







## Call us if you do not speak or read English.

Amharic: 차가/ሲ개성 ლ가ር ወይም ማዝብ የሚያችሉ ከሆን ይይውሉልን.
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 알하거나 읽는데 어려움이 있으면 전화주십시오.

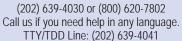
Spanish: Llámenos si no habla ni lee inglés.

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.







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.

		no otamp i						
Head of Household Information	Today's date:	1	1					
Name:				Birth date:	mm/dd/yyyy)	1	1	
Address:				Phone #:				
Medicaid #:				Social Securi	ty#: —			
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	Doo	ctor's name						(mm/dd/yyyy)
1.	1.					1.	1	1
2.	2.					2.	/	1
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	Nar	me of medicine				Date medicine	runs	out (mm/dd/yyyy)
1.	1.					1.	/	1
2.	2.					2.	/	1
3.	3.					3.	1	1
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	Тур	e of care (Such a	as home health ag	gency, hospice	e, etc.)			
1.	1.							
2.	2.							
4. Are you or a family member pregnant?	☐ Yes ☐ No	(If 'yes' tell us	about the pregna	ncy below)				
Pregnant woman's name	Doo	ctor's name				Date baby is d	lue (	mm/dd/yyyy)
1.	1.					1.	1	1
2.	2.					2.	/	1
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	Doo	ctor's name				Appointment of	late	(mm/dd/yyyy)
1.	1.					1.	1	1
2.	2.					2.	1	1
3.	3.					3.	1	1
6. When was the last time you and your fan	nily members saw a	a dentist? (Te	ell us about all der	ntist visits in t	he past year.)			
Name of family member	Der	ntist's name				Appointment of	late	(mm/dd/yyyy)
1.	1.					1.	1	1
2.	2.					2.	1	1
3.	3.					3.	/	1
7. Tell us about any health problems or treatment plans that you or your family members have.								
Name of family member	Des	scribe the health p	oroblem or treatme	nt plan				!
1.	1.							
2.	2.							
3.	3.							17