Community Care Plan
The Health Plan with a Heart

Community Care Plan ("CCP") wants to make sure that our members get the best health care. Answering these questions will help the member's primary care physician and our nurses know what the member's needs are.

This information is kept private. Answers do not affect member benefits in any way. Please return it in the envelope given here. You do not need a stamp.

If you need help filling out this form, call us at 1-866-899-4828 TTY/TDD 1-855-655-5303 Monday to Friday from 8:00am to 7:00pm. You can also take this form with you to your next doctor's appointment.

Today's date _____ **Name of person filling out this form** _____

I am filling out this form for

Myself ☐ Child ☐ Spouse ☐ Parent ☐ Friend ☐ Sibling ☐ Foster child ☐

Member Name_____ **ID #** _____

Address _____ **Phone** _____

_____

Do you (member) agree to get email and/or text communications (e.g., reminders, letters, educational materials, etc.) from CCP? Yes ☐ No ☐

If YES, please provide cell phone number _____ **E-Mail** _____

What is your (member) preferred method of contact? Phone ☐ Text ☐ E-Mail ☐

What language are you (member) most comfortable speaking? English ☐ Spanish ☐ Other _____

What language are you (member) most comfortable reading? English ☐ Spanish ☐ Other _____

Member's Date of Birth _____ **Height and Weight** **Ft** ___ **In** ___ **Lbs** ___.

Member's Race - Select one or more

American Indian/Alaskan Native	☐	Asian	☐	Black or African American	☐
Native Hawaiian or Pacific Islander	☐	White	☐	Multiple Races	☐
Some other race	☐	Prefer Not to Say	☐		
Hispanic or Latino/a/x	☐	Not Hispanic or Latino/a/x	☐		

Member's Gender

Male	☐	Female	☐		
Transgender male/ trans man/ female to male	☐	Transgender female/ trans woman/ male to female	☐	Genderqueer, neither exclusively male nor female	☐
Other	☐	Prefer Not to Say	☐		

Member's Preferred Pronoun He/him ☐ She/her ☐ They/them ☐

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We know that health isn't only about your medications or medical history. To help us learn about your (member's) health-related social needs, we want to ask these questions.

SAFETY

Do you (member) feel physically and emotionally safe where you live? Yes ☐ No ☐
IF NO – Do you feel like you are unsafe at this very moment? Yes ☐ No ☐

Within the past 12 months, have you (member) been hit, slapped, kicked, or otherwise physically hurt by someone? Yes ☐ No ☐

Within the past 12 months, have you (member) been disgraced or emotionally abused in other ways by a partner, ex-partner, or family member? Yes ☐ No ☐

FOOD

Within the past 12 months, did you (member) worry that your food would run out before you got money to buy more? Yes ☐ No ☐

Within the past 12 months, did the food you (member) bought not last, and you didn't have money to get more? Yes ☐ No ☐

HOUSING/UTILITIES

Do you (member) have housing? Yes ☐ No ☐

Do you (member) worry about losing your housing? Yes ☐ No ☐

Within the past 12 months, have you (member) or the family members that you live with been unable to get heat, electricity, or water when it was really needed? Yes ☐ No ☐

TRANSPORTATION

Within the past 12 months, has lack of transportation kept you (member) from going to medical appointments, non-medical meetings or appointments, work, or getting medicines or other things that you need? Yes ☐ No ☐

FEMALE MEMBERS ONLY

Are you (member) pregnant? Yes ☐ No ☐ **If YES, are you (member) receiving pre-natal care?** Yes ☐ No ☐

Provider Name _____ **Phone** _____

What is the baby's expected due date? _____/_____/_____

Have you (member) been told you have high blood pressure during this pregnancy? Yes ☐ No ☐

Do you (member) currently have diabetes or been told you have diabetes with this pregnancy? Yes ☐ No ☐

Have you (member) been referred to see a high-risk obstetrics (OB) doctor during this pregnancy?
Yes ☐ No ☐ If YES, what was the reason? _____

Have you (member) been pregnant before? Yes ☐ No ☐

If YES, have you (member) delivered a baby before 37 weeks of pregnancy? Yes ☐ No ☐

Have you (member) delivered a baby in the last six (6) months? Yes ☐ No ☐

Have you (member) ever had a cesarean section? Yes ☐ No ☐

If you (member) are not pregnant, are you using birth control to prevent pregnancy? Yes ☐ No ☐

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Have you (member) ever been diagnosed with or thought to have any of the following conditions?

