

Health Care Needs of Children in DC HealthCare Alliance

PLEASE COMPLETE ONE FORM FOR EACH CHILD IN YOUR HOUSEHOLD.

Please complete this form on behalf of the following child (name and Alliance ID#):	
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HEAD OF HOUSEHOLD INFORMATION:	Enter corrections / updates below	CHILD'S INFORMATION:	Enter updates/ corrections below
NAME (FIRST, MI, LAST):		NAME (FIRST, MI, LAST)	
BIRTH DATE		HOME ADDRESS (STREET, APT, CITY, STATE, ZIP)	
HOME ADDRESS (ST, APT, CITY, STATE, ZIP)		BIRTH DATE	
		ALLIANCE NUMBER	

The following questions will be used by your managed care organization (MCO) to improve the services provided to your child/ren. Fill out one of these forms for each child in your household. For this survey, we're defining children as those individuals **under 21 years of age**. Your answers will help your MCO meet the health care needs of your child/children.

Q1. Does this child have any health problems or medical treatments your health plan should know about?

- Yes
- No → Skip to Q2

1a. [IF YES] Please describe (any health problems or medical treatments): _____

Q2. Is this child pregnant?

- Yes
- No → Skip to Q2

Q2a. [IF YES] What is the name of her doctor? _____

Q2b. What is her expected delivery date (if known)? ____/____/____ (MO / DD / YYYY)

Q3. Does your child currently need or use medicine prescribed by a doctor (other than vitamins)

- Yes
- No → Skip to Q4

3a. [IF YES] What are the names of these medications? [Please check bottle if unsure of name.]

Specify: _____

3b. Does your child need or use these medications because of a condition that has lasted, or is expected last, for at least one year?

- Yes
- No

For the remaining questions, please check the box below that best describes your answer. Continue to the next row for the next item unless there is an instruction to skip to another item.

	Check one for each item below, as directed.		
	Yes	No	Don't Know
Q4. Does your child need or use more <u>medical care, mental health, or educational services</u> than is usual for most children of the same age?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ → Skip to Q 5	<input type="checkbox"/> ₈ → Skip to Q 5
4a. [If YES] Is this because of <u>any</u> medical, behavioral, or other health condition?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ → Skip to Q 5	<input type="checkbox"/> ₈ → Skip to Q 5
4b. [If YES] Has this condition lasted, or is it expected to last, for <u>at least</u> one year?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₈
Q5. Is your child <u>limited or prevented</u> in any way in [his / her] ability to do things most children the same age can do?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ → Skip to Q 6	<input type="checkbox"/> ₈ → Skip to Q 6
5a. [If Yes] Is this because of any medical, behavioral, or other health condition?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ → Skip to Q 6	<input type="checkbox"/> ₈ → Skip to Q 6
5b. [If Yes] Has this condition lasted, or is it expected to last, for at least one year?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₈
Q6. Does your child need or get <u>special therapy, such as physical, occupational, or speech therapy</u>?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ → Skip to Q 7	<input type="checkbox"/> ₈ → Skip to Q 7
6a. [If Yes] Is this because of any medical, behavioral, or other health condition?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ → Skip to Q 7	<input type="checkbox"/> ₈ → Skip to Q 7
6b. [If Yes] Has this condition lasted, or is it expected to last, for at least one year?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₈
Q7. Does your child have any kind of emotional, developmental, or behavioral problem?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ → Skip to Q 8	<input type="checkbox"/> ₈ → Skip to Q 8
Q7a. [If Yes] Does your child need or get treatment or counseling for this problem?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂ → Skip to Q 8	<input type="checkbox"/> ₈ → Skip to Q 8
Q7b. [If Yes] Has this problem lasted, or is it expected to last, for at least one year?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₈
Q8. Does this child have <u>any special medical procedures</u> that have already been scheduled? Examples could include: chemotherapy, surgery, allergy shots, or other therapy of any kind.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₈

Those are all the questions we have for you. Please complete a separate form for each child in your household. Please return this form in the envelope provided.

Si no puede leer esta carta, por favor llame a Servicios para Miembros al 202 639-4030.
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如果您需要我們寄其他語言的表格給您，或有任何問題，請聯絡我們，電話是：202 639-4030。
영어 이외의 언어로 작성된 양식을 원하거나 기타 질문 사항이 있는 경우 다음 번호로 연락하십시오. 202 639-4030.
Nếu bạn muốn mẫu đơn này được gửi đến bạn bằng một ngôn ngữ khác không phải tiếng Anh hoặc nếu bạn có bất kỳ câu hỏi nào, xin hãy liên hệ với chúng tôi theo số điện thoại: 202 639-4030.