DC Healthy Families
Because some of the best things in life are free.

DCHealthCare Alliance

DHCE

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

Call us if you do not speak or read English.

Amharic: አማሊኛኛ መናገር ወይም ማንበብ የማይችሉ ከሆነ ይደውሉልን.
Chinese: 如果您不會講英語或不會閱讀英語，請打電話告訴我們。
French: Appelez-nous si vous ne parlez pas ou ne savez pas lire l'anglais.
Korean: 영어로 말하거나 읽는데 어려움이 있으면 전화주십시오.
Spanish: Llámenos si no habla ni lee inglés.
Vietnamese: Hãy gọi chúng tôi nếu quý vị không nói hoặc đọc tiếng Anh.

Personal Health Assessment Form

To get the most from your health plan, please tell us about yourself and your family members.

(202) 639-4030 or (800) 620-7802
Call us if you need help in any language.
TTY/TDD Line: (202) 639-4041

Mail this form back to us.
There's an envelope enclosed;
no stamp is needed.

www.DCHealthyFamilies.com
Fill out this form online. It's fast and easy.

Head of Household Information	**Today's date:** / /
Name:	Birth date: (mm/dd/yyyy) / /
Medicaid #:	Social Security #: — —

Information about your family's health

If you need more space to write, use another piece of paper and send it in with your form.

1. Do you or a family member have any doctors appointments in the next month? ☐ Yes ☐ No (If 'yes' tell us about the appointments below)

Name of family member	Doctor's name	Appointment date (mm/dd/yyyy)
1.	1.	1. / /
2.	2.	2. / /

2. Do you or a family member take any medicines that have been prescribed by a doctor? ☐ Yes ☐ No (If 'yes' tell us about the medicines below)

Name of family member	Name of medicine	Date medicine runs out (mm/dd/yyyy)
1.	1.	1. / /
2.	2.	2. / /
3.	3.	3. / /

3. Do you or a family member get home-based care? ☐ Yes ☐ No (If 'yes' tell us about the care below)

Name of family member	Type of care (Such as home health agency, hospice, etc.)
1.	1.
2.	2.

4. Are you or a family member pregnant? ☐ Yes ☐ No (If 'yes' tell us about the pregnancy below)

Pregnant woman's name	Doctor's name	Date baby is due (mm/dd/yyyy)
1.	1.	1. / /
2.	2.	2. / /

5. When was the last time you and your family members saw a doctor? (Tell us about all doctor visits in the past year.)

Name of family member	Doctor's name	Appointment date (mm/dd/yyyy)
1.	1.	1. / /
2.	2.	2. / /
3.	3.	3. / /

6. When was the last time you and your family members saw a dentist? (Tell us about all dentist visits in the past year.)

Name of family member	Dentist's name	Appointment date (mm/dd/yyyy)
1.	1.	1. / /
2.	2.	2. / /
3.	3.	3. / /

7. Tell us about any health problems or treatment plans that you or your family members have.

Name of family member	Describe the health problem or treatment plan
1.	1.
2.	2.
3.	3.

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