Condition Name	Have you (member) ever been diagnosed with this condition?	If YES, were you (member) diagnosed in the last 6 months?	If YES, are you (member) now under the care of a doctor for this condition?	Do you (member) have a family history of any of these conditions?
Asthma/COPD	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Diabetes/Pre-Diabetes	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
High Blood Pressure	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Heart Disease	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Cancer	Yes ☐ No ☐ Type of Cancer _____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ Type of Cancer _____
Kidney/Urinary Problems	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Sickle Cell Disease or Trait	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Endocrine Problems (i.e.. Hyper/Hypo-thyroidism, Cushing's, Addison's Disease)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Hemophilia	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Orthopedic Problems	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Bowel/Gastrointestinal Problems	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Gynecological Problems (Females)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Neurological Disorders	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

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Have you (member) ever been diagnosed with any of these mental health conditions?

If treated, please list Provider Name _____ **Phone#** _____

Condition Name	Have you (member) ever been diagnosed with this condition?	If YES, were you (member) diagnosed within the last 6 months?	If YES, are you (member) now under the care of a doctor for this condition?	Do you (member) have a family history of any of these conditions?
Depression	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Anxiety	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Bipolar Disorder	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Schizophrenia	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Attention Deficit Disorder with or without Hyperactivity (ADD or ADHD)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Eating Disorder	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Oppositional defiant disorder (ODD)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Substance Use Alcohol ☐ Street Drugs ☐ Marijuana ☐ Opiates ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

How many times have you (member) been to the emergency room in the past 12 months? _____

Reason(s) _____

How many times have you (member) been admitted to a hospital in the past 12 months? _____

Reason(s) _____

What medications do you (member) take? List all medicines, including vitamins and over the counter drugs.

_____

Do you have any questions about your (member's) medications? Yes ☐ No ☐

If YES, please explain _____

Do you (member) need help with daily living activities? Things like bathing, preparing meals, shopping, and/or paying bills? Yes ☐ No ☐

If YES, which one(s) _____

Are you (member) under the care of a home health agency? Yes ☐ No ☐

Are you (member) receiving any of these therapies? Speech ☐ Physical ☐ Occupational ☐

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Do you (member) smoke, vape, or use tobacco? Yes ☐ No ☐

If YES, are you (member) interested in learning how to quit? Yes ☐ No ☐

In the past 7 days, how often did you (member) have (5 or more for men, 4 or more for women) drinks at one time? 1 drink = 1 beer, 1 glass of wine or 1 shot (mixed or straight)

6-7 days ☐ 5 days ☐ 3-4 days ☐ 1-2 days ☐ 0 days ☐

In the past 7 days, how many days have you (member) done a total of 30 minutes or more of physical activity, which was enough to feel the heart rate go up? This may include sport, exercise, brisk walking, or bicycling. Whether for fun or to get to and from places. This is not cleaning the house. This is not physical activity that may be part of your (member) job.

6-7 days ☐ 5 days ☐ 3-4 days ☐ 1-2 days ☐ 0 days ☐

Over the past seven (7) days, how often did you (member) eat 3 or more servings of fruits and/or vegetables each day?

3 or more times ☐ 2 times ☐ 1 time ☐ 0 times ☐

Over the past seven (7) days, how many times did you (member) eat fast food, fried foods, or pizza?

3 or more times ☐ 2 times ☐ 1 time ☐ 0 times ☐

If you are filling out this form for a member under age 21

Are the child's vaccinations up to date? Yes ☐ No ☐

If YES, where did the child receive their vaccinations? _____

Does the child have any medical problems that keeps them out of school or day care? Yes ☐ No ☐

If YES, please explain _____

School Name _____ **Phone** _____ **School Nurse** _____

In the past month, has the child seemed sad or depressed? Or shows less interest in activities they used to enjoy? Yes ☐ No ☐

In the past year, have you worried about your child being bullied at school? Yes ☐ No ☐

Are you worried about your child's weight? Yes ☐ No ☐

Does your child have access to a pool? Yes ☐ No ☐ Is the pool fenced? Yes ☐ No ☐

Does your child know how to swim? Yes ☐ No ☐

Are you interested in learning more about how to help your child lose weight or water safety?

If YES, which one(s)? _____

Thank you for answering these questions.
If you are doing the paper form, please use the FREE self-addressed stamped envelope to return it.

Email Form

Note: E-mails and attachments you send by an unencrypted message can be captured, read, and copied. It can then be sent to others. Sending personal health information by an unencrypted message can make your information open to others.