

HRA Supplement

Applicant Name _____ **Today's Date** ___/___/___

Applicant Date of Birth ___/___/___ **Medicare ID#** _____ **Enrollment Period** ___/___/___

This form is voluntary and will be kept confidential. The answers will not affect plan premium, benefits, or coverage in any way. The responses will help KCA better serve new members and connect them with other needed services. This brief survey does not replace the Health Risk Assessment the member will complete with their primary care provider.

Please clearly mark your answer for each question.

1. Do you expect to seek specialty care in the next 6 months?

- Yes
- No

1(a) If so, what specialties? [Check all that apply]

- Cardiology
- Cosmetic Services
- Diabetes Care
- Gastroenterology
- Gynecology
- Oncology
- Optometry
- Orthopedics
- Urology
- Other (Describe): _____

2. How many times per year do you expect to see your PCP (routine/preventative and sick care)?

- Never seen a PCP
- 0 times per year
- 1 – 2 times per year
- 3 – 5 times per year
- More than 5 times per year

3. Would you consider seeing a mid-level provider for specialty care (e.g., Physician Assistants, Nurse Practitioners)?

- Yes
- No

4. What are your most important health care priorities in the next 6 months? [Check all that apply]

- Establishing care with a PCP
- Seeking specialty care
- Completing routine age-appropriate screenings
- Learning how to manage your health conditions
- Focusing on wellness (e.g., weight management, diet, exercise, smoking cessation, etc.)
- None of the above

5. What do you believe is an appropriate amount of time to wait to see your PCP for a non-emergency?

- Next day
- 2-3 days
- 1 week
- 2 weeks
- 3 or more weeks

6. Would you opt for virtual care (e.g., phone, video) for urgent health care needs if it allowed you to be seen faster by your provider?

- Yes
- No

7. What do you believe is an appropriate amount of time to wait to see a specialist for a non-emergency?

- Next day
- 2-3 days
- 1 week
- 2 weeks
- 3 or more weeks

8. What is the most important to you when selecting a health care provider?

- Patient reviews (published or word of mouth)
- Years of experience
- Soonest available appointment
- Wait time in office
- Distance from your home
- Bedside manner / ability to establish rapport
- Provider that speaks the same language as you

Applicant Signature _____ Date ____/____/____

Agent Name _____ Date ____/____/____

Agent Signature _____ Date ____/____/____

Please submit the signed form completed in its entirety to KCABrokerSupport@KelseyCareAdvantage.com.

FOR AGENT USE ONLY:

HRA Supplement Policy & Submission Procedure:

KCA will pay contracted agents \$100 per approved HRA Supplement Survey submitted on newly enrolled members beginning with 4/1/2023 effective enrolls.

HRA Supplements will be approved or rejected based on the following criteria:

- HRA Supplement surveys must be completed in their entirety and signed by both the new member and broker to be considered valid.
- Eligible members must be new to KCA with an effective date of 4/1/2023 or later.
- HRA Supplement forms must be submitted no later than 7 days following the applicant's enrollment effective date via email to KCABrokerSupport@kelseycareadvantage.com.
- Forms may be submitted as scanned copies, faxes, or photo images, but must be fully legible.
- KCA will confirm that the applicant's membership goes effective prior paying any related fees.
- KCA reserves the right to change the scope, duration, language, and/or compensation for the collection of supplemental health risk assessment survey data submitted to KCA.
- KCA shall maintain records of compensation paid for the collection of supplemental health risk assessment data.