Health Plan of San Joaquin

Health Information Form

You are receiving this form because you have enrolled in Health Plan of San Joaquin. Your new plan will use this form to make sure you get needed care. Please mark the circle for the answers that apply to you. Complete one form for each person in your family who is enrolling in Health Plan of San Joaquin.	If you have any questions, please call Health Plan of San Joaquin at 888.936.7526, TTY/TDD 711. Monday through Friday between 8 AM and 6 PM. Please return completed form in self-addressed stamp envelope to: **Health Plan of San Joaquin** **ATTN: CARE MANAGEMENT DEPARTMENT** **7751 S. Manthey Road, French Camp, CA 95231**

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Member ID#: _____ Phone number: _____
Member Name: _____ DOB: _____

1. Do you need to see a doctor within the next 60 days?. . . . . ○ Yes ○ No
   a. Have you met your doctor? . . . . . ○ Yes ○ No
2. Do you take 3 or more prescription medicines each day? . . . . . ○ Yes ○ No
3. Do you see a doctor for a mental health issue like changes in mood, actions, or avoiding social time? . . . . . ○ Yes ○ No
4. Have you been to the emergency room two or more times in the last 12 months? . . . . . ○ Yes ○ No
5. Have you been admitted to the hospital in the last 12 months? . . . . . ○ Yes ○ No
6. Have you needed help with personal care, such as bathing, getting dressed or changing bandages in the last 6 months? . . . . . ○ Yes ○ No
7. Are you using medical supplies, such as a hospital bed, wheelchair, walker, oxygen, or ostomy bags? . . . . . ○ Yes ○ No
8. Do you have a condition that limits your activates or what you can do? . ○ Yes ○ No
9. Are you pregnant? . . . . . ○ Yes ○ No
   If yes, are you currently seeing a doctor for this pregnancy? . . . ○ Yes ○ No
10. Do you see a doctor regularly for a chronic medical condition? . . . . . ○ Yes ○ No

If yes, fill in all that apply:

○ Asthma	○ Cancer	○ Cystic Fibrosis	○ Diabetes
○ Heart Problems	○ Hepatitis	○ High Blood Pressure	○ HIV or AIDS
○ Kidney Disease	○ Seizures	○ Sickle Cell Anemia	○ Tuberculosis

If you think you need to see a doctor before HPSJ contacts you, you should go to the doctor or hospital.

Signature: _____ Date: _____

Health Plan of San Joaquin complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。**ATTENTION: If you speak another language, free language assistance services are available to you. Call 888.936.7526, TDD/TTY 711.** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **888.936.7526, TDD/TTY 711**

ENROLLED:_____