



HEALTH INFORMATION FORM

You are receiving this form because you are in a new Medi-Cal health plan. Santa Clara Family Health Plan (SCFHP) will use this form to make sure you get needed care.

If you have questions, please call SCFHP, toll free at 1-800-260-2055 Monday through Friday, between 8:30 a.m. and 5:00 p.m. TDD/TTY users should dial 1-800-735-2929 or 711.

Please fill in the circles with black or blue pen for the answers that apply to you. Complete one form for each person in your family who is enrolling in a new Medi-Cal health plan.

Please return completed form in the enclosed postage paid envelope to:

Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Member Name: _____

Date of Birth: _____ Member ID: _____

Name of Person Completing Form: _____

1. Do you need to see a doctor within the next 60 days? Yes No
2. Do you take 3 or more prescription medicines each day? Yes No
3. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia? Yes No
4. Have you been to the emergency room two or more times in the last 12 months? Yes No
5. Have you been admitted to the hospital in the last 12 months? Yes No
6. Have you needed help with personal care, such as bathing, getting dressed, meal preparation or other daily activities in the last 6 months? Yes No
7. Are you using medical equipment or supplies, such as a hospital bed, wheelchair, walker, oxygen, or ostomy bags? Yes No
8. Do you have a condition that limits your activities or what you can do? Yes No
9. Are you pregnant? Yes No
- 9a. If Yes, are you currently seeing a doctor for this pregnancy? Yes No

10. Do you see a doctor regularly for a chronic medical condition? Yes No

If Yes, fill in all that apply:

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| <input type="radio"/> Asthma | <input type="radio"/> Heart Problems | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Cancer | <input type="radio"/> Hepatitis | <input type="radio"/> Seizures |
| <input type="radio"/> Cystic Fibrosis | <input type="radio"/> High Blood Pressure | <input type="radio"/> Sickle Cell Anemia |
| <input type="radio"/> Diabetes | <input type="radio"/> HIV or AIDS | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Other _____ | | |

If you think you need to see a doctor right away, call us at 1-800-260-2055. We also have a 24 hour Nurse Advice line you can reach at 1-877-509-0294.