

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	test L members
Evaluator Name :	test clinicianFE, FNP
Assessment Type :	Health Risk Assessment
DOB :	2020-10-17
Evaluation Date :	2022-10-18 06:49 PM
Visit Type :	Virtual: Video & Audio Capability

CHILD-DEMOGRAPHICS

Name	test L members
Gender	Female
Address	Bangalore
City	Bangalore
State	Bangalore
Zip	555322
Date of Birth	2020-10-17
Age(as of date)	2
Marital Status	Single
Member Identification Number	1122334455
HICN	7688
Phone Number	11001379
Cell Number	564322
Email	11001379e
Emergency Contact	11001379e
Phone Number	98635432
Primary Care Physician	11001379e
Phone Number	11001379
Guardian Name	11001379e
Relationship to Child	11001379e
Phone Number	11001379
Cell Number	11001379
Email	11001379e
PCP Address	11001379e
PCP City	11001379e

PCP State	11001379e
PCP Zip	11001379
PCP County	11001379e
Office ID	11001379e
Office Name	11001379e

ASSESSMENT INFORMATION

1. Does the member or legal guardian give verbal permission to discuss PHI?

☐ Yes ☒ No

comments

2. Does member or authorized legal representative give verbal permission to share the results of this assessment verbally and/or electronically with members of the healthcare team?

☐ Yes ☒ No

comments

3. Is your child enrolled in foster care program?

☐ Yes ☒ No

comments

4. Preferred language

☐ English ☒ Other

 If other,

- | | | |
|---|---|----------------------------------|
| <input type="checkbox"/> African languages | <input type="checkbox"/> Arabic | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> French | <input type="checkbox"/> French Creole | <input type="checkbox"/> German |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Hebrew |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Persian |
| <input type="checkbox"/> Polish | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Scandinavian Languages | <input type="checkbox"/> Serbo-Croatian | <input type="checkbox"/> Spanish |

5. Race

- | | | |
|---|---|--|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> African American | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Latino | <input checked="" type="checkbox"/> Native American | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Alaskan Native | | |

6. Does your child have Allergies

☒ Yes

☐ No

Substance	Reaction

7. Has the child experienced or witnessed an event that caused, or threatened to cause, serious harm to him or herself or to someone else?

☐ Yes

☐ No

8. What age was the member when this event occurred?

comments

555322

Specify Age:

555322

Other Event
INSTRUCTIONS: The following is a list of behaviors that describe reactions that children may have following a frightening event. For each item that describes your child NOW or WITHIN THE PAST MONTH, please tell me if it is VERY TRUE or OFTEN TRUE of your child: SOMEWHAT or SOMETIMES TRUE of your child; or NOT TRUE of your child. The term “event” refers to the most stressful experience that you have described above.

9. Child reports more physical complaints such as headaches, stomach aches, nausea when reminded of the event.

☐ Not True (as far as you know)

☐ Often True

☐ Somewhat or Sometimes True

☒ **Very True**

10. Child avoids doing things that remind him/her of the event

☒ **Not True (as far as you know)**

☐ Often True

☐ Somewhat or Sometimes True

☐ Very True

11. Child startles easily (jumps when hears sudden loud noises)

☐ Not True (as far as you know)

☒ **Often True**

☐ Somewhat or Sometimes True

☐ Very True

12. Child gets upset if reminded of event.

☒ **Not True (as far as you know)**

☐ Often True

☐ Somewhat or Sometimes True

☐ Very True

13. Does your child currently need to use medicine prescribed by a doctor (other than vitamins)?

☒ **Yes**

☐ No

☐ Is this because of ANY medical, behavioral, or health condition?

☐ Is this a condition that has lasted or is expected to last for at least 12

months?

☒ Yes

☐ No

🔗 Explain:

Medications

14. List Prescription Medication

Frequency	Prescription Status	Route
AC PC AC & HS BID TID QID QAM QD QOD QPM QW QOW HS	N = New O = Ongoing D = Discontinued H = Hold	PO = By Mouth SQ = Subcutaneous IM = Intramuscular INH = Inhalation IV = Intravenous N = Nasal R = Rectal S = Sublingual

Prescription	Dose / Units	Route	Frequency	Status	Reason
comments	555322				
555322	555322		Select	N = New	555322

15. List Over the Counter Medications / Supplements

☒ Yes

☐ No

Prescription	Dose/Units	Route	Frequency	Status	Reason
		R = Rectal			

16. Does your child need or use more medical care, mental health or educational services than is usual for most children of the same age?

