

HRA Form

|                   |                                       |
|-------------------|---------------------------------------|
| Plan :            | VPHP - VIRGINIA PREMIER               |
| Program :         | Medicare                              |
| LOB :             | DSNP                                  |
| Region :          | CENTRAL                               |
| Aligned :         | Y                                     |
| Health Plan :     | Virginia Premier Healthcare Advantage |
| Member Name :     | ANTONIO FACUNDO                       |
| Evaluator Name :  |                                       |
| Assessment Type : | Health Risk Assessment                |
| DOB :             | 1959-09-02                            |
| Evaluation Date : |                                       |
| Visit Type :      |                                       |

Demographics

|                              |                             |
|------------------------------|-----------------------------|
| Name                         | ANTONIO FACUNDO             |
| Gender                       | Male                        |
| Address                      | 9616 STONERIDGE LANE        |
| City                         | RICHMOND                    |
| State                        | VA                          |
| Zip                          | 232295326                   |
| Date of Birth                | 1959-09-02                  |
| Age(as of date)              | 61                          |
| Marital Status               |                             |
| Member Identification Number | 11003370                    |
| HICN                         | 3NT2W09RM11                 |
| Phone Number                 | 8047542935                  |
| Cell Number                  | 8043980158                  |
| Email                        |                             |
| Emergency Contact            |                             |
| Phone Number                 |                             |
| Primary Care Physician       | STEWART, JACQUELINE         |
| Phone Number                 | 8047557581                  |
| PCP Address                  | 10150 Staples Mill Rd Ste E |
| PCP City                     | Glen Allen                  |

|             |   |
|-------------|---|
| PCP State   | VA  |
| PCP Zip     | 230603452                                 |
| PCP County  |   |
| Office ID   | P0123404                                  |
| Office Name | CROSSRIDGE PEDIATRICS & INTERNAL MEDICINE |

1. Race

Answer: Other

Describe

Answer: ASIAN/PACIFIC

Patient's Ethnicity

Answer:

2. Preferred language

Answer:

Covid Screening

In the last 14 days, have you:

Traveled internationally?

Answer:

Had known exposure to anyone diagnosed with Corona virus (COVID-19)

Answer:

Had close contact with someone who has traveled to a high risk area?

Answer:

Developed Fever?

Answer:

Developed Cough?

Answer:

Developed Flu like symptoms?

Answer:

Developed Shortness of breath?

Answer:

Self-Assessment and Social History

3. How much school have you completed?

Answer:

4. When you get written information at a doctor's office would you say it is

|   |
|---|
| Answer:   |
| 5. When you read the instructions on a prescription bottle would you say that it is   |
| Answer:   |
| 6. How confident are you in filling out medical forms by yourself?  |
| Answer:   |
| 7. How would you rate your health compared to other persons your age?   |
| Answer:   |
| 8. During past 3 months, has your physical and or emotional health limited your social activities with family, friends, neighbours or groups? |
| Answer:   |
| 9. Where do you currently live?   |
| Answer:   |
| 10. Do you have someone you can rely on to help if you are sick or have problems you need to discuss?   |
| Answer:   |
| 11. Who do you currently live with?   |
| Answer:   |
| 12. Are you currently a caregiver for someone?  |
| Answer:   |
| 13. Tobacco use   |
| Answer:   |
| Comment:  |
| 14. Alcohol Use   |
| Answer:   |
| 15. Do you or have you used recreational drugs or pain medication?  |
| Answer:   |
| 16. Do you have a Healthcare Proxy?   |
| Answer:   |
| 17. Do you have a Durable Power of Attorney?  |
| Answer:   |
| 18. Do you have an Advance Directive?   |
| Answer:   |
| Within the past 12 months we worried whether our food would run out before we got money to buy more. Was that _____ for your household?       |
| Answer:   |
| Within the past 12 months the food we bought just didn't last and we didn't have money to get   |

more. Was that \_\_\_\_\_ for your household?

