Alameda Alliance for Health
1240 South Loop Road
Alameda, CA 94502

Phone Number: **1.510.747.4567**
Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**

www.alamedaalliance.org

Health Information Form

You are receiving this form because you are newly enrolled in Medi-Cal at Alameda Alliance for Health (Alliance). We will use this form to better understand your health needs.

Please fill in the circle using a black or blue ink pen for the answers that best apply to you. Complete one form for each person in your family who is a new Alliance member.

If you have questions, please call Alliance Member Services at **1.510.747.4567**, toll-free **1.877.932.2738**, people with hearing and speaking impairments (CRS/TTY) **711/1.800.735.2929**.

Please return the completed form to:
Alameda Alliance for Health
Attn: Medical Management HIF/MET
1240 S. Loop Road
Alameda, CA 94501

A postage-paid envelope is enclosed.

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

Member Name:	**Date of Birth:** ____ / _____ / _____	**Alliance ID#:**
Member Address:		

1.	Do you need to see a doctor within the next 60 days?	⬭ Yes	⬭ No
2.	Do you take three (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 (2) 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 or changing bandages in the last six (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

10a. ***If yes***, fill in all that apply*:*

⬭ a. Asthma	⬭ b. Cancer	⬭ c. Cystic Fibrosis	⬭ d. Diabetes
⬭ e. Heart Problems	⬭ f. Hepatitis	⬭ g. High Blood Pressure	⬭ h. HIV or AIDS
⬭ i. Kidney Disease	⬭ j. Seizures	⬭ k. Sickle Cell Anemia	⬭ l. Tuberculosis

⬭ m.Other: _____

If you think you need to see a doctor, you should go to the doctor or hospital at that time.

Signature: _____ Date signed: _____

If not signed by the member, specify relationship (parent, guardian, other):

_____

CONFIDENTIAL