

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	HAYLEE B GOMEZ
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	2003-01-25
Evaluation Date :	2021-9-25 08:31 AM
Visit Type :	In Person

CHILD-DEMOGRAPHICS

Name	HAYLEE B GOMEZ
Gender	Female
Address	1123 DOUBLE D DRIVE
City	CHILHOWIE
State	VA
Zip	24319-4514
Date of Birth	2003-01-25
Age(as of date)	18
Marital Status	
Member Identification Number	7946183
HICN	
Phone Number	2766462414, 2766462414
Cell Number	2762740642
Email	abc@gmail.com
Emergency Contact	GINA
Phone Number	2319090123
Primary Care Physician	PARKER, DAVID G
Phone Number	2319090123
Guardian Name	TONAT
Relationship to Child	none
Phone Number	2319090123
Cell Number	2390129010
Email	bca@gail.com
PCP Address	1020 Terrace Dr, Ste 100
PCP City	Marion

PCP State	VA
PCP Zip	243544392
PCP County	Irfan
Office ID	12390090123
Office Name	ST JOSEPH STANGVHE

ASSESSMENT INFORMATION

1. Does the member or legal guardian give verbal permission to discuss PHI?
☒ Yes ☐ No
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
3. Is your child enrolled in foster care program?
☒ Yes ☐ No
4. Preferred language
☐ English ☒ Other
 ↳ If other,
 ☒ African languages ☐ Arabic ☐ Chinese
 ☐ French ☐ French Creole ☐ German
 ☐ Greek ☐ Gujarati ☐ Hebrew
 ☐ Hindi ☐ Hungarian ☐ Italian
 ☐ Japanese ☐ Korean ☐ Persian
 ☐ Polish ☐ Portuguese ☐ Russian
 ☐ Scandinavian Languages ☐ Serbo-Croatian ☐ Spanish
- comments Africans
5. Race
☒ Caucasian ☐ African American ☐ Asian
☐ Latino ☐ Native American ☐ Native Hawaiian or other Pacific Islander

☐ Alaskan Native
- comments Causian
6. Does your child have Allergies
☒ Yes ☐ No

Substance	Reaction
substances 1	reaction 1
substances 2	reaction 2
substances 3	reaction 3
Conditions	Radiations

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

comments

Yes it is

What was the event

☒ Car or Other Accident
☐ Fire
☐ Storm
☐ Physical Illness or Assault
☐ Sexual Assault

Describe

donated

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

Specify Age:

09

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) ☐ Somewhat or Sometimes True ☐ Very True ☐ Often True

comments

Not found

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

☒ Not True (as far as you know) ☐ Somewhat or Sometimes True ☐ Very True ☐ Often True

comments

Not true

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

☒ Not True (as far as you know) ☐ Somewhat or Sometimes True ☐ Very True ☐ Often True

comments

Don't know

12. Child gets upset if reminded of event.

☒ Not True (as far as you know)
☐ Often True

☐ Somewhat or Sometimes True
☐ Very True

comments

distances

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

☒ Yes
☐ No

comments

Didn't know value

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

None of above

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

☒ Yes
☐ No

Explain:
that is all

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
Prescribed	100 MG/ML	PO = By Mouth	AC	O = Ongoing	rtrytyutyu
ngfdgcth	10 MG/ML	SQ = Subcutaneous	PC	N = New	ytiifuirgue
njyhjuujuy	30 - 100 MG/ML	IM = Intramuscular	AC & HS	D = Discontinued	npfieule
htyuyuhjuk	20 MG	INH = Inhalation	BID	H = Hold	fvyufreuyre
ujyuuu	10 MG	IV = Intravenous	TID	Select	hfjeufekfeeh

15. List Over the Counter Medications / Supplements

☐ Yes
☐ No

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

☐ Yes
☒ No

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

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

☐ 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

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

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

He is fine now

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

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


comments

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 :	
Time exam finished	
Provider Signature	<div>shweDigitally signed by test clinicianFE, FNP 2021-10-08 11:18</div>
Addendum	<div></div>

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.