ☐ Genderqueer/non-binary, neither exclusively male nor female
- ☐ Other _____

33. What is your sexual orientation? Select all that apply.

- ☐ I choose not to answer this question
- ☐ Straight or heterosexual
- ☐ Lesbian, gay, or homosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Do not know

34. What are your pronouns? Select all that apply.

- ☐ I choose not to answer this question
- ☐ He/him/his
- ☐ She/her/hers
- ☐ They/them/theirs
- ☐ Other _____

35. What is your race? Select all that apply.

- ☐ I choose not to answer this question
- ☐ Native American or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Middle Eastern
- ☐ White
- ☐ Not listed _____
- ☐ Unknown

36. What is your Ethnicity? Select all that apply.

- ☐ I choose not to answer this question
- ☐ African
- ☐ African American
- ☐ American
- ☐ Asian
- ☐ Brazilian
- ☐ Cambodian
- ☐ Caribbean Islander
- ☐ Central American
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ East African
- ☐ Eastern European
- ☐ English
- ☐ Egyptian
- ☐ Ethiopian
- ☐ European
- ☐ Filipino
- ☐ French
- ☐ German
- ☐ Guatemalan
- ☐ Haitian
- ☐ Hispanic
- ☐ Honduran
- ☐ Iranian
- ☐ Irish
- ☐ Italian
- ☐ Israeli
- ☐ Jamaican
- ☐ Japanese
- ☐ Korean
- ☐ Laotian/Lao
- ☐ Latino
- ☐ Lebanese
- ☐ Mexican
- ☐ Mexican American
- ☐ Middle Eastern African
- ☐ Moroccan
- ☐ Native American
- ☐ Nigerian
- ☐ North African
- ☐ Polish
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ South African
- ☐ South American
- ☐ Syrian
- ☐ Vietnamese
- ☐ West African
- ☐ Ethnicity not listed _____
- ☐ Unknown

Health Risk Assessment (Please select all answers which apply to you.)

General information

37. Do you speak a language other than English at home?

☐ I choose not to answer this question ☐ Yes ☐ No

If yes, what language: _____

We may reach out to you for more information about your answers and needs. Based on your answers, you may be eligible to take part in a great program called care management. If you agree to care management, we can help you receive the right care.

1. How to submit your completed Health Risk Assessment

After you've finished the assessment, please return this document using the information in the chart below.

Managed care organization	Humana Healthy Horizons® in Kentucky
Contanct number	**800-444-9137 (TTY: 711)**
Email	**medicaidhra@humana.com**
Fax	888-899-6741
Mail	Humana Healthy Horizons in Kentucky P.O. Box 14823 Lexington, KY 40512-4823

2. Managed Care Organization completes the section below once the HRA is returned.

Date returned by member or completed by member: _____

Method of completion: ☐ Phone ☐ Online ☐ Mail ☐ In-person ☐ Mobile app ☐ Other _____

Reason for the HRA: ☐ Initial ☐ Annual ☐ Care plan ☐ Care needs ☐ Member's request

Risk score: _____ Health risks: _____

Chronic/complex condition(s): _____

Offered care management: ☐ Yes ☐ No Date: _____ Enrolled: ☐ Yes ☐ No

MCO services offered: _____

Community or resource referrals:

_____

_____

_____

_____

_____

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **800-444-9137 (TTY: 711)**. We are available Monday through Friday, from 7 a.m. to 7 p.m., Eastern Time. We can help you at no cost to you. We can explain the document in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **800-444-9137** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the
  U.S. Department of Health and Human Services, Office for Civil Rights
  electronically through their Complaint Portal, available at
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf**.

Auxiliary aids and services, free of charge, are available to you. **800-444-9137 (TTY: 711)**

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Humana Healthy Horizons in Kentucky is a Medicaid Product of Humana Health Plan Inc.

Language assistance services, free of charge, are available to you.
800-444-9137 (TTY: 711)

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

Tiếng Việt (Vietnamese): Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

Srpsko-hrvatski (Serbo-Croatian): Nazovite gore navedeni broj ako želite besplatne usluge jezične pomoći.

日本語 (Japanese): 無料の言語支援サービスを受けるには、上記の番号までお電話ください。

Français (French): Appelez le numéro ci-dessus pour recevoir des services gratuits d'assistance linguistique.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Deitsch (Pennsylvania Dutch): Ruf die Nummer owwe fer koschdefrei Hilf in dei eegni Schprooch.

नेपाली (Nepali): निःशुल्क भाषासम्बन्धी सहयोग सेवाहरू प्राप्त गर्नका लागि माथिको नम्बरमा फोन गर्नुहोस् ।

Oroomiffa (Oromo): Tajaajila gargaarsa afaan argachuudhaf bilbila armaan oli irratti bilbilaa.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Ikirundi (Bantu – Kirundi): Hamagara izo numero ziri hejuru uronswe ubufasha kwa gusa bw'uwugusobanurira mu rurimi wumva.