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MEDICARE ANNUAL WELLNESS HEALTH RISK ASSESSMENT

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Please complete this Medicare Annual Wellness Visit Health Risk Assessment Form so we may better help you with your healthcare needs.

GENERAL HEALTH

In general, how would you rate your overall health? ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

In general, how satisfied are you with your life? ☐ Very Satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied

How is your physical activity compared to one year ago? ☐ Same ☐ Increased ☐ Decreased

Do you have any of the following: ☐ Living Will ☐ Advanced Directives ☐ Medical Power of Attorney

PAIN

In the past 2 weeks, how often have you felt pain?

☐ Never ☐ Almost Never ☐ Sometimes ☐ Most Times ☐ Always

If you're feeling pain, rate your pain on a scale of 1-10? (10 is the highest pain) _____

In the past 4 weeks, have you used prescription narcotic or opioid medications? ☐ Yes ☐ No

FALL RISK

Have you had more than one fall in the past 12 months? ☐ Yes ☐ No

Were you injured from a fall over the past 12 months? ☐ Yes ☐ No

Are you feeling imbalanced or unsteady? ☐ Yes ☐ No

Do all stairways have a railing / banister? ☐ Yes ☐ No

Do bathrooms have safety rails / grab bars? ☐ Yes ☐ No

Are there non-slip mats on surfaces in all bathtubs and showers? ☐ Yes ☐ No

Do you use a mobility assist device? (cane, walker, brace, wheelchair) ☐ Yes ☐ No

Are rugs and electrical cords secured properly to prevent falls? ☐ Yes ☐ No

Are doorways, halls, stairs, sidewalks and outdoor steps free of clutter? ☐ Yes ☐ No

TRANSPORTATION NEEDS

In the past 12 months, has lack of transportation kept you from the following: (Check all that apply)

☐ Medical Appointments ☐ Getting Medications ☐ Non-Medical Meetings/Appointments

☐ Work ☐ Getting Necessites for Daily Living

EMPOYMENT

Do you want help finding or keeping work or a job? ☐ Finding Work ☐ Keeping A Job ☐ None

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Patient Name: _____ **Date of Birth:** _____ **Date:** _____

EDUCATION AND FINANCE

Do you speak a language other than English at home? ☐ Yes ☐ No

Do you want help with school or training? (e.g. getting a high school diploma, GED, or equivalent) ☐ Yes ☐ No

What is the highest grade level you completed in school?_____

How hard is it for you to pay for basic needs such as food, housing, medical care, and heating?

☐ Very Hard ☐ Somewhat Hard ☐ Not Hard At All

HOME (UTILITIES, INSTABILITY AND SAFETY)

Where do you live?

☐ Your own home/apartment ☐ Independent living facility
☐ Assisted living/nursing facility ☐ I am homeless

Do you have problems with any of the following?

☐ Bug Infestation ☐ Inadequate Heat ☐ Water Leaks
☐ Mold ☐ Oven or Stove Not Working ☐ None of the Above
☐ Lead Paint or Pipes ☐ None or Not Working Smoke Detectors

With whom do you live? ☐ Alone ☐ Spouse ☐ Family ☐ Friend/Roommate ☐ Group Home Residents

Do you feel safe in your home or residence? ☐ Yes ☐ No

Are emergency numbers stored in your phone or wallet and regularly updated? ☐ Yes ☐ No

Do you have a working fire extinguisher and smoke detectors in your home? ☐ Yes ☐ No

Do you have an emergency exit plan and alternate exit plan in case of fire? ☐ Yes ☐ No

If you have firearms in your home, are they stored unloaded & securely locked? ☐ Yes ☐ No

In the past 12 months, has the electric, gas, oil, or water company threatened to disconnect services in your home? ☐ Yes ☐ No ☐ Already Disconnected

Do you always fasten your seat belt when you are driving? ☐ Yes ☐ No

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MEDICARE ANNUAL WELLNESS HEALTH RISK ASSESSMENT

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

ACTIVITIES OF DAILY LIVING, FUNTIONAL CAPACITY AND EXERCISE

Do you need assistance with any of the following Activities of Daily Living?

