Dear McLaren Health Plan Healthy Michigan Plan Member,

McLaren Health Plan Healthy Michigan is very interested in helping you stay healthy or get healthy. We would like to ask you a few questions about your current health. Your answers will be shared with your primary care doctor and McLaren Health Plan. They will work together with you to choose a healthy lifestyle.

This Health Risk Assessment (HRA) will only take a few minutes. Here is what you need to do:

- Make an appointment with your Primary Care Physician (PCP) immediately
- Read and answer Sections 1-3
- If you have already completed Section 1 with Michigan Enrolls, call McLaren Health Plan at (888) 327-0671, we will help you complete Sections 2 and 3
- Take this HRA with you to your PCP appointment
- Your PCP will help you complete Section 4
- Your PCP must sign Section 4, give you a copy, and send a copy of the completed HRA back to McLaren Health Plan

If you would like McLaren Health Plan to help you complete Sections 1-3 of the HRA, please call us today at (888) 327-0671. We can also help you make your PCP appointment.

We want to help you get healthy and stay healthy! Thank you for being a McLaren Health Plan Healthy Michigan Member.

Appointment Reminder	PCP Name:
Appointment Date:	Appointment Time:
Don't forget to take your HRA to your appointment!	

3245 Beecher Road • Flint, Michigan • 48532
tel (888) 327 0671 • fax (877) 502 1567
McLarenHealthPlan.org

McLaren HEALTH PLAN

HEALTHY MICHIGAN PLAN

Health Risk Assessment

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.

McLaren HEALTH PLAN

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

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**:

- ☐ Exercise regularly, eat better, and/or lose weight
- ☐ Cut back or quit smoking or using tobacco
- ☐ Get a flu shot
- ☐ 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
- ☐ Cut back or quit drinking alcohol
- ☐ Seek treatment for drug or substance abuse
- ☐ I will commit to keep up all of the healthy things I do now
- ☐ 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.

1. Thinking about your healthy behavior(s), do you want to make some small lifestyle changes in this area to improve your health?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I don't want to make changes now		I want to learn more about changes I can make		Yes, I know the changes I want to start making	

2. How much support do you think you would get from family or friends if they knew you were trying to make some changes?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I don't think family or friends would help me		I think I have some support		Yes, I think family or friends would help me	

3. How much support would you like from your doctor or your health plan to make these changes?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I do not want to be contacted		I want to learn more about programs that can help me		Yes, I am interested in signing up for programs that can help me	

McLaren HEALTH PLAN

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

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

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

McLaren HEALTH PLAN

First Name, Middle Name, Last Name, and Suffix	mihealth Card Number

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.
  Submit to McLaren Health Plan by:
  - **Fax: (877) 502-1567**
  - **Email: customerservice@mclaren.org**
  - **Mail: McLaren Health Plan**
    P.O.Box 1511
    Flint, MI 48501

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.

Michigan Department of Community Health is an equal opportunity employer.