

# DC HealthCare Alliance Managed Care Program

Si usted desea, puede procurar a  
alguien hable Español al 202-639-4030

**PERSONAL HEALTH ASSESSMENT FORM:** To help your health plan take care of you and your family, please answer the following questions for you and each family member. If you need more space, write on the back of this form.

Name of Head of Household: \_\_\_\_\_ Date: \_\_\_\_\_

Alliance Number: \_\_\_\_\_ Social Security # (optional): \_\_\_\_\_

1. Do you or a family member have any doctor's appointments in the next month?

If YES fill out form below:

Name of family member	Name of doctor	Date of appointment

2. Do you or a family member take any medicines that have been prescribed by a doctor?

If YES fill out form below:

Name of family member	Name of medicine	Date medicine runs out

3. Do you or a family member get home-based care? If YES fill out form below:

Name of family member	Type of care (home health agency, etc.)

4. Are you or a family member pregnant? If YES fill out form below:

Name of family member	Name of doctor	Expected deliver date

5. When was the last time that you or a family member saw a doctor? Fill out form below:

Name of family member	Name of doctor	Date of appointment

6. When was the last time that you or a family member saw a dentist? Fill out form below:

Name of family member	Name of dentist	Date of appointment

7. Are there any health problems or medical treatments that your health plan should know about you or a family member? If YES fill out form below:

Name of family member	Describe health problem treatment

Return in the envelope provided – no stamp needed. Or call helpline, 202-639-4030.

THANK YOU.