Transfer Member Health Risk Assessment

MSHO/ MSC+

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 MSHO and MSC+ members who have had an LTCC or MnCHOICES assessment within the past 365 days. This form should be completed within 30 days of enrollment for MSHO and MSC+ EW and non EW members. This form is to be attached to the most recent LTCC and care plan or MnCHOICES assessment summary and CSSP. A new LTCC and Collaborative Care Plan must be done if there is not a current one completed within the previous 365 days, to review and update. Please refer to the MSHO/MSC+ requirements grid for details.

Note: The next annual reassessment is due 365 days from the date of the last full LTCC 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 LTCC/HRA:

Date of last CSP/collaborative care plan: Method of last LTCC/HRA (In-person/Televideo/Phone):

Transfer Member HRA completed with member: In person ☐ Via phone ☐ Televideo ☐

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

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

MMIS Document Change as needed: 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/CCP

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** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					

Advance Directive

Do you have an Advanced Directive? YES ☐ NO ☐

If No, would you like information? YES ☐ NO ☐

SIGNATURE & TITLE OF PERSON COMPLETING THIS FORM DATE