

HealthChoice LOCAL HEALTH SERVICES REQUEST FORM

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

Client Information	
<p>Client Name:</p> <p>Address:</p> <p>City/State/Zip:</p> <p>Phone:</p> <p>County:</p> <p>DOB: / / SS Number: - -</p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>MA#:</p> <p>Private Ins.: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Unknown</p> <p>If Interpreter is needed specific language:</p>	<p>Race: <input type="checkbox"/> African-American/Black</p> <p> <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Native</p> <p> <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian</p> <p> <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White</p> <p> <input type="checkbox"/> More than one race <input type="checkbox"/> Unknown</p> <hr/> <p>Caregiver/Emergency Contact:</p> <p>Relationship:</p> <p>Phone:</p>
<p>FOLLOW-UP FOR: (Check all that apply)</p> <p><input type="checkbox"/> Child under 2 years of age</p> <p><input type="checkbox"/> Child 2 – 21 years of age</p> <p><input type="checkbox"/> Child with special health care needs</p> <p><input type="checkbox"/> Pregnant EDD: ___ / ___ / ___</p> <p><input type="checkbox"/> Adults with disability(mental, physical, or developmental)</p> <p><input type="checkbox"/> Substance use care needed</p> <p><input type="checkbox"/> Homeless (at-risk)</p>	<p>RELATED TO: (Check all that apply)</p> <p><input type="checkbox"/> Missed appointments: ___ number missed</p> <p><input type="checkbox"/> Adherence to plan of care</p> <p><input type="checkbox"/> Immunization delay</p> <p><input type="checkbox"/> Preventable hospitalization</p> <p><input type="checkbox"/> Transportation</p> <p><input type="checkbox"/> Other:</p>
Diagnosis:	
Comments:	

MCO:	Date Received: / /
<p>Document Outreach:</p> <p>Letter(s) _____ Phone Call(s) _____</p> <p>Face to Face _____</p>	<p><input type="checkbox"/> Unable to Locate</p> <p><input type="checkbox"/> Contact Date: / /</p> <p><input type="checkbox"/> Advised <input type="checkbox"/> Refused</p>
Comments:	
<p>Contact Person:</p> <p>Phone:</p> <p>Fax:</p>	<p>Provider Name:</p> <p>Provider Phone:</p>

Local Health Department (County)	Date Received: / /
<p>Document Outreach:</p> <p>Letter(s) _____ Phone Call(s) _____</p> <p>Face to Face _____</p>	<p><input type="checkbox"/> No Action (returned)</p> <p>Reason for return:</p>
<p>Contact Person:</p> <p>Contact Phone:</p>	<p>Disposition:</p> <p><input type="checkbox"/> Contact Complete: Date: / /</p> <p><input type="checkbox"/> Unable to Locate: Date: / /</p> <p><input type="checkbox"/> Referred to: Date: / /</p>
Comments:	