☐ Dressing ☐ Bathing ☐ Preparing Food/Meals
☐ Walking ☐ Shopping ☐ Driving
☐ Housekeeping ☐ Handling Finances ☐ Managing Medications

Have you experienced any problems with your memory or thinking? ☐ Yes ☐ No

Have any concerns been raised by others about your memory or thinking? ☐ Yes ☐ No

Do you have difficulty concentrating, remembering or making decisions? ☐ Yes ☐ No

Do you have difficulty doing errands alone such as visiting a doctor's office or shopping? ☐ Yes ☐ No

Have you had urine incontinence or leakage in the past 3 months? ☐ Yes ☐ No

Do you find it necessary to use some type of protection (pad or undergarments)? ☐ Yes ☐ No

Have you had problems using your teeth or dentures? ☐ Yes ☐ No

Do you wear a hearing aid / device? ☐ Yes ☐ No

Are you having problems with your vision? ☐ Yes ☐ No

How many days a week do you usually exercise? _____

On days you exercise, how long do you usually exercise? _____ minutes per day

How intense is your typical exercise?

☐ None - Currently Not Exercising
☐ Light - Stretching / Slow Walking
☐ Moderate - Brisk Walking
☐ Heavy - Jogging / Swimming
☐ Very Heavy - Fast Running / Stair Climbing

NUTRITION AND FOOD INSECURITY ASSESSMENT

On a typical day, how many servings do you eat/drink of the following foods/beverages:

_____ Fruits and Vegetables
_____ High Fiber or Whole Grain Foods
_____ Fried or High Fat Foods
_____ Caffeinated Beverages

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

☐ Often True ☐ Sometimes True ☐ Never True

Within the past 12 months, the food you bought did not last and you had no money to buy more.

☐ Often True ☐ Sometimes True ☐ Never True

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MEDICARE ANNUAL WELLNESS HEALTH RISK ASSESSMENT

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

SOCIAL AND BEHAVIORAL RISK ASSESSMENT

Over the past 2 weeks, how often have you been bothered by the following:	Not At All	Less Than Half the Days	More Than Half the Days	Nearly Every Day
Had little or no pleasure in doing things	0	1	2	3
Felt down, depressed or hopeless	0	1	2	3

Do you feel that you are able to cope with stress in your life adequately? ☐ Yes ☐ No

Do you feel you get the social and emotional support you need? ☐ Yes ☐ No

Do you currently use tobacco or a smokeless tobacco product? ☐ Yes ☐ No

If yes: What products do you use? ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ E-Cigarettes / Vaping
Are you interested in quitting? ☐ Yes ☐ No

Are you a former smoker? ☐ Yes ☐ No If yes, when did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Have you ever driven while intoxicated or rode with a driver who was intoxicated? ☐ Yes ☐ No

Have you used any illicit/illegal drugs? ☐ Yes ☐ No

Do you use marijuana or related substances? ☐ Yes ☐ No

SAFETY

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

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently

How often does anyone, including family, insult or talk down on you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently

How often does anyone, including family, threaten you with harm?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently

How often does anyone, including family, scream or curse at you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently

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MEDICARE ANNUAL WELLNESS HEALTH RISK ASSESSMENT

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FAMILY AND COMMUNITY SUPPORT

If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?

