MSHO/MSC+ TRANSITIONAL HEALTH RISK ASSESSMENT

Completion of this form will meet Initial Health Risk Assessment and care planning requirements for existing Rate Cell A or B members who have had a product change (MSC+ to MSHO or MSHO to MSC+) or new MSHO/MSC Rate Cell A or B members who have had a comprehensive assessment and care plan completed within the past 365 days. This form is to be completed within 30 days of enrollment and attached to the most recent LTCC/HRA and care plan or MnCHOICES assessment summary and CSSP. Exception: A new LTCC/HRA and Collaborative Care Plan must be completed if the member has experienced significant changes since the last assessment warranting a new HRA and care plan OR if you did not receive the required documents from the previous care coordination entity (previous assessment, care plan and DHS-6037).

Note: The next annual reassessment is due 365 days from the date of the last full LTCC attached to this form.

I. PERSONAL INFORMATION

Name	PMI Number	Birth Date
Address (Street, City, ST, ZIP)		Phone ( )
Physician	Phone ( )	Clinic
Address (Street, City, ST, ZIP)		

II. ASSESSMENT / PREVENTATIVE CARE / CARE PLAN:

New product/transfer enrollment date:

Date of last LTCC/HRA:

Date of last CSP/collaborative care plan:

Transitional Health Risk Assessment completed with member: ☐ in person ☐ via phone

LTCC/MnCHOICES reviewed and updated as needed: Date Reviewed:

Update Required? ☐ Yes ☐ No

-Review the entire attached LTCC/MnCHOICES for correctness and completeness. Date and record any changes made to the LTCC/MnCHOICES. Do not change original text/answers.

CSP/Collaborative Care Plan reviewed and updated as needed: Date Reviewed:

Update Required? ☐ Yes ☐ No

-Review the entire CSP/CCP with the Member or authorized representative. Date and record any changes directly on the CSP/CCP including date of review/change. Do not change original text/answers.

MMIS Entries:
Document Change as needed: Date Completed

COMPLETE THE REMAINING ELEMENTS ON THIS FORM IF NOT ADDRESSED ON THE CURRENT CSP/CCP
Have preventive care issues been addressed? (e.g., immunizations, tobacco and alcohol use, fall risk, medication and nutrition)? ☐ Yes ☐ No If No, explain issues which need to be addressed:
Does member need help coordinating an Annual Physician/Provider Visit for Primary and Preventive Care? ☐ Yes ☐ No ☐ NA Comments:
When was your last physician/provider visit? Date: Comments:

Member Goals	Intervention	Target Date	Monitoring Progress/Goal Revision Date	Date Goal Achieved / Not Achieved (Month/Year)

Advance Directive	
Do you have an Advanced Directive?	☐ Yes ☐ No
If No, would you like information?	☐ Yes ☐ No
SIGNATURE & TITLE OF PERSON COMPLETING THIS FORM	**DATE**