



Health Information Form

You are receiving this form because you are eligible to enroll in a new Medi-Cal health plan. Your new plan will use this form to make sure you get needed care.

Please fill in the circle with black or blue pen for the answers that apply to you. Complete one form for each person in your family who is enrolling in a new Medi-Cal health plan.

If you have questions, please call Health Care

Options, toll free at 1-800-430-4263 Monday through Friday, between 8:00 a.m. and 5:00 p.m. TDD/TTY users should dial 1-800-430-7077.

Please return completed form with your Medi-Cal Choice Form or mail separately to:

CA Department of Health Care Services
Health Care Options - PO Box 989009
West Sacramento, CA 95798-9850

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

Date of birth: _____

Name of Person Completing Form: _____

1. Do you need to see a doctor within the next 60 days? Yes No
2. Do you take 3 or more prescription medicines 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 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 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 regularly for a chronic medical condition? Yes No

If Yes, fill in all that apply:

- | | | | |
|---|------------------------------------|--|---------------------------------------|
| <input type="radio"/> a. Asthma | <input type="radio"/> b. Cancer | <input type="radio"/> c. Cystic Fibrosis | <input type="radio"/> d. Diabetes |
| <input type="radio"/> e. Heart Problems | <input type="radio"/> f. Hepatitis | <input type="radio"/> g. High Blood Pressure | <input type="radio"/> h. HIV or AIDS |
| <input type="radio"/> i. Kidney Disease | <input type="radio"/> j. Seizures | <input type="radio"/> k. Sickle Cell Anemia | <input type="radio"/> l. Tuberculosis |
| <input type="radio"/> m. Other _____ | | | |

When you become a health plan member, DHCS will send this information to your Medi-Cal health plan.

If you think you need to see a doctor before your Medi-Cal health plan contacts you, you should go to the doctor or hospital at that time.

I understand that this information will be disclosed to Health Care Options and my new plan.

Signature: _____ Date Signed: _____

If not signed by beneficiary, specify relationship: Parent of minor Guardian Other representative