

HRA Form

|                   |                                   |
|-------------------|-----------------------------------|
| Health Plan :     | Optima Health                     |
| Member Name :     | test S members                    |
| Evaluator Name :  | test clinicianFE, FNP             |
| Assessment Type : | Health Risk Assessment            |
| DOB :             | 2008-08-23                        |
| Evaluation Date : | 2022-8-25 06:26 PM                |
| Visit Type :      | Virtual: Video & Audio Capability |

CHILD-DEMOGRAPHICS

|                              |                  |
|------------------------------|------------------|
| Name                         | test S members   |
| Gender                       | Female           |
| Address                      | Bangalore        |
| City                         | Bangalore        |
| State                        | KARNATAKA        |
| Zip                          | 422334           |
| Date of Birth                | 2008-08-23       |
| Age(as of date)              | 13               |
| Marital Status               | Single           |
| Member Identification Number | 900038001*05     |
| HICN                         | 456              |
| Phone Number                 | 9873452343       |
| Cell Number                  | 422455           |
| Email                        | members@gmail.co |
| Emergency Contact            | MOTHER           |
| Phone Number                 | 9873452343       |
| Primary Care Physician       | DOLL             |
| Phone Number                 | 9873452343       |
| Guardian Name                |                  |
| Relationship to Child        |                  |
| Phone Number                 |                  |
| Cell Number                  |                  |
| Email                        |                  |
| PCP Address                  | BANGALORE        |
| PCP City                     | BANGALORE        |

|             |                |
|-------------|----------------|
| PCP State   | KARNATAKA      |
| PCP Zip     | 53344          |
| PCP County  | INDIAN         |
| Office ID   | 345            |
| Office Name | SYSTEM PVT LTD |

## 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,

- |   |  |                                  |
|---|--|----------------------------------|
| <input type="checkbox"/> African languages      | <input checked="" 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 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

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?

Specify Age:

### 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

## 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

## 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

## 12. Child gets upset if reminded of event.

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

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

- ☐ Yes
 ☐ No

### Medications

## 14. List Prescription Medication

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

| Prescription | Dose / Units | Route | Frequency | Status | Reason |
|--------------|--------------|-------|-----------|--------|--------|
|--------------|--------------|-------|-----------|--------|--------|

## 15. List Over the Counter Medications / Supplements

☐ Yes ☐ No

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

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?

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


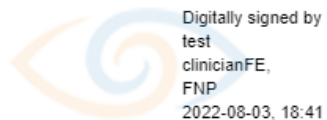
28. Is there any additional information you would like to share about your child?

## 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                |   |
| Addendum                          |   |

### 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.