HUMAN SERVICES
DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

DEPARTMENTAL MEMORANDUM
MAD-MR: 18-03
DATE: 2/26/2018

TO: MEDICAL ASSISTANCE DIVISION

FROM: NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION

THROUGH: MEGAN PFEFFER, BUREAU CHIEF, QUALITY BUREAU

BY: ANDREA MCNEILLEY, QUALITY BUREAU

SUBJECT: STANDARDIZED HRA

GENERAL INFORMATION
This form is for use by Care Coordinators when they perform an HRA.

FILING INSTRUCTIONS
Please make the following changes to the MAD forms manuals:

INSERT MAD 747

Please address any questions concerning these guidelines to:
Megan.Pfeffer@state.nm.us or call (505) 827-7722.

Attachment: MAD 747 Issued 2/16/16 Standardized HRA Form

HUMAN SERVICES DEPARTMENT
MEDICAL ASSISTANCE DIVISION

Health Risk Assessment (HRA)

Member's Name (First, Middle, Last)		Member's Medicaid ID	Date
Has Member Given Permission for Another Person to Complete this form? ☐ Yes ☐ No	**Name of Person Completing/Assisting with the Completion of This Assessment and Their Relationship to Member**		
Member's Address	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Other Phone**	
Emergency Contact Name/Phone		**Date of Birth**	
Assessment Method ☐ Telephonic ☐ In-person ☐ Other		**Demographics Verified?** ☐ Yes ☐ No	
Assessment Type ☐ Initial assessment ☐ Reassessment ☐ Change in health status			

	Question	Response
1.	Do you have a language need other than English? Do you need translation services? Please describe:	☐ Yes ☐ No ☐ Yes ☐ No _____
2.	Do you have any special preferences we should be aware of?	☐ Cultural preference ☐ Hearing Impairment ☐ Religion/Spiritual needs or preferences ☐ Visual Impairment ☐ Literacy ☐ None ☐ Other (describe):_____
3.	What is your main health concern right now?	_____
4.	Do you have any current or past physical and/or behavioral health conditions or diagnoses?	☐ Behavioral health diagnosis ☐ Comorbid conditions ☐ ICF/MR/DD ☐ High risk pregnancy ☐ Transplant patient ☐ Medically Fragile Waiver Program ☐ Medically frail ☐ Traumatic brain injury ☐ Other acute or terminal disease: _____
5.	(*Adult only question*) Compared to others your age, would you say your health is.....?	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
6.	Do you have any pending physical health procedures or behavioral health appointments? Date of most recent physical examination or medical appointment:	☐ Yes ☐ No _____
7.	Have you visited the Emergency Room in the past 6 months? If yes, how many visits? Date(s) of ER visit(s): Reason for visit(s):	☐ Yes ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 or more _____ _____

	Question	Response
8.	Have you stayed overnight in the hospital in the past 6 months? If yes, how many times? If yes, were you readmitted within 30 days of discharge?	☐Yes ☐No ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 or more ☐Yes ☐No
9.	How many medicines are you currently taking?	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐6+
10.	What is your current living situation?	☐ Homeless ☐ Living alone ☐ Living in group home ☐ Living in shelter ☐ Living with other family ☐ Living with others unrelated ☐ Living with spouse ☐ Living in assisted living facility ☐ Lives in out of state facility ☐ Lives in out of home placement ☐ Dependent child in out of home placement ☐ Living in a nursing facility ☐ Other (describe): _____
11.	Do you need assistance with 2 or more of the following? Is your need for assistance being met today?	☐ Yes ☐ No ☐ Dressing ☐ Bathing/grooming ☐ Eating ☐ Meal acquisition/preparation ☐ Transfer ☐ Mobility ☐ Toileting ☐ Bowel/bladder ☐ Daily medication ☐ Other: _____ ☐ Yes ☐ No
12.	Do you need or are you interested in Long-Term Care services?	☐ Yes ☐ No
13.	An advance directive is a form that lets your loved ones know your health care choices if you are too sick to make them yourself. Do you have a living will or an advance directive in place? Could I send you more information?	☐ Living will ☐ Advance directive (for medical care) ☐ Advance directive (for psychiatric care) ☐ No living will or advance directive in place ☐ Declined discussion ☐ Requested further information
14.	Are you interested in receiving Care Coordination Services?	☐ Yes ☐ No

The MCO shall provide the following information to every Member during his or her HRA:

1. Information about the services available through Care Coordination
2. Information about the Care Coordination Levels (CCLS)
3. Notification of the Member's right to request a higher Care Coordination Level
4. Requirement for an in-person Comprehensive Needs Assessment for the purpose of providing services associated with Care Coordination level 2 or level 3
5. Information about specific next steps for the Member