Healthy Behaviors reminder

Complete your Healthy Behaviors. Keep your free* coverage!

Your review date is coming up.

- ○ **You need to complete your Health Risk Assessment.**
- ✓ **You had a wellness exam or a dental exam. Thank you!**

As part of the Iowa Health and Wellness Plan, you control how much you pay for your health insurance. When you complete two Healthy Behaviors each year, your insurance is free*.

If you don't complete them, you'll get a bill each month from the Iowa Department of Human Services (depending on your income). You must pay the bill to keep your insurance. If you don't pay this bill (depending on your income), you may be disenrolled from the Iowa Health and Wellness Plan.

Here's how you can complete your Health Risk Assessment (HRA).

The HRA is sometimes called the initial health screener. You can choose one of these ways to complete your form.

- Online: Follow this link: www.myamerigroup.com/IA. Click login to get started. Then log in or register for secure access to complete your form.
- On your phone: Call 1-800-600-4441 (TTY 711) 7:30 a.m. to 6:00 p.m. Central time
- On paper: Fill out the enclosed form and return it in the stamped envelope.

Remember: Complete your Healthy Behaviors. Keep your free* coverage! Thank you.

NOTICE: Iowa Health and Wellness Plan members must pay a copay for ER visits when it's not an emergency. In the case of a true emergency, you don't pay a copay. To learn more about copays, contact Amerigroup Iowa at 1-800-600-4441 (TTY 711).

* There are very few, or no, out-of-pocket costs for the first year and very few costs after that. Depending on your family income, a small monthly premium might be required. There is an $8 copay for using the emergency room for non-emergency services.

Initial Health Screener

[redacted]

Thank you for being an Amerigroup Iowa, Inc. member. To help you or your child get the best medical care you can, we ask you to complete this initial health screener.

It's important for you to complete a health screener for each person in your household who is an Amerigroup member.

Date completed: _____

Street address: _____

City:_____State:_____ZIP code: _____

Home phone number:_____-_____-_____ Relationship to member: _____

Please read each question below. Fill in the circles completely next to answers that best describe you or the member for whom you are filling out this form.

If a question doesn't apply to you or the member, fill in the circle next to N/A (not applicable). By completing this assessment, you're agreeing to share the information in it with your or your child's primary care provider (PCP). It will assist him or her in helping you identify issues that are important in managing your health.

REMEMBER: If you're filling out this form for someone else, answer the questions as they would answer them.

Gender: ○ Male ○ Female ○ Other

Is the PCP on your Amerigroup ID card correct? ○ Yes ○ No

Do you need help finding a PCP? ○ Yes ○ No

Do you need assistance in scheduling a PCP appointment? ○ Yes ○ No

1. How do you feel you or your child's health has been recently?	○ Excellent ○ Very good ○ Good ○ Fair ○ Poor
2. Do you feel confident managing your or your child's health?	○ Yes ○ No

3. Have you or your child ever been told you have any of the following health conditions? Fill in the circle for Yes, No, Not sure or N/A for each condition listed. Please choose only one response for each.

	Yes	No	Not sure	N/A
Heart disease	○	○	○	○
Breast cancer	○	○	○	○
Colorectal cancer	○	○	○	○
Cervical cancer	○	○	○	○
Other cancer	○	○	○	○
Asthma	○	○	○	○
Other respiratory illness, such as bronchitis or emphysema	○	○	○	○
Back pain	○	○	○	○
High blood pressure	○	○	○	○
Arthritis	○	○	○	○
Diabetes	○	○	○	○
Pre-diabetes	○	○	○	○
Behavioral health condition	○	○	○	○
Any other chronic condition not listed	○	○	○	○

4. Have you discussed any of these problems with a doctor or a nurse?	○ Yes ○ No

5. Have you or your child had any of the following medical visits or tests in the last 12 months? Fill in the circle for Yes, No, Not sure or N/A for each visit or test listed. Please choose only one response for each.

