Vea al dorso para la versión en Español

HealthChoice

MARYLAND'S MEDICAID MANAGED HEALTH CARE PROGRAM

MARYLAND Department of Health and Mental Hygiene

Case Number:

PIN:

MDHealthChoice.org

Welcome to HealthChoice –
the State of Maryland's Medicaid managed health care program.

In HealthChoice you will get these services through a managed health care organization called an MCO (also called a health plan).

You need to choose your MCO by 11/25/2015

If you do not pick an MCO by this date, the state will choose one for you and your doctors may not be in that MCO. You may change your MCO within the first 90 days of enrollment. If you do not change at that time, you must remain with your MCO for 12 months before you can change again.

It is easy to get help and choose your MCO. To find out what you need to do, start by reading the information on the back of this letter.

The brochures sent with this letter also tell you more about the HealthChoice program and choosing an MCO. When you are ready to pick your MCO you can:

- Enroll online at MDHealthChoice.org (You will need your Case number or Medical Assistance number and the PIN number above to log in to your account online); or
- Call HealthChoice at 1-800-977-7388 Monday-Friday 7am to 7pm to enroll over the phone; or
- Complete the MCO enrollment form in this packet and return it in the envelope provided (no stamp needed).

Choose now

If you are hearing impaired, you can call the TDD line 1-800-977-7389

See other side for more information.

Sponsored by the Maryland Department of Health and Mental Hygiene

Why do I need to choose an MCO?

In the HealthChoice program health care services are provided through an MCO.

That means when you get sick or need a check-up, you will get all your care through your MCO.

You will also have your own personal doctor in your MCO called a PCP, or Primary Care Provider.

I already see a doctor I like. Can I stay with my current doctor?

Yes, but your doctor must work with one of the MCOs you can join. Many Maryland doctors and clinics are in the HealthChoice program.

If you want to continue to see your doctor, you must pick a HealthChoice MCO that participates with your doctor. To find out more, call your doctor's office and ask the staff which MCOs the doctor works with. Then sign-up with one of these MCOs and pick your doctor to be your PCP.

Choosing a PCP is an important decision. You want to see a doctor you trust and can talk to easily. You will see your PCP for most of your medical needs. If you need to see another doctor or have a test, your PCP will help you get this care. This is called a referral.

If you sign-up with an MCO that does not work with your doctor, you will NOT be able to see your doctor. If this happens, the MCO will pick one of its doctors to be your PCP.

How do I sign-up with an MCO?

There are a number of different ways you can sign-up with an MCO. You can:

- enroll online at MDHeatlhChoice.org; or
- call 1-800-977-7388 to enroll over the phone; or
- complete and send in the enclosed HealthChoice application.

More information and help is always just a phone call away at 1-800-977-7388.

Does everyone in my family have to be in the same MCO?

No, you have a choice. You can all be in the same MCO, or you can each be in a different MCO. You choose what you feel is best for your family.

What health care services are provided by my MCO?

All basic services are covered by each HealthChoice MCO, including check-ups, doctor and hospital visits, and medications. There is a more complete list of these services in the MCO Comparison Chart sent with this letter. Plus, each MCO lists in the chart additional services it offers.

It is important for children and pregnant women to get the care they need to stay healthy. Each HealthChoice MCO provides well-child care, including immunizations and prenatal care for pregnant women and their babies.

In most cases, you cannot get services outside of your MCO or doctor. There are some exceptions including community based or self-referral services, which include family planning and school-based health centers.

There are some services that are not provided by your MCO but are available to everyone in HealthChoice:

- Specialty mental health and substance abuse treatment through the Behavioral Heatlh System 800-888-1965
- Transportation services (provided through your local health department)
- Dental care, including exams, cleanings, fillings, and braces if medically necessary (through Healthy Smiles Dental Program 888-696-9596) for pregnant adults and children under age 21

More information on these services is in the Member Handbook your MCO will send you after you sign-up.

My child has special medical needs, how can I be sure the MCO will provide the right care?

Each HealthChoice MCO has specially trained providers for patients with special medical needs.

