Answer the questions below for the family members in the household who are covered by Medicaid. This information will help your MCO decide how soon you and your family need to see a doctor and what health care services may be needed.

HealthChoice
Maryland's Medicaid Managed Care Program

The Maryland Department of Health

HEALTH SERVICE NEEDS INFORMATION

Complete the information for yourself as Head of Household and each family member. After completion, return this form with your *Health*Choice enrollment form in the self-addressed stamped envelope to P.O. Box 857, Lanham, MD 20703-0857

Date: ______________________	**Head of Household**	**Family Member 1**	**Family Member 2**
Member Name			
Medical Assistance Number			
Primary Language			
Health Questions			
1. Do you need to see a doctor in the next month?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you need to refill a prescription within the next month?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you use any medical equipment or supplies?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Do you currently receive dialysis, chemotherapy, or radiation treatments?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Do you have any of the following health problem(s)?	☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ HIV/AIDS ☐ Physical Disability ☐ Mental Health ☐ Alcohol/Drug Use	☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ HIV/AIDS ☐ Physical Disability ☐ Mental Health ☐ Alcohol/Drug Use	☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ HIV/AIDS ☐ Physical Disability ☐ Mental Health ☐ Alcohol/Drug Use
6. Are you pregnant right now? (*If yes, answer a and b. If no, skip to question 7.)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, how many months pregnant?	☐ 1-3 months ☐ 4-6 months ☐ 7-9 months	☐ 1-3 months ☐ 4-6 months ☐ 7-9 months	☐ 1-3 months ☐ 4-6 months ☐ 7-9 months
b. What is the name of the doctor, nurse, or clinic where household member is receiving prenatal care?	Doctor/Clinic Name: ____________ ☐ Not receiving prenatal care	Doctor/Clinic Name: ____________ ☐ Not receiving prenatal care	Doctor/Clinic Name: ____________ ☐ Not receiving prenatal care

HealthChoice
Maryland's Medicaid Managed Care Program

The Maryland Department of Health

HEALTH SERVICE NEEDS INFORMATION

Date: _____	Head of Household		Family Member 1		Family Member 2	
Member Name						
Health Questions						
7. Have you had a baby in the past two months?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
8. If you are under 21 years old, do you have a special health care need (e.g., developmental delay, physical disability, etc.)?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
9. If you are under 21 years old, do you need to see a dentist?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
10. Have you been hospitalized in the past 6 months?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
11. Does a home health worker or personal care assistant come to your home?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
12. Do you need assistance getting transportation to medical appointments?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
13. Are you homeless or living in a shelter?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

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Date: ______________________	**Family Member 3**	**Family Member 4**	**Family Member 5**
Member Name			
Medical Assistance Number			
Primary Language			
Health Questions			
1. Do you need to see a doctor in the next month?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you need to refill a prescription within the next month?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you use any medical equipment or supplies?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Do you currently receive dialysis, chemotherapy, or radiation treatments?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Do you have any of the following health problem(s)?	☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ HIV/AIDS ☐ Physical Disability ☐ Mental Health ☐ Alcohol/Drug Use	☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ HIV/AIDS ☐ Physical Disability ☐ Mental Health ☐ Alcohol/Drug Use	☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ HIV/AIDS ☐ Physical Disability ☐ Mental Health ☐ Alcohol/Drug Use
6. Are you pregnant right now? (*If yes, answer a and b. If no, skip to question 7.)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, how many months pregnant?	☐ 1-3 months ☐ 4-6 months ☐ 7-9 months	☐ 1-3 months ☐ 4-6 months ☐ 7-9 months	☐ 1-3 months ☐ 4-6 months ☐ 7-9 months
b. What is the name of the doctor, nurse, or clinic where household member is receiving prenatal care?	Doctor/Clinic Name: ______________ ☐ Not receiving prenatal care	Doctor/Clinic Name: ______________ ☐ Not receiving prenatal care	Doctor/Clinic Name: ______________ ☐ Not receiving prenatal care

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Maryland's Medicaid Managed Care Program

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HEALTH SERVICE NEEDS INFORMATION

Date: _____	Family Member 3		Family Member 4		Family Member 5	
Member Name						
Health Questions						
7. Have you had a baby in the past two months?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
8. If you are under 21 years old, do you have a special health care need (e.g., developmental delay, physical disability, etc.)?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
9. If you are under 21 years old, do you need to see a dentist?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
10. Have you been hospitalized in the past 6 months?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
11. Does a home health worker or personal care assistant come to your home?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
12. Do you need assistance getting transportation to medical appointments?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
13. Are you homeless or living in a shelter?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

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Date: ______________________	Family Member 6	Family Member 7	Family Member 8
Member Name			
Medical Assistance Number			
Primary Language			
Health Questions			
1. Do you need to see a doctor in the next month?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you need to refill a prescription within the next month?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you use any medical equipment or supplies?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Do you currently receive dialysis, chemotherapy, or radiation treatments?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Do you have any of the following health problem(s)?	☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ HIV/AIDS ☐ Physical Disability ☐ Mental Health ☐ Alcohol/Drug Use	☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ HIV/AIDS ☐ Physical Disability ☐ Mental Health ☐ Alcohol/Drug Use	☐ Asthma ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ HIV/AIDS ☐ Physical Disability ☐ Mental Health ☐ Alcohol/Drug Use
6. Are you pregnant right now? (*If yes, answer a and b. If no, skip to question 7.)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
a. If yes, how many months pregnant?	☐ 1-3 months ☐ 4-6 months ☐ 7-9 months	☐ 1-3 months ☐ 4-6 months ☐ 7-9 months	☐ 1-3 months ☐ 4-6 months ☐ 7-9 months
b. What is the name of the doctor, nurse, or clinic where household member is receiving prenatal care?	Doctor/Clinic Name: ______________________ ☐ Not receiving prenatal care	Doctor/Clinic Name: ______________________ ☐ Not receiving prenatal care	Doctor/Clinic Name: ______________________ ☐ Not receiving prenatal care

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HEALTH SERVICE NEEDS INFORMATION

Date: _____	Family Member 6		Family Member 7		Family Member 8	
Member Name						
Health Questions						
7. Have you had a baby in the past two months?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
8. If you are under 21 years old, do you have a special health care need (e.g., developmental delay, physical disability, etc.)?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
9. If you are under 21 years old, do you need to see a dentist?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
10. Have you been hospitalized in the past 6 months?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
11. Does a home health worker or personal care assistant come to your home?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
12. Do you need assistance getting transportation to medical appointments?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
13. Are you homeless or living in a shelter?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No