Answer:

Activities of Daily Living

19. Do you have any difficulty with the following activities?

A. Getting in or out of bed

Answer:

B. Getting in or out of chairs

Answer:

C. Toileting

Answer:

D. Bathing

Answer:

E. Dressing

Answer:

F. Eating

Answer:

G. Walking

Answer:

H. Going up or down stairs

Answer:

Medical History

20. Do you use any assistive devices? (Check device or none if no devices used)

Answer:

21. Are you currently seeing any specialists?

22. In the past 12 months how many times have you?

A. Seen your PCP

Answer:

B. Visited the Emergency Room

Answer:

C. Stayed in the hospital overnight

Answer:

D. Been in a nursing home

Answer:

|  |
|--|
| <div>E. Had Surgery</div> <div>Answer:</div>   |
| <div>23. Have you ever been hospitalized prior to the last 12 months?</div> <div>Answer:</div>   |
| <div>24. In the past year have you received health services from any of the providers below:</div> <div><div>Physical Therapist</div><div>Answer:</div><div>Occupational Therapist</div><div>Answer:</div><div>Dietician</div><div>Answer:</div><div>Social Worker</div><div>Answer:</div><div>Pharmacist</div><div>Answer:</div><div>Speech Therapist</div><div>Answer:</div><div>Chiropractor</div><div>Answer:</div><div>Personal Care Worker (HHA, CNA, PCA)</div><div>Answer:</div><div>Meals on Wheels</div><div>Answer:</div></div> |
| <div>25. In the past two years have you received any of the treatments below?</div> <div><div>Chemotherapy</div><div>Answer:</div><div>Catheter Care</div><div>Answer:</div><div>Oxygen</div><div>Answer:</div><div>Wound Care</div><div>Answer:</div><div>Regular Injections</div><div>Answer:</div><div>Tube Feedings</div></div>  |

Answer:

Family History

26. Family History

Preventive Care

27. In the past three years have you had?

| Screen                     | Answer |
|----------------------------|--------|
| Colonoscopy                |        |
| Breast Exam/Mammography    |        |
| Cervical Screening         |        |
| Bone Density               |        |
| Prostate Exam/PSA          |        |
| If Diabetic Eye Exam       |        |
| If Diabetic Foot Exam      |        |
| If Diabetic Hgb A1c screen |        |
| Lipid Panel                |        |

28. Last colonoscopy if more than 2 years ago

Answer:

29. Screen for abnormal glucose / diabetes - age 40 - 70

Answer:

30. One time screen for Abdominal Aortic Aneurysm if male with history of smoking, age 65 - 75

Answer:

31. One time screen for Hepatitis C if born between 1945 - 1965

Answer:

32. Do you get Flu Vaccine each year?

Answer:

33. Have you been vaccinated for Pneumonia?

Answer:

34. Have you been vaccinated for Herpes Zoster?

Answer:

Allergies / Medications

35. Allergies

Answer:

Medications

| Dose Date | Label Name | Dose / Units | Route | Frequency | Status |
|-----------|------------|--------------|-------|-----------|--------|
|-----------|------------|--------------|-------|-----------|--------|

36. Over the Counter Medications / Supplements

Answer:

37. Chronic Use of

Answer:

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?

Answer:

2. Do you sometimes not pay enough attention to your medication?

Answer:

3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?

Answer:

4. When you feel better do you sometimes stop taking your medicine?

Answer:

5. Sometimes if you feel worse when you take your medicine do you stop taking it?

Answer:

6. Do you sometimes forget to refill your prescription on time?

Answer:

Review of Systems and Diagnoses

EYES

Eye Problems (Glaucoma, Cataracts, Macular Degeneration, Blindness, Retinal Detachment, Other)

Answer:

EARS

Ear Problems (Hard of hearing, Deaf, Vertigo, Ear Infections)

Answer:

NOSE

Nose Problems (Nose Bleeds, Sinus infections, Other)

Answer:

**MOUTH AND THROAT**

**Mouth and Throat Problems (Difficulty Chewing, Difficulty Swallowing, Bleeding Gums, Other )**

Answer:

**NECK**

**Neck Problems (parotid Disease, Carotid Stenosis, Other)**

Answer:

**RESPIRATORY**

**Respiratory Problems (COPD, Emphysema, Asthma, Chronic Bronchitis Pneumonia, Other)**

Answer:

**CARDIOVASCULAR**

**Cardiovascular (Hypertension, Angina, Ischemic Heart Disease(CAD), Myocardial Infarction, Other)**

Answer:

**GASTROINTESTINAL**

**Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other)**

Answer:

**Bowel Movements**

Answer:

**Abdominal Openings**

Answer:

**Rectal Problems**

Answer:

**Last Bowel Movement**

Answer:

**NEURO-PSYCH**

**Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)**

Answer:

**Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)**

**Are you nervous, anxious, feel on the edge or often feel stressed?**

Answer:

**Do you worry too much about different things?**



Answer:

Do you feel afraid that something bad might happen?

Answer:

How often do you go out to meet with family or friends

Answer:

GPCOG Score or MMSE Score

|               |  |
|---------------|--|
| GPCOG Score   |  |
| or MMSE Score |  |

If GPCOG or MMSE is not done, is

Patient oriented to person

Answer:

Patient oriented to place

Answer:

Patient oriented to time

Answer:

Recall

Answer:

Patient describes recent news event

Answer:

Affect

Answer:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

Answer:

Feeling down, depressed or hopeless

Answer:

PHQ 2 Score : <3

Speech

Answer:

Finger to Nose

Answer:

Heel (Shin) to Toe

Answer:

|   |
|---|
| <b>Thumb to Finger Tips</b><br><i>Answer:</i>   |
| <b>Sitting to Standing</b><br><i>Answer:</i>  |
| <b>Facial / Extremity Movement</b><br><i>Answer:</i>  |
| <b>Gait</b><br><i>Answer:</i>   |
| <b>GENITOURINARY</b><br><br>Genitourinary Problems (Overactive Bladder, Urinary Incontinence Stress Incontinence, Benign Prostatic Hypertrophy, Others)<br><i>Answer:</i>                               |
| <b>MUSCULOSKELETAL</b><br><br>Musculoskeletal Problems (Spinal Stenosis, Rheumatoid Arthritis, Gout, Osteoporosis, Others)<br><i>Answer:</i>  |
| <b>INTEGUMENT</b><br><br>Integument Problems (Eczema, Psoriasis, Dermatitis, Urticaria, Other)<br><i>Answer:</i>  |
| <b>ENDOCRINE</b><br><br>Endocrine Problems<br><i>Answer:</i>  |
| <b>Have you lost weight in the past 6 months?</b><br><i>Answer:</i>   |
| <b>HEMATOLOGY / IMMUNOLOGY / INFECTIOUS DISEASE</b><br><br>Hematology / Immunology / Infection Disease Problems (Anemia, easy bruising or abnormal bleeding Thrombocytopenia , Other)<br><i>Answer:</i> |
| <b>CANCER</b><br><br>Diagnosis of Cancer<br><i>Answer:</i>  |

Pain

Does the patient experience pain?  
*Answer:*

Vital Signs

Vital Signs

|                  |  |
|------------------|--|
| Blood Pressure   |  |
| Pulse            |  |
| Respiratory Rate |  |
| Temp             |  |
| Pulse Oximetry   |  |
| Pain Scale /10   |  |

BMI

*Comment:*

|                 |  |
|-----------------|--|
| Patients Height |  |
| Patients Weight |  |
| BMI             |  |

Exam Review

Constitutional

General appearance:  
*Answer:*

Head and Face

Examination of head and face:  
*Answer:*

Palpation of the face and sinuses:  
*Answer:*

Eyes

Inspection of conjunctiva and lids:  
*Answer:*

Examination of pupils and irises:  
*Answer:*

Ears, Nose, Mouth and Throat

|   |
|---|
| <b>External Inspection of ears and nose:</b><br><i>Answer:</i>            |
| <b>Otoscopic examination:</b><br><i>Answer:</i>                           |
| <b>Assessment of hearing:</b><br><i>Answer:</i>                           |
| <b>Inspection of nasal mucosa, septum and trubينات:</b><br><i>Answer:</i> |
| <b>Inspection of lips, teeth and gums:</b><br><i>Answer:</i>              |
| <b>Examination of oropharynx:</b><br><i>Answer:</i>                       |