Plus, each MCO has a Special Needs Coordinator who will work directly with you to make sure your child gets the care he or she needs. Call your MCO after you sign-up to get the name and number of the Special Needs Coordinator.

You have rights.

You choose your MCO.

If an employee or provider of a HealthChoice MCO tries to influence your decision, you need to report this immediately at 1-800-284-4510.

¿Por qué necesito escoger un MCO?

En el programa de HealthChoice los servicios de cuidados de salud son proporcionados por un MCO.

Esto quiere decir que cuando usted se enferma o necesita una revisión médica, usted conseguirá todos sus cuidados por medio de su MCO.

Usted también tendrá su propio doctor personal en su MCO, a quien se le llama PCP o Proveedor de Cuidados Primarios.

Yo ya tengo un doctor que me gusta. ¿Puedo continuar con el mismo doctor?

Sí, pero su doctor debe trabajar con uno de los MCOs que usted pueda pertenecer. Muchos doctores y clínicas del Maryland participan en el programa de HealthChoice.

Si usted quiere seguir viendo a su doctor, usted debe escoger un MCO de HealthChoice que participa con su doctor. Para averiguar más, llame al consultorio de su doctor y pregunte con cuales MCOs trabaja su doctor Luego, inscríbase con uno de esos MCOs y escoja a su doctor para que sea su PCP.

Escoger un PCP es una decisión importante. Usted quiere ver a un doctor que usted confía y con quien puede hablar fácilmente. Usted visitara a su PCP para la mayoría de sus servicios médicos necesarios. Si usted necesita ver a otro doctor o necesita un examen, su PCP le ayudará a conseguir este cuidado. A esto se le llama una referencia.

Si usted se inscribe con un MCO que no trabaja con su doctor, usted no podrá ver a su doctor. Si esto sucede, el MCO escogerá a uno de sus doctores para que sea su PCP.

¿Cómo me inscribo con un MCO?

Hay diversas formas de inscribirse con un MCO. Usted puede:

- Inscribase en internet en MDHealthChoice.org; o
- Llamar al 1-800-977-7388 y hacerlo por teléfono; o
- Llenar y enviar la aplicación de HealthChoice incluida con esta carta.

Mayor información y ayuda están siempre cerca a una llamada telefónica al 1-800-977-7388.

¿Necesita todos los miembros de mi familia pertenecer al mismo MCO?

No, usted tiene la opción. Todos pueden estar en el mismo MCO, o cada uno puede pertenecer a un MCO diferente. Usted escoge al que considere que es el mejor para su familia.

¿Qué servicios de cuidado de salud son proporcionados por mi MCO?

Todos los servicios básicos son cubiertos por cada MCO de HealthChoice, incluyendo revisiones médicas, visitas al doctor y al hospital, y además de medicamentos. Hay una lista más completa sobre estos servicios en la Tabla de Comparación de MCO enviada con esta carta. Cada MCO ofrece otros servicios adicionales indicados en la tabla.

Es importante que los niños y madres embarazadas que consigan los cuidados indispensables para mantenerse saludables. Todos los MCOs proveen cuidados-de-salud-para-niños, estos incluyen: vacunas y cuidados prenatales para las mujeres embarazadas y sus bebés.

En la mayoría de los casos, usted no puede obtener servicios fuera de su MCO o doctor. Hay algunas excepciones, incluyendo los servicios basados en la comunidad basada o de auto referencia, los cuales incluye: planificación familiar y cuidados de salud de centros escolares.

Hay algunos servicios que no son proveídos por su MCO, pero que son disponibles para todos en HealthChoice.

- Especialidad de tratamiento de salud mental y consumo en el abuso de sustancias, a través del sistema de salud del comportamiento, 800-888-1965.
- Servicios de transporte (proporcionado a través de su departamento local de salud)
- Cuidado dental, incluyendo exámenes, limpieza dental, rellenos y correctores dentales si fuera necesario por razones médicas (por medio de Healthy Smiles Dental Program 888-696-9596) para adicionales para mujeres embarazadas o personas menores de 21 años

Hay mayor información de estos servicios en la guía para los Miembros que su MCO le enviará luego que se haya inscrito.

