Medica®

# Transfer Member Health Risk Assessment
## Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+)
## Special Needs Basic Care (SNBC) & SNBC Enhanced

Completion of this form as described will meet requirements for a Health Risk Assessment (HRA) and a supplement to the existing care plan for the following members:

- MSHO/MSC+: Members who are newly enrolled community members with a HRA completed within the past 365 days, community members with a product change, transferred community members who have had a HRA/Long Term Care Consultation (LTCC)/MnCHOICES assessment within the past 365 days, or members with a product change who have had a LTCC/MnCHOICES assessment indicating opening of Elderly Waiver services (65th birthday assessment and must be full LTCC/MnCHOICES assessment).

- SNBC/SNBC Enhanced: Members with a product change who have had a HRA completed within the past 365 days.

This form should be completed within 30 days of transfer for all eligible MSHO/MSC+ members and within 60 days of transfer for all SNBC/SNBC Enhanced members. This form is to be attached to the most recent HRA/LTCC/MnCHOICES assessment and care plan. A new assessment and care plan must be completed if the Care Coordinator is unable to obtain a copy of the prior assessment and care plan to review and update. Throughout this form, the term "Assessment" may be used to refer to an HRA, LTCC or MnCHOICES assessment. **NOTE:** The next annual reassessment is due 365 days from the date of the last full HRA/ LTCC/MnCHOICES assessment attached to this form. Please refer to the Assessment Schedule Policy for details.

## I. PERSONAL INFORMATION

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

## II. ASSESSMENT/ CARE PLAN / PREVENTIVE CARE:

**New product/Transfer enrollment date:** Date of last Assessment:

Date of last Community Support Plan (CSP)/Collaborative Care Plan (CCP):

Reason for Transfer: Select one

Transfer From: Transfer to:

**Transfer Assessment & CSP/CCP review completed with member:** ☐ In person ☐ Via phone ☐ Via Video Conference

**Assessment reviewed and updated as needed:**

Date Reviewed: Update Required: ☐ Yes ☐ No

- Review the entire attached Assessment for correctness and completeness. Document any changes with dates on the Assessment form.

**CSP/CCP reviewed and updated as needed:**

Date Reviewed: Update Required: ☐ Yes ☐ No

-Review the entire CSP/CCP with the Member or authorized representative and document any changes with dates directly on the CSP/CCP including date of review/change.

**Medicaid Management Information Systems (MMIS) Document Change as needed:**

Date Completed:

-Required for transfers from another Managed Care Organization (MCO), another Care System, County or Agency; or for a product change (even if CC does not change). N/A if member is on another waiver (other than Elderly Waiver (EW)).

**Financial Worker notification of change in Care Coordinator or product:** Date Completed:

**Primary Care Physician notification of change in Care Coordinator or product:** Date Completed:

**Complete following section if not addressed on the current care plan or if using a CSP/CSSP as the member's care plan**

Does member need help coordinating an annual physician/provider visit for primary and preventive care?

☐ Yes ☐ No

Comments:

When was member's last physician/provider visit? Date: Comments:

**Member Goals:**

| Rank by Priority | Member Goals | Intervention | Target Date | Monitoring Progress/Goal Revision date | Date Goal Achieved/ Not Achieved (Month/Year) |
|---|---|---|---|---|---|
| ☐ Low<br>☐ Medium<br>☐ High | | | | | |
| ☐ Low<br>☐ Medium<br>☐ High | | | | | |

**Advance Directive**

Do you have an Advance Directive? ☐ Yes ☐ No

If No, would you like information? ☐ Yes ☐ No

Comments:

Member has been informed of data privacy and appeal rights: ☐ Yes

Care Coordinator Signature: Date:

Care Coordinator Name & Credentials (printed or typed):

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