AmeriHealth Caritas
New Hampshire

Health Risk Assessment

Please complete all sections that apply to you and each member in your family. The answers to these questions will help us see how we can best help you and will not affect the Medicaid benefits for you or your child in any way. All answers are kept private. If you need help filling out this form, please call **1-833-704-1177 (TTY 1-855-534-6730)**.

Date:		
Mailing address:		Apt #:
City:	State:	ZIP code:

Complete this survey for each family member on this health plan. Write "**same**" when answers for additional members match answers for Member 1.

	Member 1	Member 2	Member 3
Name of person filling out the form for each member			
Relationship to member	☐ Self ☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ Child ☐ Other	☐ Self ☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ Child ☐ Other	☐ Self ☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ Child ☐ Other

	Member 1	Member 2	Member 3
Member name			
Member ID #			
Spoken language	☐ English ☐ Spanish ☐ Other	☐ English ☐ Spanish ☐ Other	☐ English ☐ Spanish ☐ Other
Written language	☐ English ☐ Spanish ☐ Other	☐ English ☐ Spanish ☐ Other	☐ English ☐ Spanish ☐ Other
Race (List up to two)			
Ethnicity (List up to two)			
Best phone number			
What type of phone number is this?	☐ Home ☐ Cell ☐ Other	☐ Home ☐ Cell ☐ Other	☐ Home ☐ Cell ☐ Other
Best email address			
How would you like us to contact you?	☐ Phone ☐Mail ☐ Email ☐ Text ☐ Other	☐ Phone ☐Mail ☐ Email ☐ Text ☐ Other	☐ Phone ☐Mail ☐ Email ☐ Text ☐ Other

	Member 1	Member 2	Member 3
Where do you live?	☐ Own/Rent ☐ Shelter ☐ Homeless ☐ Staying with family/friend ☐ Other	☐ Own/Rent ☐ Shelter ☐ Homeless ☐ Staying with family/friend ☐ Other	☐ Own/Rent ☐ Shelter ☐ Homeless ☐ Staying with family/friend ☐ Other
How many places have you lived in the past year?	☐ One ☐ Two ☐ Three or more	☐ One ☐ Two ☐ Three or more	☐ One ☐ Two ☐ Three or more
Do you feel safe at home?	☐ Yes, always ☐ Unsure ☐ Yes, sometimes ☐ No ☐ Choose not to answer	☐ Yes, always ☐ Unsure ☐ Yes, sometimes ☐ No ☐ Choose not to answer	☐ Yes, always ☐ Unsure ☐ Yes, sometimes ☐ No ☐ Choose not to answer
Do you have reliable transportation to doctor visits?	☐ Always ☐ Sometimes ☐ Rarely or never	☐ Always ☐ Sometimes ☐ Rarely or never	☐ Always ☐ Sometimes ☐ Rarely or never
General health information			
Are you being treated for any of these conditions? Check all that apply.	☐ Acquired brain disorder ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Hepatitis ☐ HIV/AIDs ☐ Intellectual or developmental disability ☐ Lung disease ☐ Serious physical condition *(such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures)* ☐ Sickle cell disease (not trait) ☐ Stroke ☐ Transplant ☐ Other (please explain) **Child only** ☐ Juvenile arthritis ☐ Developmental issues ☐ Neonatal abstinence syndrome	☐ Acquired brain disorder ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Hepatitis ☐ HIV/AIDs ☐ Intellectual or developmental disability ☐ Lung disease ☐ Serious physical condition *(such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures)* ☐ Sickle cell disease (not trait) ☐ Stroke ☐ Transplant ☐ Other (please explain) **Child only** ☐ Juvenile arthritis ☐ Developmental issues ☐ Neonatal abstinence syndrome	☐ Acquired brain disorder ☐ Asthma ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Hepatitis ☐ HIV/AIDs ☐ Intellectual or developmental disability ☐ Lung disease ☐ Serious physical condition *(such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures)* ☐ Sickle cell disease (not trait) ☐ Stroke ☐ Transplant ☐ Other (please explain) **Child only** ☐ Juvenile arthritis ☐ Developmental issues ☐ Neonatal abstinence syndrome
Are you currently on IV antibiotics for more than 3 weeks?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Member 1	Member 2	Member 3
Do you have constant pain?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, how intense is the pain on a scale of 1 - 10 (10 being highest).	Pain level:	Pain level:	Pain level:
Have you ever experienced trauma or abuse? (e.g. being physically hurt by, humiliated, or emotionally abused by another person)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If you ever experienced trauma or abuse, would you like support (e.g. to talk with a counselor)**?**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
How often in the past 3 months were you worried that your food would run out?	☐ Always ☐ Sometimes ☐ Rarely or never	☐ Always ☐ Sometimes ☐ Rarely or never	☐ Always ☐ Sometimes ☐ Rarely or never
If completing for a child, does your child participate in any of the following?	☐ Family-Centered Early Supports and Services ☐ Special Medical Services ☐ Partners in Health ☐ None	☐ Family-Centered Early Supports and Services ☐ Special Medical Services ☐ Partners in Health ☐ None	☐ Family-Centered Early Supports and Services ☐ Special Medical Services ☐ Partners in Health ☐ None
Are you pregnant?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
If yes, are there pregnancy complications (e.g. diabetes, high blood pressure, or multiples)**?**	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Have alcohol, prescription drugs, or other substances been used during the pregnancy?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Are you being treated for any of these mental health or substance use conditions? Check all that apply.	☐ ADHD ☐ Autism ☐ Bipolar disorder ☐ Depression ☐ Eating disorder (anorexia, bulimia, other) ☐ Schizophrenia ☐ Serious mental illness ☐ Substance use problems ☐ Other ☐ None **Child only** ☐ Serious emotional disturbance	☐ ADHD ☐ Autism ☐ Bipolar disorder ☐ Depression ☐ Eating disorder (anorexia, bulimia, other) ☐ Schizophrenia ☐ Serious mental illness ☐ Substance use problems ☐ Other _____ ☐ None **Child only** ☐ Serious emotional disturbance	☐ ADHD ☐ Autism ☐ Bipolar disorder ☐ Depression ☐ Eating disorder (anorexia, bulimia, other) ☐ Schizophrenia ☐ Serious mental illness ☐ Substance use problems ☐ Other _____ ☐ None **Child only** ☐ Serious emotional disturbance