¿Mi niño tiene necesidades médicas especiales, cómo me puedo asegurar que el MCO ofrecerá los cuidados apropiados?

Cada MCO de HealthChoice tiene proveedores especialmente entrenados para necesidades médicas necesarias. Además, cada MCO tiene un Coordinador de Necesidades Especiales, quien trabajará directamente con usted para asegurarse que su hijo o hija reciban los cuidados que necesiten.. Llame a su MCO luego de inscribirse para obtener los nombres y números del Coordinador de Necesidades Especiales.

Usted tiene derechos. Usted escoge su MCO. Si un empleado o proveedor de un MCO de HealthChoice trata de influenciar en su decisión, usted tiene que reportarlo inmediatamente al 1-800-284-4510.

Statement of Understanding

I understand that I may call my personal doctor at any time for medical advice, care or a referral if myself or anyone in my family covered by HealthChoice is sick or injured.

I understand that unless I have a medical emergency, I must contact my personal doctor for medical care. I understand that in an emergency, I must contact my personal doctor or the Managed Care Organization (MCO) as soon as possible, after I received emergency care.

I understand that I am choosing to enroll in the MCO indicated and selecting a primary care doctor for myself and for each family member on this form.

I understand that receiving health care services without my personal doctor or MCO approval may result in a denial of payment by the MCO and may result in my being billed for the service.

I understand that, after twelve months, I may change MCOs once a year without giving a reason and that I may change MCOs at any time with an approved reason and that I can call the HealthChoice Enrollment Line for help.

I understand that it is my responsibility to notify the MCO and my caseworker of any change in the number of my family members.

I understand that I must follow Medical Care Program regulations to stay eligible for HealthChoice.

I understand that all information is confidential.

Declaración de entendimiento

Entiendo que puedo llamar a mi médico personal en cualquier momento, para pedir consejo médico, cuidados o una preautorización, si yo o alguna persona de mi familia cubierta por HealthChoice está enferma o lesionada.

Entiendo que a menos que tenga una emergencia médica, debo comunicarme con mi médico personal para recibir cuidados médicos. Entiendo que en una emergencia debo comunicarme con mi médico personal o la Organización de cuidados administrados (MCO), tan pronto como sea posible después de recibir los cuidados de emergencia.

Entiendo que he elegido inscribirme en la MCO indicada y que he seleccionado un médico personal para mí mismo y para cada familiar de este formulario.

Entiendo que si recibo servicios de cuidado de salud sin la aprobación de mi médico personal o MCO, la MCO podría negar el pago y me pueden facturar a mí los servicios. Si no sigo las instrucciones requeridas por la MCO, HealthChoice no será responsable por la factura y no pagará por los servicios.

Entiendo que, después de doce meses, podré cambiar de MCO una vez al año sin dar un motivo; que podré cambiar de MCO en cualquier momento con un motivo aprobado y que puedo llamar a la línea de Inscripción de HealthChoice si necesito ayuda.

Entiendo que soy responsable de avisar a la MCO y a mi trabajador de casos de cualquier cambio en la cantidad de mis familiares.

Entiendo que debo obedecer los reglamentos del programa de cuidados médicos para seguir siendo elegible para HealthChoice.

Entiendo que toda la información es confidencial.

Enroll by completing this form and the Health Service Needs Form and mailing them as soon as possible in the enclosed postage paid envelope to *Health*Choice, P.O. Box 17008, Baltimore, MD 21297-1008.

HealthChoice

The Maryland Department of Health and Mental Hygiene

Enrollment Form

Annual Right To change Form

Or enroll by calling the *Health*Choice toll free number at **1-800-977-7388.** Before you call have all medical assistance numbers and your answers to the Health Service Needs questions ready.

To enroll by mail, complete the following information for yourself as the Head of Household and each eligible family member.

