Please answer the questions below This information will be given to your MCO. It will help your MCO decide how soon you may need to see a doctor or nurse and what health care services you may need.

Health Choice

The Maryland Department of Health and Mental Hygiene

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 to *Health*Choice, P.O. Box 17008, Baltimore, MD 21203

Information about you and family members	Head of Household	Family Member 1	Family Member 2	Family Member 3**
Please write in today's date				
Please write in names				
Please write in Medical Assistance Numbers				
Health questions				
1. Are you (or a family member) taking any prescription medications that need to be refilled?	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No
2. Are you (or a family member) using any medical equipment or supplies that need to be renewed?	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No
3. Does a health care worker come to your house?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
4. Are you (or a family member getting counseling for any of the following:	Mental health? ❑ Yes ❑ No Alcohol use? ❑ Yes ❑ No Drug use? ❑ Yes ❑ No	Mental health? ❑ Yes ❑ No Alcohol use? ❑ Yes ❑ No Drug use? ❑ Yes ❑ No	Mental health? ❑ Yes ❑ No Alcohol use? ❑ Yes ❑ No Drug use? ❑ Yes ❑ No	Mental health? ❑ Yes ❑ No Alcohol use? ❑ Yes ❑ No Drug use? ❑ Yes ❑ No
5. a. Are you (or a family member) pregnant or have you (or a family member) had a baby in the past two months?	❑ Yes ❑ No *If yes, answer 5b and 5c.*	❑ Yes ❑ No *If yes, answer 5b and 5c.*	❑ Yes ❑ No *If yes, answer 5b and 5c.*	❑ Yes ❑ No *If yes, answer 5b and 5c.*
b. If pregnant, how far along in months?	❑ 1-3 ❑ 4-6 ❑ 7-9	❑ 1-3 ❑ 4-6 ❑ 7-9	❑ 1-3 ❑ 4-6 ❑ 7-9	❑ 1-3 ❑ 4-6 ❑ 7-9
c. Are you (or a family member) seeing a doctor or nurse for this pregnancy? If yes, write in the doctor's or nurse's name.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

** If you need additional space for extra family members, please call the *Health*Choice Enrollment Line at 1-800-977-7388

HealthChoice

The Maryland Department of Health and Mental Hygiene

HEALTH SERVICE NEEDS INFORMATION

Health questions	Head of Household	Family Member 1	Family Member 2	Family Member 3**
Please write in names				
6. Do you (or a family member) have any of the following health problem(s)? *Check all that apply.*	❑ Asthma ❑ Cerebral palsy ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ Sickle cell disease ❑ Lead poisoning ❑ Other ____________	❑ Asthma ❑ Cerebral palsy ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ Sickle cell disease ❑ Lead poisoning ❑ Other ____________	❑ Asthma ❑ Cerebral palsy ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ Sickle cell disease ❑ Lead poisoning ❑ Other ____________	❑ Asthma ❑ Cerebral palsy ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ Sickle cell disease ❑ Lead poisoning ❑ Other ____________
7. Have you (or a family member) been seeing or are scheduled to see a doctor, nurse or visit a clinic? If yes, please write in the name of the doctor, nurse or clinic.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
8. Members of certain groups need special services. Are you (or a family member) a member of any of the special needs groups listed below:				
a. A child with a special health care need? If yes, please explain the special need.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b. Have a developmental delay?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c. Homeless?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d. Have a physical disability?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e. Have HIV/AIDS?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
9. If you (or a family member) are between the ages of 2 and 21, when did you last see a dentist?	❑ Less than 6 months ago ❑ 6 – 12 months ago ❑ 12 months or more	❑ Less than 6 months ago ❑ 6 – 12 months ago ❑ 12 months or more	❑ Less than 6 months ago ❑ 6 – 12 months ago ❑ 12 months or more	❑ Less than 6 months ago ❑ 6 – 12 months ago ❑ 12 months or more

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