Health Information Form

You are receiving this form because you have enrolled into Community Health Group's (CHG) Medi-Cal health plan. Community Health Group will use this form to make sure you get needed care. Please check the box 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 Community Health Group's Medi-Cal health plan. If you have questions, please call CHG, toll free at 1-800-224-7766 Monday through Friday, between 8:00 a.m. and 5:00 p.m. TDD/TTY users should dial 1- 800-735-2929

Please return completed form to:

Community Health Group
Department #28
2420 Fenton Street Suite 100, Chula Vista, CA 91914

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

Date of birth:
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, or changing bandages 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? ☐ 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:

☐ 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 before CHG contacts you, you should go to the doctor or hospital at that time.

I understand that this information will be disclosed to Community Health Group.

Signature:______________________ Date Signed: ______________________

If not signed by beneficiary, specify relationship: ☐ Parent of minor ☐ Guardian ☐ Other representative

CONFIDENTIAL