1. Information about you and family members	**Head of Household**	**Family Member 1**	**Family Member 2**
Names			
Social Security Numbers			
Medical Assistance Numbers			
Dates of Birth			
2. Information about your choices			
Doctor or clinic choice			
Doctor or clinic address			
MCO choice			
3. Information about other health insurance Do you or any family member have any other health insurance coverage or Medicare? If yes, what is the name of the insurance company?	Yes No	Yes No	Yes No

4. Language Information

Primary language in the home (circle one) English Spanish Vietnamese French Other _____

5. DSS Case Worker Information

First Name: _____ Last Name: _____

Office: _____ Phone Number: (____)_____-_____

6. Emergency Contact

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____)_____-_____

Relationship: _____

If you have a new address or phone number, please write it below.

_____ _____

Signature Date:

My signature says I have read and understand the Statement of Understanding at the end of this form.

Please answer the questions below. This information will be given to your MCO. it will help your MCO decide how soon you may need to see a doctor or nurse and what health care services you may need.

Health Choice

The Maryland Department of Health and Mental Hygiene

HEALTH SERVICE NEEDS INFORMATION

Complete the information for yourself as Head of Household and each family member. After completion, return this form with your Health*Choice* enrollment form to Health*Choice*, P.O. Box 17008, Baltimore, MD 21297-1008

Information about you and family members	Head of Household	Family Member 1	Family Member 2
Please write in today's date			
Member Name			
Medical Assistance Number			
Health Questions			
1. Are you (or a family member) taking any prescription medications that need to be refilled?	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No
2. Are you (or a family member) using any medical equipment or supplies that need to be renewed?	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No
3. Does a health care worker come to your house?	Yes No	Yes No	Yes No
4. Are you (or a family member) getting counseling for any of the following:	Mental Health? Yes No Alcohol Use? Yes No Drug Use? Yes No	Mental Health? Yes No Alcohol Use? Yes No Drug Use? Yes No	Mental Health? Yes No Alcohol Use? Yes No Drug Use? Yes No
5. a. Are you (or a family member) pregnant, or have you (or a family member) had a baby in the past two months?	Yes No *If yes, answer 5b and 5c*	Yes No *If yes, answer 5b and 5c*	Yes No *If yes, answer 5b and 5c*
b. If pregnant, how far along in months?	1-3 4-6 7-9	1-3 4-6 7-9	1-3 4-6 7-9
c. Are you (or a family member) seeing a doctor or nurse for this pregnancy? If Yes, write in the Doctor or Nurse's name.	Yes No	Yes No	Yes No

Health Choice

El Departamento de salud e higiene mental de Maryland

INFORMACIÓN SOBRE NECESIDADES DE SERVICIOS DE SALUD

Información sobre usted y sus familiares	Jefe de la familia	Familiar 1	Familiar 2
Nombre del miembro			
Preguntas de salud			
6. ¿Usted (o un familiar) tienen alguno de los siguientes problemas de salud? *Marque todo lo aplicable.*	☐ Asma ☐ Parálisis cerebral ☐ Diabetes ☐ Enfermedad del corazón ☐ Presión sanguínea alta ☐ Anemia de células falciformes ☐ Envenenamiento con plomo ☐ Otro ____________	☐ Asma ☐ Parálisis cerebral ☐ Diabetes ☐ Enfermedad del corazón ☐ Presión sanguínea alta ☐ Anemia de células falciformes ☐ Envenenamiento con plomo ☐ Otro ____________	☐ Asma ☐ Parálisis cerebral ☐ Diabetes ☐ Enfermedad del corazón ☐ Presión sanguínea alta ☐ Anemia de células falciformes ☐ Envenenamiento con plomo ☐ Otro ____________
7. ¿Usted (o un familiar) han visto o tienen cita con un médico, enfermera o han visitado una clínica? Si es "Sí", por favor escriba que nombre del médico, enfermera o clínica	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
8. Los miembros de ciertos grupos necesitan servicios especiales. ¿Usted (o un familiar) son miembros de alguno de los grupos con necesidades especiales anotados abajo?			
a. ¿Un niño con necesidades especiales de cuidado de salud? Si es "Sí", por favor explique la necesidad específica.	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
b. ¿Tiene algún retraso del desarrollo?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
c. ¿No tiene hogar?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
d. ¿Tiene alguna discapacidad física?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
e. ¿Tiene VIH/SIDA?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
9. Si usted (o un familiar) tienen entre 2 y 21 años de edad ¿cuándo fue la última vez que fue al dentista?	☐ Hace menos de 6 meses ☐ Hace de 6 a 12 meses ☐ Hace 12 meses o más	☐ Hace menos de 6 meses ☐ Hace de 6 a 12 meses ☐ Hace 12 meses o más	☐ Hace menos de 6 meses ☐ Hace de 6 a 12 meses ☐ Hace 12 meses o más

