# Transfer Member Risk Assessment

**UCare Connect/UCare Connect + Medicare**

Completion of this form will meet requirements for documentation that the Health Risk Assessment (HRA) and care plan were reviewed for product changes, transferred members or newly enrolled UCare Connect/UCare Connect + Medicare members who have had a Health Risk Assessment within the past 365 days. This form should be completed within 60 days of enrollment for UCare Connect/UCare Connect + Medicare members. This form is to be attached to the most recent Health Risk Assessment **AND** a signed CSP/ CSSP/Plan of Care (POC). A new Health Risk Assessment and POC must be done if there is not a current one completed within the previous 365 days, to review and update. Please refer to the UCare Connect/UCare Connect + Medicare requirements grid for details.
**Note: The next annual reassessment is due 365 days from the date of the last full HRA attached to this form.**

**I. PERSONAL INFORMATION**

| Name | PMI Number | Birth Date |
|---|---|---|
| Address (Street, City, ST, ZIP) | | Phone |
| Physician | Phone | Clinic |
| Address (Street, City, ST, ZIP) | | |

**II. ASSESSMENT/ PREVENTATIVE CARE/CARE PLAN:**

New product/Transfer enrollment date: Date of last HRA:

Date of last CSP/CSSP/POC: Method of last HRA (In-person, Phone, Televideo):

**Transfer Member Health Risk Assessment completed with member:** In person ☐ Via phone ☐ Televideo ☐

**Health Risk Assessment reviewed and updated as needed:** Date Reviewed:
Update Required ☐Yes ☐No
-Review the entire attached HRA for correctness and completeness. Record any changes with dates, on the HRA form and enter updated MMIS Screening Document as per the Guidelines instructions for product changes.

**CSP/CSSP/POC reviewed and updated as needed:** Date Reviewed:
Update Required ☐Yes ☐No
-Review the entire CSP/CSSP/POC with the Member or authorized representative and record any changes directly on the CSP/CSSP/POC including date of review/change.

**MMIS Entry Reviewed:** Date Completed:
Required for transfers from another Managed Care Organization, another care system or county, for a member that is internally assigned a new care coordinator, or for a product change (even if the care coordinator does not change).

**Complete the remaining elements on this form if not addressed on the current CSP/CSSP/POC**

Have preventive care issues been addressed? (e.g. immunizations, tobacco and alcohol use, fall risk, medication and nutrition)? ☐Yes ☐No

If No, explain issues which need to be addressed:

Does member need help coordinating an Annual Physician/Provider Visit for Primary and Preventive Care?
Yes ☐ No ☐ NA Comments:

When was your last physician/provider visit? Date:
Comments:

| Rank by Priority | Member Goals | Intervention | Target Date | Monitoring Progress/Goal Revision date | Date Goal Achieved/ Not Achieved (Month/Year) |
|---|---|---|---|---|---|
| ☐ **Low**<br>☐ **Medium**<br>☐ **High** | | | | | |
| ☐ **Low**<br>☐ **Medium**<br>☐ **High** | | | | | |
| ☐ **Low**<br>☐ **Medium**<br>☐ **High** | | | | | |

**Advance Directive**

| | YES | NO |
|---|---|---|
| Do you have an Advanced Directive? | ☐ | ☐ |
| If No, would you like information? | ☐ | ☐ |

SIGNATURE & TITLE OF PERSON COMPLETING THIS FORM

DATE