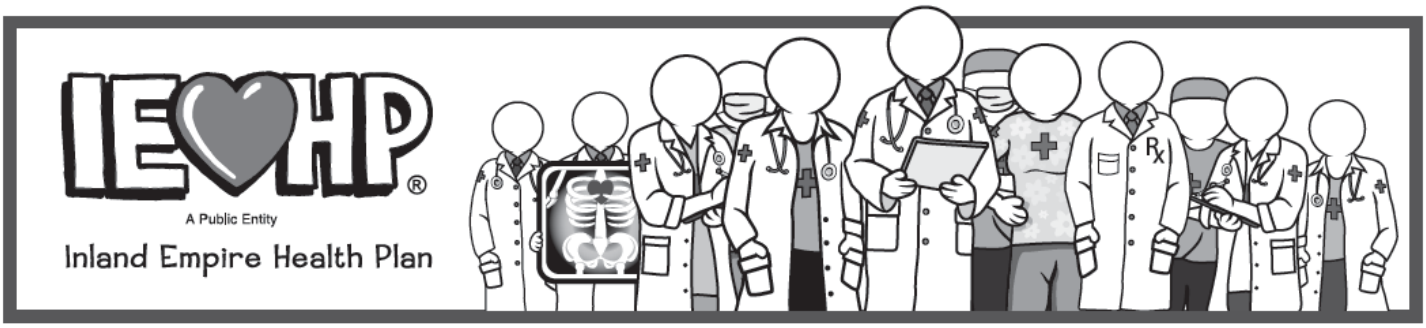

To: Medi-Cal IPAs and Primary Care Providers

From: IEHP – Provider Relations

Date: August 3, 2017

Subject: **Health Information Form for New Medi-Cal Members**

In accordance with 42 CFR § 438.208(b), IEHP shall comply with the following Medicaid Final Rule ("Mega Reg") and contractual requirements:

1. Mail a DHCS-approved Health Information Form (HIF) to all new Medi-Cal Members as part of their Welcome Kit, and include a postage paid envelope for response;
2. Make at least two (2) call attempts to remind and/or collect their HIF response;
3. Conduct an initial screening of all HIF received within 90 days of the Member's enrollment into the plan (any screening process currently required in Exhibit A, Attachment 11, Case Management and Coordination of Care, may be used); and
4. Upon a Member's disenrollment from the plan, make the HIF assessment results available to their new Medi-Cal Managed Care Plan, upon request.

The HIF (attached) consists of ten (10) questions that can be used as an initial screening of Members' health status and needs. IEHP is actively working on a process to make completed HIF and/or response data available for Delegates and Providers to view from the Provider Portal and/or SFTP server. **IEHP will send out a notification once the HIF is made available to you.**

If you have any questions, please do not hesitate to contact the IEHP Provider Relations Team at (909) 890-2054.

<Date >

A Public Entity
Inland Empire Health Plan

<Member Name>
<Street Address>
<City>, <State> <Zip Code>

Health Information Form

You are receiving this form because you have been enrolled in a new Medi-Cal health plan, which is Inland Empire Health Plan (IEHP). IEHP uses this form to make sure you get needed care.

Please fill in the circle with black or blue pen only (no pencil) for the answers that apply to you. **Fill out one form for each person, in your family, who enrolled in a new Medi-Cal health plan.**

If you have questions, please call IEHP Member Services at **1-800-440-IEHP (4347)** or **1-800-718-4347** for TTY users, 8am – 5pm, Monday – Friday.

Please mail back this completed form in the envelope provided. No stamp is needed.

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Date of birth: |__|__| - |__|__| - |__|__|__|__|

Name of person completing form: Last name |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

First name |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

1. Do you need to see a Doctor within the next 60 days? ..... ○ Yes ○ No
2. Do you take three or more prescription medicines each day? ..... ○ Yes ○ No
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. Have you needed help with personal care, such as bathing, getting dressed, or changing bandages in the last six months? ..... ○ Yes ○ No
7. Are you using medical equipment or supplies, such as a hospital bed, wheelchair, walker, oxygen or ostomy bags? ..... ○ Yes ○ No
8. Do you have a condition that limits your activities or what you can do? ..... ○ Yes ○ No
9. Are you pregnant? ..... ○ Yes ○ No
   9a. If Yes, are you currently seeing a Doctor for this pregnancy? ..... ○ Yes ○ No

Continue on other Side

CONFIDENTIAL

Health Information Form

10. Do you see a Doctor regularly for a chronic medical condition? ..... ○ Yes ○ No

If Yes, fill in all that apply:

○ a. Asthma	○ b. Cancer	○ c. Cystic Fibrosis	○ d. Diabetes
○ e. Heart Problems	○ f. Hepatitis	○ g. High Blood Pressure	○ h. HIV or AIDS
○ i. Kidney Disease	○ j. Seizures	○ k. Sickle Cell Anemia	○ l. Tuberculosis

○ m. Other |___|___|___|___|___|___|___|___|___|___|___|

I understand that this information will be shared with the IEHP Care Team and Providers to help me get the care I need. If I were to change health plans, IEHP would make this form available to my new plan upon my request.

Signature: _____ Date signed: |___|___| - |___|___| - |___|___|___|___|

If not signed by the person completing this form, specify relationship:

☐ Parent of minor ☐ Guardian ☐ Other representative