Por favor responda las preguntas de abajo. Daremos esta información a su MCO. La información ayudará a la MCO a decidir qué tan pronto podría necesitar ver al médico o enfermera y qué servicios de cuidado de salud posiblemente necesite.

Health Choice

El Departamento de salud e higiene mental de Maryland

INFORMACIÓN SOBRE NECESIDADES DE SERVICIOS DE SALUD

Complete la información de usted mismo como jefe de familia y de cada familiar. Cuando termine, devuelva este formulario con su solicitud de inscripción de *Health*Choice a *Health*Choice, P.O. Box 17008, Baltimore, MD 21297-1008.

Información sobre usted y sus familiares	**Jefe de familia**	**Familiar 1**	**Familiar 2**
Por favor escriba la fecha de hoy			
Nombre del miembro			
Número de asistencia médica			
Preguntas de salud			
1. ¿Usted (o un familiar) toman algún medicamento de receta que tenga que resurtir?	¿En una semana? ☐ Sí ☐ No ¿En 1 mes? ☐ Sí ☐ No ¿En 2 meses? ☐ Sí ☐ No	¿En una semana? ☐ Sí ☐ No ¿En 1 mes? ☐ Sí ☐ No ¿En 2 meses? ☐ Sí ☐ No	¿En una semana? ☐ Sí ☐ No ¿En 1 mes? ☐ Sí ☐ No ¿En 2 meses? ☐ Sí ☐ No
2. ¿Usted (o un familiar) usan algún equipo médico o suministros que tengan que renovarse?	¿En una semana? ☐ Sí ☐ No ¿En 1 mes? ☐ Sí ☐ No ¿En 2 meses? ☐ Sí ☐ No	¿En una semana? ☐ Sí ☐ No ¿En 1 mes? ☐ Sí ☐ No ¿En 2 meses? ☐ Sí ☐ No	¿En una semana? ☐ Sí ☐ No ¿En 1 mes? ☐ Sí ☐ No ¿En 2 meses? ☐ Sí ☐ No
3. ¿Algún trabajador de salud viene a su casa?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
4. ¿Usted (o un familiar) reciben asesoría por alguno de lo siguiente?	¿Salud mental? ☐ Sí ☐ No ¿Consumo de alcohol? ☐ Sí ☐ No ¿Consumo de drogas? ☐ Sí ☐ No	¿Salud mental? ☐ Sí ☐ No ¿Consumo de alcohol? ☐ Sí ☐ No ¿Consumo de drogas? ☐ Sí ☐ No	¿Salud mental? ☐ Sí ☐ No ¿Consumo de alcohol? ☐ Sí ☐ No ¿Consumo de drogas? ☐ Sí ☐ No
5. a. ¿Usted (o un familiar) está embarazada o usted (o un familiar) tuvo un bebé en los dos meses anteriores?	☐ Sí ☐ No *Si es "Sí", responda 5b y 5c*	☐ Sí ☐ No *Si es "Sí", responda 5b y 5c*	☐ Sí ☐ No *Si es "Sí", responda 5b y 5c*
b. Si está embarazada ¿cuántos meses de embarazo tiene?	☐ 1-3 ☐ 4-6 ☐ 7-9	☐ 1-3 ☐ 4-6 ☐ 7-9	☐ 1-3 ☐ 4-6 ☐ 7-9
c. ¿Usted (o un familiar) ve un médico o enfermera por este embarazo? Si es "Sí", escriba el nombre del médico o enfermera.	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No

Please answer the questions below. This information will be given to your MCO. it will help your MCO decide how soon you may need to see a doctor or nurse and what health care services you may need.