	Member 1	Member 2	Member 3
Do you drink alcoholic beverages?	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer
If yes, has anyone told you that your alcohol use is a problem?	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer
Do you feel that you need help with drug or alcohol use?	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer
Are you currently using street drugs (e.g. heroin, cocaine) **or other drugs other than as prescribed?**	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer
Have you had an overdose in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you smoke cigarettes, use smokeless tobacco, or vape?	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer
Would you like to speak to someone about quitting?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Over the past 2 weeks, how often have you had little interest or pleasure in doing things?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Over the past 2 weeks, how often have you felt down, depressed, or hopeless?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Would you like to speak with someone about mental health/substance use services?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you have difficulty doing the following activities by yourself? Check all that apply.	☐ Bathing ☐ Dressing ☐ Walking ☐ Eating ☐ Using the toilet ☐ Getting in and out of chairs ☐ Preparing meals ☐ Managing money ☐ Taking medication as prescribed ☐ Performing home chores ☐ Grocery shopping ☐ Not applicable due to member's age	☐ Bathing ☐ Dressing ☐ Walking ☐ Eating ☐ Using the toilet ☐ Getting in and out of chairs ☐ Preparing meals ☐ Managing money ☐ Taking medication as prescribed ☐ Performing home chores ☐ Grocery shopping ☐ Not applicable due to member's age	☐ Bathing ☐ Dressing ☐ Walking ☐ Eating ☐ Using the toilet ☐ Getting in and out of chairs ☐ Preparing meals ☐ Managing money ☐ Taking medication as prescribed ☐ Performing home chores ☐ Grocery shopping ☐ Not applicable due to member's age

	Member 1	Member 2	Member 3
Have you used the emergency room 3 times or more in the last 3 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been hospitalized for more than a 2-week period in the last 3 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, was it for a new baby in the NICU (neonatal intensive care unit)**?**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you made a suicide attempt in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have you been released from jail or prison in the last 6 months?	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer	☐ Yes ☐ No ☐ Choose not to answer
Would you like a care manager to reach out to you to assist you with health concerns, community resources, or other questions or issues?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Thank you for taking the time to answer these questions. Is there anything else you think we should know about you, your child, or your family?