- ☐ I don't need any help
- ☐ I get all the help I need
- ☐ I could use a little more help
- ☐ I need a lot more help

How often do you feel lonely or isolated from those around you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

MEDICAL HISTORY UPDATE

Have any family members developed new medical concerns in the past 12 months:

Family Member (relation to you)	Medical Concern

Do you keep an updated list of your medications (including herbals and supplements)? ☐ Yes ☐ No

Have you developed any new food or medication allergies over the past year? ☐ Yes ☐ No

If so, please list: _____

Have you had any ER or hospital visits over the past year which we have not discussed? ☐ Yes ☐ No

If so, when did this happen and why: _____

_____

_____

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MEDICARE ANNUAL WELLNESS HEALTH RISK ASSESSMENT

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

LIST OF PROVIDERS, SUPPLIERS AND PHARMACIES

Please write down a list of the specialists whom you are currently seeing:
(Please include physicians and alternative medicine providers such as chiropractors, dentists, optometrists, counselors)

Name of Doctor or Specialist	Specialty

Where do you get your medical supplies/equipment? (diabetes, ostomy, prosthetics, CPAP, eetc.)

Name of Doctor or Specialist	Specialty

Please update your preferred pharmacies

Local	Specialty
Mail Order	

Arizona Care Network — A Better State of Care

ANNUAL SCREENING QUESTIONAIRE

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Patient Name: _____ **Date of Birth:** _____ **Date:** _____

PHQ-9 DEPRESSION SCREENING QUESTIONNAIRE

Over the past 2 weeks, how often have you been bothered by the following problems?	Not at All	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed or hopeless?	0	1	2	3
Troubling falling or staying asleep, or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV?	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself?	0	1	2	3
	TOTAL:			

☐ I decline completing this depression screening questionnaire.

☐ I have an active diagnosis of depression or bipolar disorder.

Please complete the following section only if you have Medicare or Medicare replacement plan.

MEDICARE ANNUAL RISK ASSESSMENTS

Are you taking Aspirin, another antiplatelet therapy medication or a blood thinner? ☐Yes ☐No
Are you currently using a tobacco product? *(cigarettes, cigars, chew, snuff, pipe, vaping)* ☐Yes ☐No
Have you had one or more falls within the past year? ☐Yes ☐No

When were these studies last done?

Test	Date	Normal	Abnormal
Mammogram *(Women)*			
Pap Testing *(Women)*			
Bone Density Scan			
Colon Cancer Screening ☐ Colonoscopy ☐ Sigmoidoscopy ☐ Cologuard ☐ Stool FIT/FOBT			
PSA test *(Men)*			
Dilated Eye Exam Provider Name:			

Vaccinations:

Please list date of last OR provide a copy of your immunization record

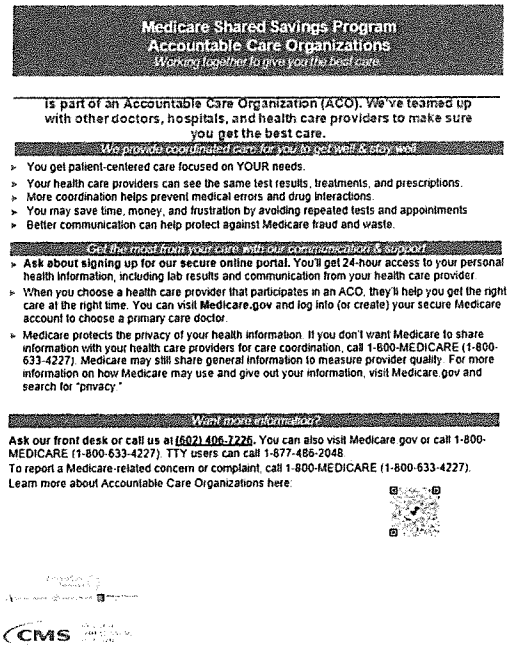
_____ Influenza (Flu)
_____ Pneumovax (PPSV23)
_____ Prevnar 13 (PCV13) Prevnar 20
_____ Tetanus: ☐Td ☐ Tdap
_____ Shingles: ☐Shingrix
_____ HPV Vaccine (Gardasil)
_____ Hepatitis B
_____ RSV
_____ COVID

☐I decline all vaccines
☐I decline only these vaccines: _____

Arizona Care Network

Abrazo Health · Dignity Health · Phoenix Children's Care Network

MSSP Enhanced Patient Notification Attestation



Medicare Shared Savings Program
Accountable Care Organizations
Working together to give you the best care.