Health Choice

The Maryland Department of Health and Mental Hygiene

HEALTH SERVICE NEEDS INFORMATION

Complete the information for yourself as Head of Household and each family member. After completion, return this form with your Health*Choice* enrollment form to Health*Choice*, P.O. Box 17008, Baltimore, MD 21297-1008

Information about you and family members	**Head of Household**	**Family Member 1**	**Family Member 2**
Member Name			
Health Questions			
6. Do you (or a family member) have any of the following health problem(s)? *Check all that apply.*	Asthma Cerebral Palsy Diabetes Heart Disease High Blood Pressure Sickle Cell Disease Lead Poisoning Other_____	Asthma Cerebral Palsy Diabetes Heart Disease High Blood Pressure Sickle Cell Disease Lead Poisoning Other_____	Asthma Cerebral Palsy Diabetes Heart Disease High Blood Pressure Sickle Cell Disease Lead Poisoning Other_____
7. Have you (or a family member) been seeing or are scheduled to see a doctor, nurse or visit a clinic? If yes, please write the name of the doctor, nurse or clinic.	Yes No	Yes No	Yes No
8. Members of certain groups need special services. Are you (or a family member) a member of any of the special needs groups listed below?			
a. A child with a special health care need? If yes, please explain the special need.	Yes No	Yes No	Yes No
b. Have a developmental delay?	Yes No	Yes No	Yes No
c. Homeless?	Yes No	Yes No	Yes No
d. Have a physical disability?	Yes No	Yes No	Yes No
e. Have HIV/AIDS?	Yes No	Yes No	Yes No
9. If you (or a family member) are between the ages of 2 and 21, when did you last see a dentist?	Less than 6 months ago 6-12 months ago 12 months or more	Less than 6 months ago 6-12 months ago 12 months or more	Less than 6 months ago 6-12 months ago 12 months or more

Enroll by completing this form and the Health Service Needs Form and mailing them as soon as possible in the enclosed postage paid envelope to *Health*Choice, P.O. Box 17008, Baltimore, MD 21297-1008.

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Enrollment Form

Annual Right To change Form

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To enroll by mail, complete the following information for yourself as the Head of Household and each eligible family member.

1. Information about you and family members	**Family Member 3**	**Family Member 4**	**Family Member 5**
Names			
Social Security Numbers			
Medical Assistance Numbers			
Dates of Birth			
2. Information about your choices			
Doctor or clinic choice			
Doctor or clinic address			
MCO choice			
3. Information about other health insurance Do you or any family member have any other health insurance coverage or Medicare? If yes, what is the name of the insurance company?	Yes No	Yes No	Yes No

4. Language Information

Primary language in the home (circle one) English Spanish Vietnamese French Other _____

5. DSS Case Worker Information

First Name: _____ Last Name: _____

Office: _____ Phone Number: (____) _____-_____

6. Emergency Contact

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____-_____

Relationship: _____

If you have a new address or phone number, please write it below.

_____ Signature

_____ Date:

My signature says I have read and understand the Statement of Understanding at the end of this form.

Please answer the questions below. This information will be given to your MCO. it will help your MCO decide how soon you may need to see a doctor or nurse and what health care services you may need.

