Health Information Form

You are receiving this form because you are newly assigned to Partnership HealthPlan of California. Partnership will use this form to make sure you get the care that you need.

Please circle each answer that applies to you. Complete one form for each person in your family who is newly assigned to Partnership.

If you have questions, please call Partnership at **(800) 863-4155** Monday – Friday, 8 a.m. – 5 p.m. TTY users can call **(800) 735-2929**.

Please return this completed form in the (yellow) envelope provided or mail to:

Q&A Research Inc
#357, 22052 W 66th Street
Shawnee KAS 66226-9905

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

Name of Partnership Member:_____

Date of Birth: _____**Medi-Cal ID Number:**_____

1. Do you need to see a doctor within the next 60 days?	YES	NO
2. Do you take 3 or more prescription medications each day?	YES	NO
3. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia?	YES	NO
4. Have you been to the emergency room two (2) or more times in the last twelve (12) months?	YES	NO
5. Have you been admitted to the hospital in the last twelve (12) months?	YES	NO
6. Have you needed help with personal care such as bathing, getting dressed, or changing bandages in the last six (6) months?	YES	NO
7. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, oxygen or ostomy bags?	YES	NO
8. Do you have a condition that limits your activities or what you can do?	YES	NO
9. Are you pregnant?	YES	NO
9a. *If yes, are you currently seeing a doctor for this pregnancy*?	YES	NO

10. Do you see a doctor for a chronic medical condition? YES NO

If yes, circle all that apply:

a. Asthma / Lung Problems b. Heart Problems c. Diabetes
d. HIV or AIDS e. Kidney Disease f. Seizures
g. Other _____

These answers will be sent to Partnership. If you think you need to see a doctor before Partnership contacts you, you should go to the doctor or hospital at that time.

Please note, if you change to another health plan and we get a request, Partnership will share this health information form with your new plan.

Signature:_____ Date: _____

If not signed by member, specify relationship: Parent/ Guardian/ Other Representative

CONFIDENTIAL