



Stop! Take **action** today

1

Make an appointment with your doctor.

2

Complete this *Health Risk Assessment* form and take it with you to your doctor.

3

Ask your doctor to return the form to Blue Cross Complete of Michigan.

4

Call 1-888-803-4947 for a free ride to your doctor's appointment.

5

Commit to a healthy behavior and qualify for cost-sharing reductions.



Health Risk Assessment



INSTRUCTIONS

The Healthy Michigan Plan is very interested in helping you get healthy and stay healthy. We want to ask you a few questions about your current health. Your doctor and your health plan will use this information to better meet your health needs. The information you provide in this form is personal health information protected by federal and state law and will be kept confidential. It CANNOT be used to deny health care coverage.

We also encourage you to see your doctor for a check-up as soon as possible after you enroll with a health plan, and at least once a year after that. An annual check-up appointment is a covered benefit of the Healthy Michigan Plan. Contact your health plan if you need transportation assistance to get to and from this appointment.

If you need assistance with completing this form, contact your health plan. You can also call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656 if you have questions.

You can also learn more at this website: www.healthymichiganplan.org.

Blue Cross Complete of Michigan 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.

For more information on your Healthy Michigan Plan benefits, visit mibluecrosscomplete.com, hover over *Member Benefits* and select *Healthy Michigan Plan*.

If you have questions, call Blue Cross Complete’s Rapid Response and Outreach team at 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.

This is the Healthy Michigan Plan Health Risk Assessment form for Blue Cross Complete of Michigan members. The Healthy Michigan Plan is a health care program from the Michigan Department of Community Health. Blue Cross Complete administers Healthy Michigan Plan benefits to eligible members.

Instructions for completing this Health Risk Assessment for Healthy Michigan Plan:

- Answer the questions in sections 1-3 as best you can. You are not required to answer all of the questions.
- Call your doctor’s office to schedule an annual check-up appointment. Take this form with you to your appointment.
- Your doctor or other primary care provider will complete section 4. He or she will send your results to your health plan.
- Don’t forget to complete a new health risk assessment each year.

After your appointment, keep a copy or printout of this form that has your doctor’s signature on it. This is your record that you completed your annual Health Risk Assessment.

<p>For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.</p> <p>Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656</p> <p>Arabic: TTY 1-866-501-5656</p> <p>إذا كان لديكم أي سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥</p>

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. Has a doctor told you that you have hearing loss or are deaf? Yes No

3. (For women only) Are you currently pregnant? Yes No Not applicable (men only)


4. 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.

5. 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.

6. 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.

7. 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


8. 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

First Name, Middle Name, Last Name, and Suffix

mihealth Card Number

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.

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

- | | | | | | | | |
|--|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--|
| <p>1. Thinking about your healthy behavior, do you want to make some small lifestyle changes in this area to improve your health?</p> | <input type="checkbox"/>
0 | <input type="checkbox"/>
1 | <input type="checkbox"/>
2 | <input type="checkbox"/>
3 | <input type="checkbox"/>
4 | <input type="checkbox"/>
5 | <p>I don't want to make changes now</p> <p>I want to learn more about changes I can make</p> <p>Yes, I know the changes I want to start making</p> |
| <p>2. How much support do you think you would get from family or friends if they knew you were trying to make some changes?</p> | <input type="checkbox"/>
0 | <input type="checkbox"/>
1 | <input type="checkbox"/>
2 | <input type="checkbox"/>
3 | <input type="checkbox"/>
4 | <input type="checkbox"/>
5 | <p>I don't think family or friends would help me</p> <p>I think I have some support</p> <p>Yes, I think family or friends would help me</p> |
| <p>3. How much support would you like from your doctor or your health plan to make these changes?</p> | <input type="checkbox"/>
0 | <input type="checkbox"/>
1 | <input type="checkbox"/>
2 | <input type="checkbox"/>
3 | <input type="checkbox"/>
4 | <input type="checkbox"/>
5 | <p>I do not want to be contacted</p> <p>I want to learn more about programs that can help me</p> <p>Yes, I am interested in signing up for programs that can help me</p> |

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.

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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.



Nondiscrimination Notice and Language Services

Discrimination is against the law

Blue Cross Complete of Michigan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross Complete of Michigan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross Complete of Michigan:

- Provides free (no cost) aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Information in other formats (large print, audio, accessible electronic formats)
- Provides free (no cost) language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Blue Cross Complete of Michigan Customer Service, 24 hours a day, 7 days a week at **1-800-228-8554** (TDD/TTY: **1-888-987-5832**).

If you believe that Blue Cross Complete of Michigan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

- **Blue Cross Complete of Michigan Member Grievances**

P.O. Box 41789

North Charleston, SC 29423

1-800-228-8554

(TDD/TTY: 1-888-987-5832)

- If you need help filing a grievance, Blue Cross Complete of Michigan Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal available at

ocrportal.hhs.gov/ocr/portal/lobby.jsf,
by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019

(TDD/TTY: 1-800-537-7697)

Complaint forms are available at:

hhs.gov/ocr/office/file/index.html.

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mibluecrosscomplete.com

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