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The Maryland Department of Health and Mental Hygiene

Health Service Needs Information

Complete the information for yourself as Head of Household and each family member. After completion, return this form with your Health*Choice* enrollment form to Health*Choice*, P.O. Box 17008, Baltimore, MD 21297-1008

Information about you and family members	**Family Member 6**	**Family Member 7**	**Family Member 8**
Member Name			
Health Questions			
6. Do you (or a family member) have any of the following health problem(s)? *Check all that apply.*	Asthma Cerebral Palsy Diabetes Heart Disease High Blood Pressure Sickle Cell Disease Lead Poisoning Other_____	Asthma Cerebral Palsy Diabetes Heart Disease High Blood Pressure Sickle Cell Disease Lead Poisoning Other_____	Asthma Cerebral Palsy Diabetes Heart Disease High Blood Pressure Sickle Cell Disease Lead Poisoning Other_____
7. Have you (or a family member) been seeing or are scheduled to see a doctor, nurse or visit a clinic? If yes, please write the name of the doctor, nurse or clinic.	Yes No	Yes No	Yes No
8. Members of certain groups need special services. Are you (or a family member) a member of any of the special needs groups listed below?			
a. A child with a special health care need? If yes, please explain the special need.	Yes No	Yes No	Yes No
b. Have a developmental delay?	Yes No	Yes No	Yes No
c. Homeless?	Yes No	Yes No	Yes No
d. Have a physical disability?	Yes No	Yes No	Yes No
e. Have HIV/AIDS?	Yes No	Yes No	Yes No
9. If you (or a family member) are between the ages of 2 and 21, when did you last see a dentist?	Less than 6 months ago 6-12 months ago 12 months or more	Less than 6 months ago 6-12 months ago 12 months or more	Less than 6 months ago 6-12 months ago 12 months or more

Please answer the questions below. This information will be given to your MCO. it will help your MCO decide how soon you may need to see a doctor or nurse and what health care services you may need.

Health Choice

The Maryland Department of Health and Mental Hygiene

HEALTH SERVICE NEEDS INFORMATION

Complete the information for yourself as Head of Household and each family member. After completion, return this form with your Health*Choice* enrollment form to Health*Choice*, P.O. Box 17008, Baltimore, MD 21297-1008

Information about you and family members	Family Member 6	Family Member 7	Family Member 8
Please write in today's date			
Member Name			
Medical Assistance Number			
Health Questions			
1. Are you (or a family member) taking any prescription medications that need to be refilled?	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No
2. Are you (or a family member) using any medical equipment or supplies that need to be renewed?	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No
3. Does a health care worker come to your house?	Yes No	Yes No	Yes No
4. Are you (or a family member) getting counseling for any of the following:	Mental Health? Yes No Alcohol Use? Yes No Drug Use? Yes No	Mental Health? Yes No Alcohol Use? Yes No Drug Use? Yes No	Mental Health? Yes No Alcohol Use? Yes No Drug Use? Yes No
5. a. Are you (or a family member) pregnant, or have you (or a family member) had a baby in the past two months?	Yes No *If yes, answer 5b and 5c*	Yes No *If yes, answer 5b and 5c*	Yes No *If yes, answer 5b and 5c*
b. If pregnant, how far along in months?	1-3 4-6 7-9	1-3 4-6 7-9	1-3 4-6 7-9
c. Are you (or a family member) seeing a doctor or nurse for this pregnancy? If Yes, write in the Doctor or Nurse's name.	Yes No	Yes No	Yes No

Please answer the questions below. This information will be given to your MCO. it will help your MCO decide how soon you may need to see a doctor or nurse and what health care services you may need.

Health Choice

The Maryland Department of Health and Mental Hygiene

HEALTH SERVICE NEEDS INFORMATION

Complete the information for yourself as Head of Household and each family member. After completion, return this form with your Health*Choice* enrollment form to Health*Choice*, P.O. Box 17008, Baltimore, MD 21297-1008

Information about you and family members	Family Member 3	Family Member 4	Family Member 5
Please write in today's date			
Member Name			
Medical Assistance Number			
Health Questions			
1. Are you (or a family member) taking any prescription medications that need to be refilled?	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No
2. Are you (or a family member) using any medical equipment or supplies that need to be renewed?	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No	Within a week? Yes No Within 1 month? Yes No Within 2 months? Yes No
3. Does a health care worker come to your house?	Yes No	Yes No	Yes No
4. Are you (or a family member) getting counseling for any of the following:	Mental Health? Yes No Alcohol Use? Yes No Drug Use? Yes No	Mental Health? Yes No Alcohol Use? Yes No Drug Use? Yes No	Mental Health? Yes No Alcohol Use? Yes No Drug Use? Yes No
5. a. Are you (or a family member) pregnant, or have you (or a family member) had a baby in the past two months?	Yes No *If yes, answer 5b and 5c*	Yes No *If yes, answer 5b and 5c*	Yes No *If yes, answer 5b and 5c*
b. If pregnant, how far along in months?	1-3 4-6 7-9	1-3 4-6 7-9	1-3 4-6 7-9
c. Are you (or a family member) seeing a doctor or nurse for this pregnancy? If Yes, write in the Doctor or Nurse's name.	Yes No	Yes No	Yes No