☒ Yes

☐ No

🔗 Is this because of ANY medical, behavioral, or health condition?

🔗 is this a condition that has lasted or is expected to last for at least 12 months?

☒ Yes

☐ No

🔗 Explain:

17. Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

☒ Yes

☐ No

🔗 Is this because of ANY medical, behavioral, or health condition?

🔗 Is this a condition that has lasted or is expected to last for at least 12 months?

☒ Yes

☐ No

🔗 Explain:

18. Does your child need or get special therapy, such as physical, occupational or speech?

☒ Yes

☐ No

- ↳ Is this because of ANY medical, behavioral, or health condition?
- ↳ Is this a condition that has lasted or is expected to last for at least 12 months?
- ☒ Yes ☐ No

19. Does your child have any kind of emotional, developmental, or behavioral problem for which he or she needs or gets treatment or counseling?

☒ Yes ☐ No

↳ Is this because of ANY medical, behavioral, or health condition?

20. Does your child receive support services in the home?

☒ Nursing Care ☐ Personal Care Attendant ☐ Home Health Aide
☐ No

21. Has your child had a medical checkup in the last 12 months?

☒ Yes ☐ No ☐ Doesn't Know

22. Do you know your child's height and weight?

☒ Yes ☐ No

Childs Height		Childs Weight	Calculate BMI
555322 (Feet)	56 (Inch)	5.6 (lbs)	0.0

23. How would you describe your child's weight?

comments

555322

555322

24. For female children >=12: Is your child pregnant?

☒ Yes ☐ No ☐ Doesn't Know
☐ N/A

25. How often do you worry you don't have enough food for your family?

☐ Never ☐ Sometimes ☐ Always
☒ Decline to answer

26. Do you know what community resources are available to help you?

☒ Yes ☐ No

27. Does your child have any of the following conditions?

☒ Asthma ☒ Diabetes ☒ Sickle cell disease
☒ Hemophilia ☒ DD/ADHD ☒ Substance use

Asthma

↳ Does your child see a specialist?

☒ Yes ☐ No

comments

555322

↳ If yes, name

555322

Diabetes

Do you test your child's blood sugar?

☒ Yes ☐ No

comments 555322

Sickle cell disease

Do you know what an Hgb A1C is?

☒ Yes ☐ No

comments 555322

If yes what is your child's last Hgb A1C?

555322

Hemophilia

Do you follow a special diet?

☒ Yes ☐ No

comments 555322

If yes, diet

555322

28. Is there any additional information you would like to share about your child?

comments 555322


555322

PATIENT SUMMARY

Assessors Comments :

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

Member informed of acknowledgment	<input checked="" type="checkbox"/>
Date/Time of Service/Evaluation :	2022-10-11T11:18
Time exam finished	2022-10-18T11:18
Provider Signature	<div> <div>test clinicianFE</div> <div>  <div>Digitally signed by test clinicianFE, FNP 2022-10-25, 11:18</div> </div> </div>
Addendum	Also if u sort this column and try to sort

	other column, showing "no record found". live
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Disclosure Statement

Protected Health Information (PHI) is information, such as name, age, address, sex, race, and marital status, that may be used to identify your physical and mental health conditions; healthcare that you have received; and, how your healthcare services have been paid for.

FOCUS CARE does not use or disclose your PHI unless required or permitted by National or State laws or with your written consent. FOCUS CARE is required to release PHI to the Department of Health and Human Services (DHHS), or its contractors, for audits or other enforcement actions and to you, if you request access to, or an accounting of disclosures of your PHI.

FOCUS CARE may release your PHI without your authorization for treatment, payment, and health care operations of covered entities, such as providers, health plans, billing clearinghouses, and contracted business associates.

FOCUS CARE may disclose your PHI to you, unless otherwise restricted by law. FOCUS CARE may also use and disclose PHI without an individual's authorization where required by law, including statute, regulation, or valid court order.