PASSPORT
BY MOLINA HEALTHCARE

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 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 Managed Care Organization (MCO) member services at 1-800-578-0603.

Member Information

Name: _____ Address: _____

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

Managed Care Organization: _____

Phone: _____ Text Messaging Allowed: ☐ Y ☐ N

Email: _____ Email Contact Allowed: ☐ Y ☐ N

Emergency Contact Name: _____ Phone: _____

Date Completed: _____ Who Completed the HRA: _____

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

1. What is your housing situation today?

☐ I have housing
☐ 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)
☐ I choose not to answer this question

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 ☐ Phone
☐ Medicine or any healthcare needs (medical, dental, mental health, vision)
☐ Other _____ ☐ I choose not to answer this question

Note: To connect with community resources near you, contact the United Way by calling 2-1-1 or 1-800-543-7709.

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 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 (ex: student, retired, disabled, unpaid primary care giver) Please write: _____
☐ I choose not to answer this question

Health Information

6. Are you currently pregnant?

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

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 Abuse Disorder ☐ Do not have any
☐ I choose not to answer this question
Other: _____

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

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

☐ No ☐ Yes - 1 time ☐ Yes - 2 times ☐ Yes - 3 times ☐ Yes - 5 times
☐ Yes - More than 5 ☐ I choose not to answer this question
times If yes, why: _____

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? (Examples: 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 medications 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 1-800-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 1-800-662-HELP (4357) for 24/7 help finding treatment near you.

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

☐ Never ☐ Rarely ☐ Sometime ☐ 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?(For example: 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 your 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 1-800-799-SAFE to get help is someone close to you make 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.

General Information

31. What was your sex at birth?
☐ I choose not to answer this question ☐ Male ☐ Female ☐ 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?
☐ 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 _____

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.

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	Contact Number	Email
Passport by Molina Healthcare	1-833-959-2398	KYCareManagement@MolinaHealthcare.com
Fax	**Mail**	**Website**
1-800-983-9160	5100 Commerce Crossings Drive Louisville, KY 40229	www.PassportHealthPlan.com

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 ☐ Members 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: _____