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| <b>Neck</b>                                      |
| <b>Examination of neck:</b><br><i>Answer:</i>    |
| <b>Examination of thyroid:</b><br><i>Answer:</i> |

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| <b>Pulmonary</b>   |
| <b>Assessment of respiratory effort:</b><br><i>Answer:</i> |
| <b>Percussion of chest:</b><br><i>Answer:</i>              |
| <b>Palpation of chest:</b><br><i>Answer:</i>               |
| <b>Auscultation of lungs:</b><br><i>Answer:</i>            |

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| <b>Cardiovascular</b>                           |
| <b>Palpation of heart:</b><br><i>Answer:</i>    |
| <b>Auscultation of heart:</b><br><i>Answer:</i> |
| <b>Carotid Arteries:</b><br><i>Answer:</i>      |

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| <b>Abdominal Aorta:</b><br><i>Answer:</i>                     |
| <b>Pedal Pulses:</b><br><i>Answer:</i>                        |
| <b>Examination of Arterial Pulses:</b><br><i>Answer:</i>      |
| <b>Examination of Edema / Varicosities:</b><br><i>Answer:</i> |

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| <b>Lymphatic</b>  |
| <b>Palpation of cervical nodes (neck)</b><br><i>Answer:</i>                     |
| <b>Palpation of preauricular nodes (in front of the ears)</b><br><i>Answer:</i> |
| <b>Palpation of Submandibular nodes (under jaw line/chin)</b><br><i>Answer:</i> |

|   |
|---|
| <b>Musculoskeletal</b>  |
| <b>Examination of gait and station:</b><br><i>Answer:</i>                   |
| <b>Inspection/palpation of digits and nails:</b><br><i>Answer:</i>          |
| <b>Inspection/palpation of joints, bones and muscles:</b><br><i>Answer:</i> |
| <b>Assessment of range of motion:</b><br><i>Answer:</i>                     |
| <b>Assessment of stability:</b><br><i>Answer:</i>                           |
| <b>Assessment of muscle strength/tone:</b><br><i>Answer:</i>                |

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| <b>Skin</b>  |
| <b>Inspection of skin and subcutaneous tissue:</b><br><i>Answer:</i> |
| <b>Palpation of skin and subcutaneous tissue:</b><br><i>Answer:</i>  |

|   |
|---|
| <b>Neurologic</b>   |
| <b>Indicate specific cranial nerve tested</b><br><i>Answer:</i> |
| <b>Indicate cranial nerve deficits found</b><br><i>Answer:</i>  |
| <b>Romberg Test</b><br><i>Answer:</i>                           |
| <b>Examination of reflexes:</b><br><i>Answer:</i>               |
| <b>Examination of sensation:</b><br><i>Answer:</i>              |
| <b>Coordination:</b><br><i>Answer:</i>                          |

|                                     |
|-------------------------------------|
| <b>Diabetes</b>                     |
| <b>Foot Exam:</b><br><i>Answer:</i> |

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| <b>Psychiatric</b>   |
| <b>Description of patient's judgement / insight:</b><br><i>Answer:</i> |
| <b>Orientation of person, place and time:</b><br><i>Answer:</i>        |
| <b>Recent and remote memory:</b><br><i>Answer:</i>                     |
| <b>Mood and affect:</b><br><i>Answer:</i>                              |

| Screenings Needed    |                 |        |         |                 |                     |           |                  |           |          |
|----------------------|-----------------|--------|---------|-----------------|---------------------|-----------|------------------|-----------|----------|
| Screening Name       | Member Eligible | Status | Barcode | Confirm Barcode | Screening Completed | Exam Date | Screening Result | Diagnosis | Comments |
| DIGITAL_RETINAL_EXAM | Select          | Select |         |                 | Select              |           |                  |           |          |

|              |        |        |  |  |        |            |          |  |  |
|--------------|--------|--------|--|--|--------|------------|----------|--|--|
| HBA1C        | Yes    | Select |  |  | Yes    | 2021-01-28 | 6.3      |  |  |
| MICROALBUMIN | Select | Select |  |  | Select |            |          |  |  |
| FOBT         | Yes    | Select |  |  | Yes    | 2021-01-28 | Positive |  |  |
| DEXA         | Select | Select |  |  | Select |            |          |  |  |
| PAD          | Select | Select |  |  | Select |            |          |  |  |
| LDL          | No     | Select |  |  | Select |            |          |  |  |

