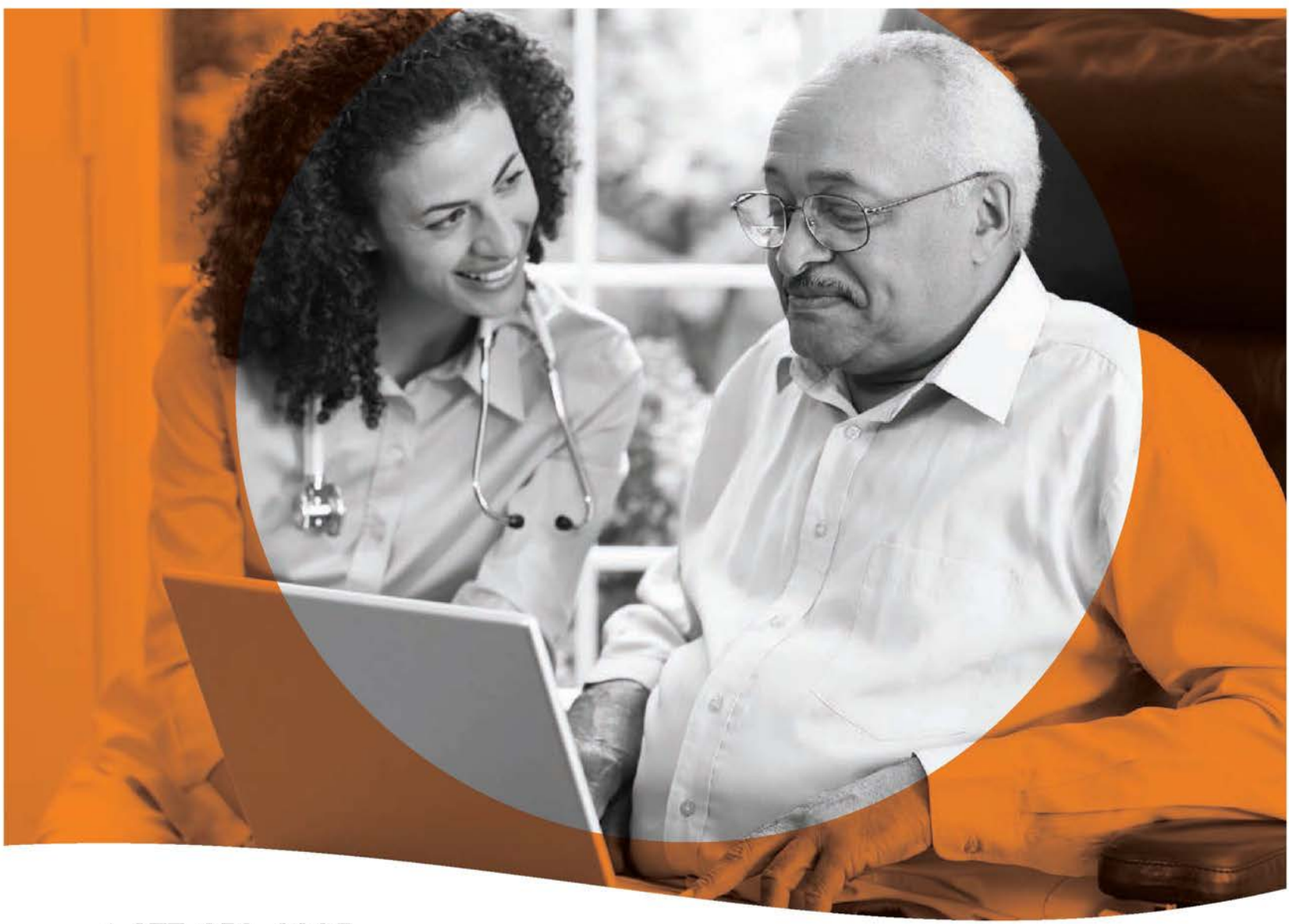
california health & wellness

Health Information Form

Questions?

- call **1-877-658-0305** (TDD/TTY: 1-866-274-6083) or
- visit **CAHealthWellness.com**

Please take a few minutes to fill out the form on the other side, or fill it out online – **CAHealthWellness.com**
This will help us identify any extra needs or services you may require. Please place this form in the provided postage paid envelope and drop in the mail.



One Member per Form *Required Field

Member First Name: Last Name:

Medi-Cal ID*: Member Date of Birth (mmddyyyy):

Name of Person Answering Questions:

Relationship to Member: O Self O Parent O Guardian O Spouse O Friend O Lawyer O Provider O Other

If not member do you have POA, conservator or guardianship? O Yes O No

If we would need to return a call to you, what is the best time and telephone number to reach you?

