Community Care Plan
The Health Plan with a Heart

Community Care Plan cares about making sure our members get the best health care. This form helps the primary care physician and our nurses to know what the needs of the member 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 the 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.

Member's First Name: _____ Today's Date:_____

Member's Last Name: _____ Member ID:_____

Your Name: _____ Relationship to Member: _____

Member's Date of Birth: _____ Male Female Transgender (circle one)

Address: _____ Phone: _____ Cell Y/N (circle one)

_____ Primary Language Spoken_____

Primary Care Physician (PCP) Name: _____ Phone # _____

1. When was the member's last well-care visit? _____
2. Member's Height and Weight? _____ Ft _____ In _____ Lbs.
3. Does the member smoke or use vape products? Yes ☐ No ☐
   a. If Yes, is the Member interested in learning how to quit? Yes ☐ No ☐
4. Has the member ever been diagnosed with or thought to have any of the following conditions?

| | | | | |
|---|---|---|---|---|
| Asthma/COPD ☐ | Diabetes/Pre-Diabetes ☐ | High Blood Pressure ☐ | Heart Disease ☐ | Cancer ☐ Type_____ |
| Kidney/Urinary Problems ☐ | Sickle Cell Disease or Trait ☐ | Endocrine Problems (ie. Hyper/Hypo-thyroidism, Cushing's, Addison's Disease) ☐ | | Orthopedic Problems ☐ |
| Hemophilia ☐ | Bowel/Gastrointestinal Problems ☐ | Gynecological Problems (Females) ☐ | | Neurological Disorders ☐ |

5. What medications does the member take? (List all medicines, including vitamins and OTC drugs)

_____

6. Do you have any questions about the member's medications? Yes ☐ No ☐

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Has the member ever been diagnosed with or thought to have any of the following conditions?

| | | | | |
|---|---|---|---|---|
| Depression ☐ | Anxiety ☐ | Bipolar Disorder ☐ | Schizophrenia ☐ | OCD ☐ |
| Eating Disorder ☐ | Attention Deficit Disorder with or without Hyperactivity) ☐ | | Substance Use:Alcohol ☐ Street Drugs ☐, Marijuana ☐,Opiates ☐ | |

7. Is the member being treated for psychiatric, substance use or behavioral problems? Yes ☐ No ☐
   Name of Provider _____ Phone#_____
8. Does the member have any questions or need help managing his/her health? If so, please explain

_____

9. How many times has the member been to an ER in the past 12 months? _____

Reason (s)? _____

10. How many times has the member been admitted to a hospital in the past 12 months? _____

Reason (s)? _____

11. (Female Enrollees Only) Is the member pregnant? Yes ☐ No ☐
    a. If Yes, is she receiving pre-natal care? Yes ☐ No ☐
    b. What is the baby's expected due date? _____/_____/_____

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

12. Are the child's shots up to date? ☐ Yes ☐ No
13. If yes, where did the child receive their shots? _____
14. Do the child's medical problems get in the way of school or day care? Yes ☐ No ☐

If yes, please explain: _____

School Name: _____ Phone: _____ School Nurse: _____

15. Is the child under the care of a home health agency? Yes ☐ No ☐
16. Is the child receiving any of these therapies? Speech ☐ Physical ☐ Occupational ☐
17. Are you concerned about your child's weight? Yes ☐ No ☐
18. Is your child physically active? Yes ☐ No ☐
19. Does your child have access to a pool? Yes ☐ No ☐ Is the pool fenced? Yes ☐ No ☐
20. Does your child know how to swim? Yes ☐ No ☐
21. Are you interested in learning more about how to help your child lose weight, stop smoking or water safety? If yes, which one (s) _____

***Thank you for completing this form. Please use the FREE self-addressed stamped envelope to return it.***