Date: / /
To:
Attention:
Address:
City/State/Zip:
Phone:

HealthChoice
LOCAL HEALTH SERVICES REQUEST FORM

Client Information

Client Name:
Address:
City/State/Zip:
Phone:
County:
DOB: / / SS#: - -
Sex: ☐M ☐F Hispanic: ☐Y ☐N
MA#:
Private Ins.: ☐ No ☐Yes
Martial Status: ☐Single ☐Married ☐Unknown
If Interpreter is needed specific language:

Race: ☐African-American/Black
☐Alaskan Native ☐American Native
☐Asian ☐Native Hawaiian
☐Pacific Islander ☐White
☐More than one race ☐Unknown

Caregiver/Emergency Contact:

Relationship:
Phone:

FOLLOW-UP FOR: (Check all that apply)
☐Child under 2 years of age
☐Child 2 – 21 years of age
☐Child with special health care needs
☐ Pregnant EDD: ____ / ____ /____
☐Adults with disability(mental, physical, or developmental)
☐Substance use care needed
☐Homeless (at-risk)

RELATED TO: (Check all that apply)
☐Missed appointments: ___ #missed
☐Adherence to plan of care
☐Immunization delay
☐Preventable hospitalization
☐Transportation
☐Other:

Diagnosis:

Comments:

MCO:

Date Received: / /

Document Outreach:
Letter(s) _____ # Phone Call(s) _____
Face to Face _____

☐Unable to Locate
☐Contact Date: / /
☐Advised ☐Refused

Comments:

Contact Person:
Phone:
Fax:

Provider Name:
Provider Phone:

Local Health Department (County)

Date Received: / /

Document Outreach:
Letter(s) _____ # Phone Call(s) _____
Face to Face _____

☐No Action (returned)
Reason for return:

Disposition:
☐Contact Complete: Date: / /
☐Unable to Locate: Date: / /
☐Referred to: Date: / /

Contact Person:
Contact Phone:

Comments: