HealthPlan OF SAN MATEO
Healthy is for everyone

Health Information Form
for New HPSM Medi-Cal Members

To help make sure you are able to get the care you may need, this Health Information Form is included with your welcome materials. Returning this form is voluntary. You will not be denied care based on your confidential answers. For questions, or to complete this form by phone, call **650-616-2133** (M-F 8am – 6pm). TTY users: **1-800-735-2929**.

Member Information

Member Name: _____ Date of Birth: _____

Phone: _____ Name of person completing form: _____

1. Do you need to see a doctor within the next 60 days? ○ Yes ○ No
   If yes, do you need help with scheduling your appointment? ○ Yes ○ No
   If yes, do you need help getting to your appointment? ○ Yes ○ No
2. How many prescription medicines do you take each day? _____
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. Do you currently need help with personal care such as bathing, getting dressed or changing bandages? ○ Yes ○ No
7. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, oxygen or ostomy bags? ○ Yes ○ No
   If yes, do you need help getting additional supplies? ○ Yes ○ No
8. Are you pregnant? ○ Yes ○ No
   If yes, are you currently see a doctor for this pregnancy? ○ Yes ○ No
9. Do you see a doctor regularly for a chronic condition? ○ Yes ○ No

   If yes to question #9, check all that apply:

   ☐ Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Kidney Disease ☐ Sickle Cell Anemia
   ☐ Cancer ☐ Heart Problems ☐ HIV or AIDS ☐ Seizures ☐ Tuberculosis
   ☐ Cystic Fibrosis ☐ Hepatitis ☐ Other: _____

10. Do any of these conditions limit your activities or what you can do? ○ Yes ○ No

I understand that this information will be disclosed to the Health Plan of San Mateo. If I change Medi-Cal managed care plans, this form may be disclosed to my new plan.

Signature: _____ Date: _____

If not signed by beneficiary, specify relationship: ○ Parent of minor ○ Guardian ○ Other: _____

Please mail this form back in the enclosed pre-paid, self-addressed reply envelope labeled HIF/MET to:

Health Plan of San Mateo
801 Gateway Blvd., Suite 100,
South San Francisco, CA 94080