



Broker Instructions

Complete this form with your Medicare Advantage member during your appointment, then return the signed form to Healthy Mississippi, Inc. using one of the methods below:

Email: HRA@qualaxahealthcare.com

Fax:

Mail:

Forms must be submitted within the timeframe required by your broker agreement.

Member Information

Member name:	
Gender:	Male ☐ Female ☐
Date of birth:	
Home address:	
Primary Phone Number	
Alternate Phone Number	
HRA Completion Date	

Your Choice and Support

1. Do you agree to fill out this health survey?

☐ Yes

☐ No

About You and How We Contact You

2. What is your race? Check all that apply.

☐ White

☐ Black or African American

☐ Asian

☐ Native Hawaiian or Pacific Islander

☐ American Indian or Alaska Native

☐ Middle Eastern or North African

☐ Other

☐ I do not want to answer

3. What is your ethnicity? Check one box.

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ I do not want to answer

4. What is your primary language? _____

5. Do you need an interpreter?

☐ Yes

☐ No

6. How should the health plan contact you? Check all that apply.

- ☐ Phone ☐ Email ☐ Text message
- ☐ Mail ☐ Other

Email address: _____

Alternate phone number: _____

7. What is the highest grade or school level you finished?

- ☐ Less than high school ☐ High school diploma or GED
☐ Some college or more ☐ I do not want to answer

Your Health

8. In the past 4 weeks, did your health keep you from spending time with other people?

- ☐ Yes ☐ No

9. If yes, what made it hard? Check all that apply.

- ☐ Trouble walking or moving ☐ Pain that lasts
☐ Shortness of breath ☐ Vision or hearing problems
☐ Feeling sad or down ☐ Worry or anxiety
☐ Memory problems ☐ Feeling alone
☐ No ride or transportation ☐ Taking care of someone else
☐ Other: _____

10. Do you have, or have you had, any of these health problems? Check all that apply.

- ☐ Bipolar disorder ☐ Cancer
☐ COPD or lung disease ☐ Heart artery disease
☐ Dementia or memory problems ☐ Depression
☐ Deaf ☐ Legally blind
☐ Dialysis or end-stage kidney disease ☐ Frailty or weakness
☐ Hearing problem ☐ Heart failure
☐ High blood pressure ☐ Diabetes
☐ Organ transplant or transplant list ☐ Kidney disease or kidney failure
☐ Schizophrenia ☐ Stroke
☐ Vision problem ☐ Seizure disorder
☐ Parkinson's disease ☐ None
☐ Other: _____

11. Do you stay in bed most of the day because of a health problem?

- ☐ Yes ☐ No

12. In the past year, have you thought about hurting yourself or ending your life?

☐ Yes

☐ No

13. If yes, do you have a plan to hurt yourself or end your life?

☐ Yes

☐ No

☐ Does not apply

14. What was your pain level in the past 4 weeks? Circle one number.

0 (No pain) 1 2 3 4 5 6 7 8 9 10 (Very bad pain)

Daily Activities

15. Can you make your own meals?

☐ Yes, without help

☐ Sometimes, with some help

☐ No, I need help

16. Can you do chores in your home such as: sweeping, mopping, dishes without assistance?

☐ Yes, without help

☐ Sometimes

☐ No, I need help

17. Do you need help with eating, bathing, dressing, using the toilet, getting in or out of a chair, or moving around?

☐ Yes

☐ No

Social Determinants of Health (SDOH)

18. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or getting things needed for daily living? ¹

☐ Yes

☐ No

19. What is your living situation today? ²

☐ I have a steady place to live

☐ I have a place to live today, but I am worried about losing it in the future.

☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

20. Think about the place where you live. Do you have problems with any of the following? ³

CHOOSE ALL THAT APPLY

☐ Pests such as bugs, ants, or mice

☐ Mold

☐ Lead paint or pipes

☐ Lack of heat

☐ The oven or stove is not working

☐ Smoke detectors are missing or not working

☐ Water leaks

☐ None of the Above

21. In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home? ⁴

☐ Yes

☐ No

☐ Already shut off

22. Because violence and abuse happen to a lot of people and affect their health, we are asking the following questions. ⁵

How often does anyone, including family and friends, physically hurt you?

☐ Never

☐ Rarely

☐ Sometimes

☐ Fairly often

☐ Frequently

How often does anyone, including family and friends, insult or talk down to you?

- ☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

23. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [6](#)

Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ☐ Often true ☐ Sometimes true ☐ Never true

24. Within the past 12 months, the food you bought just did not last, and you did not have money to get more.

- ☐ Often true ☐ Sometimes true ☐ Never true

Falls and Balance

25. Have you fallen in the past 6 months?

- ☐ Yes ☐ No

26. Do you have trouble with balance or walking?

- ☐ Yes ☐ No

Your Doctors and Medicines

27. Do you have a primary care physician (PCP)?

- ☐ Yes ☐ No

28. Have you seen your primary care physician in the past 6 months?

- ☐ Yes ☐ No

Primary care physician's name: _____

Primary care physician's phone number: _____

Primary care physician's location/address: _____

The health plan will help the member find a primary care physician, if needed.