	Yes	No	Not sure	N/A
Primary care visit	○	○	○	○
Special care doctor visit	○	○	○	○
Dentist visit	○	○	○	○
Colonoscopy	○	○	○	○
Pap smear	○	○	○	○
Breast exam	○	○	○	○
Emergency room visit	○	○	○	○
Been admitted to the hospital	○	○	○	○

6. Do you or does your child see a specialist or special care doctor on a regular basis? That would mean more than two times in the last year.	○ Yes ○ No
7. How many times have you or has your child been seen in the emergency room in the last year?	○ None ○ 1 to 2 times ○ 3 to 4 times ○ More than four times
8. How many times have you or has your child been admitted to the hospital in the last year?	○ None ○ 1 to 2 times ○ 3 to 4 times ○ More than four times
9. How many prescription medicines do you or does your child take each month?	○ None ○ 1 to 2 ○ 3 to 4 ○ More than four
10. Have you or has your child had a flu shot in the last 12 months?	○ Yes ○ No

11. Are you or is your child currently pregnant?	○ Yes ○ No ○ N/A

12. Please fill in the circle next to any feelings you or your child has had during the last two weeks. You may choose more than one.

	Yes	No	Not sure	N/A
Little or no interest in doing things	○	○	○	○
Stressed	○	○	○	○
Down, depressed or hopeless	○	○	○	○
Bad or guilty about drinking and/or recreational drug use	○	○	○	○
Criticized by family or friends about drinking and/or recreational drug use	○	○	○	○

13. Do you or does your child have any issues with physical or emotional health limiting social activities with family, friends, neighbors or groups?	○ Yes ○ No
14. If you answered yes to the previous question, was someone available if you needed help?	○ Yes ○ No
15. Do you or does your child smoke tobacco?	○ Yes ○ No
16. If yes, would you like assistance quitting?	○ Yes ○ No
17. Have you or has your child used recreational drugs or taken prescription medicines for nonmedical reasons in the past year?	○ Yes ○ No
18. Have you or has your child ever been treated for an alcohol or substance abuse problem?	○ Yes ○ No
19. Do you or does your child need help with alcohol or drug treatment?	○ Yes ○ No

20. Do you or does your child need help accessing any of the following services in order to live day to day?

	Yes	No	Not sure	N/A
Transportation	○	○	○	○
Food	○	○	○	○
Shelter	○	○	○	○
Stress management	○	○	○	○
Clothing	○	○	○	○

21. How often do you or does your child eat healthy food like fruit, vegetables or fish instead of unhealthy food like fried food or sweets?	○ Most of the time eat healthy food ○ Some of the time eat healthy food ○ Never eat healthy food
22. How often do you or does your child exercise?	○ Never ○ 1-2 times a week ○ 2-3 times a week ○ 3-4 times a week ○ More than four times a week
23. What is your or your child's current height?	
24. What is your or your child's current weight?	
25. Do you or does your child need help managing weight?	○ Yes ○ No

26. Do you or does your child need help with any of the following daily activities?

	Yes	No	Not sure	N/A
Bathing	○	○	○	○
Dressing	○	○	○	○
Taking medicines	○	○	○	○
Eating	○	○	○	○

27. In the last year have you or has your child driven in a risky or dangerous way? Some examples could include not wearing a seatbelt, drinking and driving, or driving after doing illegal drugs.	○ Yes ○ No ○ N/A
28. How many days of work or school have you or has your child missed in the last two weeks because you were sick?	○ None ○ 1 to 2 days ○ 3 to 4 days ○ Four or more days ○ N/A

29. Would you like to talk with us about how we can help you manage your health or your child's health?	○ Yes ○ No

Ethnicity:

○ White

○ Black or African American

○ Hispanic or Latino

○ Asian

○ American Indian or Alaska Native

○ Other

○ Choose not to answer