Transfer Member Health Risk Assessment

MSC+ and MSHO

This form should be completed within 30 days of enrollment for MSC+ and MSHO 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 (non-institutional only). 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 with the member or representative and revise the support plan as needed.

MMIS Document Change as needed: Date Completed:

-Required for Elderly Waiver care coordinator changes.

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 that 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

Does the member have an Advanced Directive? ☐ YES ☐ NO

If No, would the member like information? ☐ YES ☐ NO

SIGNATURE & TITLE OF PERSON COMPLETING THIS FORM

DATE