Please answer the questions below. This information will be given to your MCO. it will help your MCO decide how soon you may need to see a doctor or nurse and what health care services you may need.

Health Choice

The Maryland Department of Health and Mental Hygiene

HEALTH SERVICE NEEDS INFORMATION

Complete the information for yourself as Head of Household and each family member. After completion, return this form with your Health*Choice* enrollment form to Health*Choice*, P.O. Box 17008, Baltimore, MD 21297-1008

Information about you and family members	Family Member 3	Family Member 4	Family Member 5
Member Name			
Health Questions			
6. Do you (or a family member) have any of the following health problem(s)? *Check all that apply.*	Asthma Cerebral Palsy Diabetes Heart Disease High Blood Pressure Sickle Cell Disease Lead Poisoning Other_____	Asthma Cerebral Palsy Diabetes Heart Disease High Blood Pressure Sickle Cell Disease Lead Poisoning Other_____	Asthma Cerebral Palsy Diabetes Heart Disease High Blood Pressure Sickle Cell Disease Lead Poisoning Other_____
7. Have you (or a family member) been seeing or are scheduled to see a doctor, nurse or visit a clinic? If yes, please write the name of the doctor, nurse or clinic.	Yes No	Yes No	Yes No
8. Members of certain groups need special services. Are you (or a family member) a member of any of the special needs groups listed below?			
a. A child with a special health care need? If yes, please explain the special need.	Yes No	Yes No	Yes No
b. Have a developmental delay?	Yes No	Yes No	Yes No
c. Homeless?	Yes No	Yes No	Yes No
d. Have a physical disability?	Yes No	Yes No	Yes No
e. Have HIV/AIDS?	Yes No	Yes No	Yes No
9. If you (or a family member) are between the ages of 2 and 21, when did you last see a dentist?	Less than 6 months ago 6-12 months ago 12 months or more	Less than 6 months ago 6-12 months ago 12 months or more	Less than 6 months ago 6-12 months ago 12 months or more

Enroll by completing this form and the Health Service Needs Form and mailing them as soon as possible in the enclosed postage paid envelope to *Health*Choice, P.O. Box 17008, Baltimore, MD 21297-1008.

Health Choice

The Maryland Department of Health and Mental Hygiene

ENROLLMENT FORM
ANNUAL RIGHT TO CHANGE FORM

Or enroll by calling the *Health*Choice toll free number at **1-800-977-7388.** Before you call have all medical assistance numbers and your answers to the Health Service Needs questions ready.

To enroll by mail, complete the following information for yourself as the Head of Household and each eligible family member.

1. Information about you and family members	Family Member 6	Family Member 7	Family Member 8
Names			
Social Security Numbers			
Medical Assistance Numbers			
Dates of Birth			
2. Information about your choices			
Doctor or clinic choice			
Doctor or clinic address			
MCO choice			
3. Information about other health insurance Do you or any family member have any other health insurance coverage or Medicare? If yes, what is the name of the insurance company?	Yes No	Yes No	Yes No

4. Language Information

Primary language in the home (circle one) English Spanish Vietnamese French Other _____

5. DSS Case Worker Information

First Name: _____ Last Name: _____

Office: _____ Phone Number: (____) _____-_____

6. Emergency Contact

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____-_____

Relationship: _____

If you have a new address or phone number, please write it below.

_____ Signature

_____ Date:

My signature says I have read and understand the Statement of Understanding at the end of this form.