Is part of an Accountable Care Organization (ACO). We've teamed up with other doctors, hospitals, and health care providers to make sure you get the best care.

We provide coordinated care for you to get well & stay well.

- You get patient-centered care focused on YOUR needs.
- Your health care providers can see the same test results, treatments, and prescriptions.
- More coordination helps prevent medical errors and drug interactions.
- You may save time, money, and frustration by avoiding repeated tests and appointments.
- Better communication can help protect against Medicare fraud and waste.

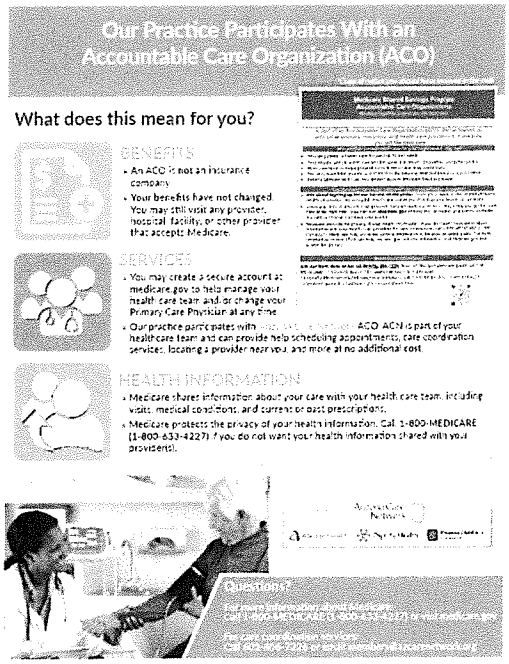
Get the most from your care with our communication & support.

- **Ask about signing up for our secure online portal.** You'll get 24-hour access to your personal health information, including lab results and communication from your health care provider.
- When you choose a health care provider that participates in an ACO, they'll help you get the right care at the right time. You can visit Medicare.gov and log into (or create) your secure Medicare account to choose a primary care doctor.
- Medicare protects the privacy of your health information. If you don't want Medicare to share information with your health care providers for care coordination, call 1-800-MEDICARE (1-800-633-4227). Medicare may still share general information to measure provider quality. For more information on how Medicare may use and give out your information, visit Medicare.gov and search for "privacy."

Want more information?

Ask our front desk or call us at (602) 406-7226. You can also visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
To report a Medicare-related concern or complaint, call 1-800-MEDICARE (1-800-633-4227).
Learn more about Accountable Care Organizations here:

CMS



Our Practice Participates With an Accountable Care Organization (ACO)

What does this mean for you?

BENEFITS
- An ACO is not an insurance company.
- Your benefits have not changed. You may still visit any provider, hospital, facility, or other provider that accepts Medicare.

SERVICES
- You may create a secure account at medicare.gov to help manage your health care team and/or change your Primary Care Physician at any time.
- Our practice participates with [illegible] ACO. ACN is part of your healthcare team and can provide help scheduling appointments, care coordination services, locating a provider near you, and more at no additional cost.

HEALTH INFORMATION
- Medicare shares information about your care with your health care team, including visits, medical conditions, and current or past prescriptions.
- Medicare protects the privacy of your health information. Call 1-800-MEDICARE (1-800-633-4227) if you do not want your health information shared with your providers.

Please sign the following attestation:

- ☐ I received a copy of the MSSP Accountable Care Organization letter (1st notification).
- ☐ I received a copy of the MSSP follow-up notification (2nd notification).
- ☐ I was afforded an opportunity to ask any/all related questions with my provider's office.

Name _____ D.O.B. _____

Signature _____ Date _____

Please scan this completed form and place in the Beneficiary's chart

Questions?

Call 1-800-MEDICARE (1-800-633-4227) or ACN's Concierge Team at 602-406-7226