Transfer Member Health Risk Assessment

UCare Connect and Connect + Medicare

This form should be completed within 60 days of enrollment for Connect and Connect + Medicare community and institutional members. Follow UCare requirements grids to determine eligibility for THRA. A new assessment and support plan must be completed if one was not completed within the previous 365 days.

Note: The annual reassessment is due 365 days from the date of the last full assessment.

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/SUPPORT PLAN:

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

Date of last support plan: Method of last assessment (In-person, Phone, Televideo):

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

Assessment reviewed and updated as needed: Date Reviewed:

Update Required ☐Yes ☐No

-Review the entire assessment for accuracy and completeness.
Complete THRA activity in MnCHOICES. Update or revise the assessment as needed.

Support Plan reviewed and updated as needed: Date Reviewed:

Update Required ☐Yes ☐No

-Review the entire support plan for accuracy and completeness.
Update or revise the support plan as needed.

Complete the remaining elements on this form if not addressed on the assessment/support plan

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

When was the member's 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** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					

Advance Directive

	YES	NO
Does the member have an Advanced Directive?	☐	☐
If No, would the member like information?	☐	☐

SIGNATURE & TITLE OF PERSON COMPLETING THIS FORM

DATE