29. Are you able to take your medications the way your doctor told you?

- ☐ Yes
☐ No

30. Do you have difficulty getting your medications (cost or transportation)?

- ☐ Yes ☐ No

31. List the medicines, vitamins, and supplements you take. If you take more than five, use the Medication Addendum.

Medication Name	Dosage & Route	How often?	Why do you take it?

Medication Name	Dosage & Route	How often?	Why do you take it?

Medication Transfer Statement

32. I understand that I may use any pharmacy for my prescriptions. For possible cost savings, I may choose to have my prescriptions transferred to the plan's preferred pharmacy.

☐ I agree

☐ I do not agree

Height: _____ **Weight:** _____

33. In the past 3 months, did you lose weight without trying?

☐ No, or less than 2 pounds

☐ Yes, 2 to 6 pounds

☐ Yes, 7 pounds or more

☐ I do not know

Social Behavior and Preventive Care

34. In the past 4 weeks, how often did you drink alcohol?

☐ None

☐ 1 time or less each week

☐ 2 to 5 times each week

☐ 6 to 9 times each week

☐ 10 or more times each week

35. Do you smoke or use tobacco?

☐ No

☐ Yes, and I want to quit

☐ Yes, I am not ready to quit

36. Do you use recreational drugs?

☐ Yes (describe): _____ ☐ No

37. On a scale of 1 to 10, how would you rate your overall health? Circle one number.

1 (Not healthy) 2 3 4 5 6 7 8 9 10 (Healthy)

38. What is the status of each vaccine? Check one box on each line.

Vaccine	Current	Past due	Never had	Not sure
Flu	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐
Td/Tdap (tetanus)	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐

Vaccine	Current	Past due	Never had	Not sure
Shingles (zoster)	☐	☐	☐	☐
Covid-19	☐	☐	☐	☐

39. What is the status of each health screening? Check one box on each line.

Screening	Up to date	Past due	Never had	Not sure	Does not apply
Mammogram	☐	☐	☐	☐	☐
Colon cancer test	☐	☐	☐	☐	☐
Pap test or cervical cancer test	☐	☐	☐	☐	☐

Emergency Room and Hospitalizations

40. How many times did you go to the emergency room in the past 3 months?

☐ 0 ☐ 1–2 ☐ 3 or more ☐ Not sure

41. How many times did you stay in a hospital or observation unit in the past 3 months?

☐ 0 ☐ 1 ☐ 2 ☐ 3 or more ☐ Not sure

42. In the past 3 months, did you have any of these services? Check all that apply.

- ☐ Skilled nursing, rehab, or behavioral health stay
- ☐ Home health care
- ☐ Hospice care
- ☐ Moved to a new place for more support
- ☐ None

Your Care Choices and Goals

43. Do you have a medical power of attorney?

- ☐ Yes, requested copy ☐ No
- ☐ I do not know ☐ I want more information

44. Do you have a living will or advance directive?

- ☐ Yes, requested copy ☐ No ☐ I do not know ☐ I want more information

45. What kind of place do you live in now?

- ☐ My own home or apartment ☐ A family member's or caregiver's home
- ☐ Assisted living or residential care ☐ Nursing home or long-term care
- ☐ Skilled nursing or rehab ☐ Other

Other: _____

46. Are you concerned about your safety where you live now?

☐ Yes ☐ No ☐ Sometimes

47. What help would you like from us? Check all that apply.

- | | |
|--|---|
| ☐ Care manager follow-up | ☐ Doctor follow-up |
| ☐ Medicine or pharmacy help | ☐ Mental health help |
| ☐ Social worker or community help | ☐ Transportation help |
| ☐ Food or nutrition help | ☐ Home safety or fall help |
| ☐ Medical equipment or supplies | ☐ Medicaid |
| | ☐ Long-term care help |
| | ☐ Other: _____ |

(A care manager will follow up with you to discuss)

48. Who helped you fill out this form? Check all that apply.

- | | |
|--|---|
| ☐ I filled it out | ☐ Family member or caregiver |
| ☐ Authorized representative | ☐ Broker |
| ☐ Facility staff | ☐ Other: _____ |

Additional Information or Notes

Use this space for information that may help the health plan follow up with the member.

Broker name:

Broker ID/NPN:

Citations

1. This question is derived from the national PRAPARE® social drivers of health assessment tool, which was developed and is owned by the National Association of Community Health Centers (NACHC). This tool was developed in collaboration with the Association of Asian Pacific Community Health Organization (AAPCHO) and the Oregon Primary Care Association (OPCA). For additional information, please visit www.prapare.org.
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3. Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. *Journal of Healthcare for the Poor and Underserved*, 26(2), 321-327.
4. Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M. M., Chilton, M., . . . Cutts, D. B. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. *Pediatrics*, 122(4), 867-875. doi:10.1542/peds.2008-0286
5. Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. *Family Medicine*, 30(7), 508-512.
6. Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. *Pediatrics*, 126(1), 26-32. doi:10.1542/peds.2009-3146

Medication Addendum