




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)


- In general, how would you rate your health?** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
- Has a doctor told you that you have hearing loss or are deaf?** ☐ Yes ☐ No
- (For women only) Are you currently pregnant?** ☐ Yes ☐ No ☐ Not applicable (men only)
- 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.*
- 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.*
- 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.*
- 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
- How often is stress a problem for you in handling everyday things such as your health, money, work, or relationships with family and friends?**
☐ Almost every day ☐ Sometimes ☐ Rarely ☐ Never

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9. 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.


10. Have you had a flu shot in the last year? ☐ Yes ☐ No

11. How long has it been since you last visited a dentist or dental clinic for any reason?


☐ Never ☐ Within the last year ☐ Between 1-2 years ☐ Between 3-5 years ☐ More than 5 years

12. Do you have access to transportation for medical appointments?

☐ Yes ☐ No ☐ Sometimes, but it is not reliable

 Transportation could be your own car, a friend who drives you, a bus pass, or taxi. Your health plan can help you with a ride to and from medical appointments.

13. Do you need help with food, clothing, utilities, or housing? ☐ Yes ☐ No

 This could be trouble paying your heating bill, no working refrigerator, or no permanent place to live.

14. 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


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.

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.

Take this form to your check-up and complete the rest of the form with your doctor at this appointment.

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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. It is also important to get any health screenings recommended by your doctor.

Now that you have thought about your healthy behavior, 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, do you want to make some small lifestyle changes in this area to improve your health?

☐

0

I don't want to make changes now

☐

1

☐

2

I want to learn more about changes I can make

☐

3

☐

4

Yes, I know the changes I want to start making

☐

5

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

I don't think family or friends would help me

☐

1

☐

2

I think I have some support

☐

3

☐

4

Yes, I think family or friends would help me

☐

5

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

☐

0

I do not want to be contacted

☐

1

☐

2

I want to learn more about programs that can help me

☐

3

☐

4

Yes, I am interested in signing up for programs that can help me

☐

5

STOP!

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 "Healthy Behaviors Goals Progress" question and select a "Healthy Behavior Goals" statement in discussion with your patient. Sign the Primary Care Provider Attestation, including the date of the appointment. Both parts of Section 4 must be filled in for the attestation to be considered complete.

Healthy Behaviors Goals Progress

Did the patient maintain or achieve/make significant progress towards their selected health behavior goal(s) over the last year?

- ☐ Not applicable – this is the first known Healthy Michigan Plan Health Risk Assessment for this patient.
- ☐ Yes
- ☐ No
- ☐ Patient had a serious medical, behavioral, or social condition or conditions which precluded addressing unhealthy behaviors.

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Healthy Behavior Goals

Choose one of the following for the next year:

- ☐ 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):
- | | |
|--|---|
| <input type="checkbox"/> Increase physical activity, learn more about nutrition and improve diet, and/or weight loss | <input type="checkbox"/> Reduce/quit alcohol consumption |
| <input type="checkbox"/> Reduce/quit tobacco use | <input type="checkbox"/> Treatment for substance use disorder |
| <input type="checkbox"/> Annual influenza vaccine | <input type="checkbox"/> Dental visit |
| <input type="checkbox"/> Follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes | <input type="checkbox"/> Follow-up appointment for maternity care/reproductive health |
| <input type="checkbox"/> Follow-up appointment for recommended cancer or other preventative screening(s) | <input type="checkbox"/> Follow-up appointment for mental health/behavioral health |
| <input type="checkbox"/> 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.
- ☐ 5. Patient has committed to maintain their previously achieved Healthy Behavior Goal(s).

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.

Provider Last Name	Provider First Name	National Provider Identifier (NPI)
Provider Telephone Number		Date of Appointment
Signature		Date

Submit form by fax or via CHAMPS:

Fax to: 517-763-0200

CHAMPS: The Health Risk Assessment form can be submitted and viewed in the CHAMPS system via the Health Risk Assessment Questionnaire Web Page.

Blue Cross Complete members: Complete Sections 1, 2 and 3 of this form and take it to your doctor. Your doctor will fill out Section 4, sign the form, and return the entire form to us. If you have questions, call 1-888-288-1722 from 8 a.m. to 6:30 p.m., Monday through Friday.

Blue Cross Complete providers: Complete both pages of Section 4 of this form. Confirm the member has completed Sections 1, 2 and 3. Sign and date the entire form and fax pages 2, 3, 4 and 5 to 1-855-287-7886. Forms should be returned within five business days of the member's appointment. If you have questions, call 1-888-312-5713 from 8 a.m. to 5 p.m., Monday through Friday.

The Michigan Department of Health and Human Services does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

AUTHORITY: MCL 400.105(d)(1)(e)

COMPLETION: Is voluntary, but required for participation in certain Healthy Michigan Plan programs.