Mini-Cog

|                   |  |
|-------------------|--|
| Word List Version |  |
| Person's Answers  |  |
| Word Recall       |  |
| Clock Draw        |  |
| Total Score       |  |

Home Safety & Personal Goals

40. In the past year how many times have you Fallen?  
*Answer:*

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?  
*Answer:*

b. Do you have electrical cords running across floors, in doorways or under a rugs?  
*Answer:*

c. Do you have no slip mats on the shower floor or bath tub?  
*Answer:*

d. Do have adequate lighting in hallways and on the stairs?  
*Answer:*

e. Do you have handrails on staircases?  
Answer:

f. Is your hot water heater set for a maximum of 120 degrees?  
Answer:

g. Do you have smoke detectors on each level of the house and in all sleeping a rooms?  
Answer:

h. Do you have carbon Monoxide detectors on each level of the house?  
Answer:

i. Have used established an escape route in the event of fire?  
Answer:

42. Are there things about yourself you wish you could change or improve?  
Answer:

43. Is there anything that you could do to improve your quality of life?  
Answer:

44. Have you ever physically or felt emotionally abused by someone  
Answer:

45. Feeling like harming others or yourself  
Answer:

46. Are you afraid of anyone or is anyone hurting you?  
Answer:

Patient Summary

|                                    |  |
|------------------------------------|--|
| Assessors Comments                 |  |
| Member informed of acknowledgment  |  |
| Date/Time of Service/ Evaluation : |  |
| Time exam finished                 |  |
| Provider Signature                 |  |
| Addendum                           |  |
| Member Acknowledgment              | I have been advised by the evaluator and understand that the services performed by the evaluator are limited to the evaluation performed today; the evaluator has no further duties to me once the evaluation performed today is completed ; the evaluator is not liable for abandonment my refusing to provide me treatment or continuing care to me beyond this evaluation; and I should contact my primary care or treating physician for all questions and |



|                      |   |
|----------------------|---|
|                      | concerns regarding medical care and treatment or, in the event of an emergency, call 911  |
| Disclosure Statement | <div><div>Your health plan has asked Focus Care to conduct, on its behalf, health assessments on its patients. The health assessment includes questions to help your health plan learn more about your current health status, including potential health risks. This information will help your health plan and your physician help you maintain or achieve your best state of health.</div><div>Generally, your personal health information (PHI) may only be used and disclosed by us with your express written authorization. Focus Care has implemented several security measures to protect your PHI from being released orally, in writing, or electronically. Additional information about these safeguards are available upon request.</div><div>Treatment Purposes. We may disclose medical information about you to other health care providers who are or will be involved in taking care of you. For example, the results of your health assessment will be sent to your health plan. Your health plan will use this information to identify your health needs and offer available programs to you. Your health plan shares your completed health risk assessment with your physician.</div><div>Payment Purposes. We may use or disclose your medical information for payment purposes. It is necessary for us to disclose your completed health assessment to your health plan so that we may bill and receive payment for this service.</div><div>Health Care Operations. We may use and disclose your personal health information in order for us to conduct our healthcare business, which is administration of the health assessment on behalf of your health plan.</div><div>Other uses and disclosures of your PHI will be made only with your written authorization unless otherwise permitted or required by law. The use or disclosure will be made in compliance with the law and will be limited to the requirements of such law.</div><div>In addition, we may release your personal health information to third party 'business associates' who perform various activities for us, such as billing or electronic transmissions of PHI. Whenever our arrangement with a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.</div></div> |

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|--|--|
|  | <div>Your agreement to participate with the health assessment implies your consent to provide the results of your health assessment to your health plan.</div> |
|--|--|