O Morning O Afternoon O Evening Telephone number: - -

Primary Language used if other than English:

Member Height: feet inches Member Weight: pounds

1. Do you know who your PCP (doctor) is? O Yes O No
2. Have you seen a dentist in the last 12 months? O Yes O No
3. Have you seen an eye doctor in the last 12 months? O Yes O No
4. Do you feel like you need to see a doctor within the next 60 days? O Yes O No
5. Do you feel your health is better, worse or about the same as it was 6 months ago? O Better O Worse O The same
6. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia?
   O Yes O No
7. Have you been prescribed anti-psychotic medication within the past 90 days? O Yes O No
8. Do you take 3 or more prescription medicines each day? O Yes O No
9. Have you been prescribed 15 or more prescriptions in the past 90 days? O Yes O No
10. Are you having a problem with any of your medications that prevent you from using them the way your doctor ordered them?
    O Yes O No
11. Have you been admitted to a hospital in the last 3 months or have had three-or-more hospitalizations within the past year?
    O Yes O No
12. Have you been to the emergency room (ER) 2 or more times in the last six months? O Yes O No
13. Are you pregnant? O Yes O No

    If yes, please answer the following and complete the online pregnancy form or complete and return the pregnancy form if one was included in your member welcome packet.

    Name of doctor caring for you during this pregnancy:

    Your baby's Due Date:
14. Do you need assistance with activities of daily living? O Yes O No
15. Do you need any special equipment, or supplies right now (DME)? O Yes O No
16. Have you been on oxygen within the past 90 days? O Yes O No
17. Do you have a condition that limits your activities or what you can do? O Yes O No

18. Do you see a doctor regularly for a chronic medical condition? O Yes O No If Yes, fill in all that apply:

O Anemia, Bleeding Problems or Hemophilia O Asthma O Cancer O Chronic Pain O COPD (Lung Disease)

O Cystic Fibrosis O Developmental Disability O Diabetes O Heart Problems O Hepatitis O High Blood Pressure

O HIV or AIDS O Kidney Disease O Neurological disorders (such as Multiple Sclerosis or ALS) O Rheumatoid arthritis

O Seizures O Sickle Cell Anemia O Transplant (on waiting list or received transplant in past 12 months) O Tuberculosis

Other

19. Are you receiving any Home Health services? O Yes O No

If yes to above-Can you list what they are?

If yes to HH-Name of agency and phone number? - -

20. Do you require private duty nursing? O Yes O No

21. **If under 21 yrs old** - Have you applied for or been certified for California Children Services (CCS)? O Yes O No

If yes: Case # and condition(s)

22. If under 21: Are you receiving EPSDT Private duty nursing or Pediatric Day Health Care under IHO (In Home Operations)?

O Yes O No

23. If under 21: Is your child receiving LEA services? O Yes O No

24. If under 21: Is your child receiving services at a Regional Center? O Yes O No

25. If under 21: Is your child enrolled in GHPP (Genetically Handicapped persons program)? O Yes O No

26. If under 21: Are you receiving MTU (Medical Therapy Unit services) PT/OT/ST? O Yes O No If so-location?

27. Have you applied for or been certified for Community Based Adult Services? O Yes O No

28. Are you or your child receiving services from the WIC program? O Yes O No

29. Have you applied for or been certified for participation in any of the following Waiver programs?

O Acquired Immune Deficiency Syndrome (AIDS) Waiver

O Assisted Living Waiver (ALW)

O Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD)

O Family Planning, Access, Care and Treatment Program (Family PACT)

O In-Home Operations (IHO)

O Developmentally Disabled – Continuous Nursing Care (DD-CNC)

O Multipurpose Senior Services Program(MSSP)

O Nursing Facility/Acute Hospital (NF/AH)

O Specialty Mental Health Consolidation Program (SMHC)

O Pediatric Palliative Care Waiver

30. Have you qualified for in home support services (IHSS)? O Yes O No

If yes, # hours

31. Do you have or require access to community resources for any of the following?

O Food (Calfresh) O Receiving Social Security disability? O Housing O Mental Health

O Utilities Other: (Describe)

If you are currently having any problems (physical, social, behavioral) that you would like to talk to a California Health & Wellness staff person about, please call us at 1-877-658-0305 (toll free #). California Health & Wellness will use the information on this form to help you get health care services. Your information will be kept private and confidential as required by State and Federal law. For more information, please see the Notice of Privacy Practice section of your member handbook or call us at 1-877-658-0305 or TDD/TYY 1-866-274-6083.