

Date: / /
 To:
 Attention:
 Address:
 City/State/Zip:
 Phone:

HealthChoice LOCAL HEALTH SERVICES REQUEST FORM

Client Information	
Client Name: Address: City/State/Zip: Phone: County: DOB: / / SS#: - - Sex: <input type="checkbox"/> M <input type="checkbox"/> F Hispanic: <input type="checkbox"/> Y <input type="checkbox"/> N MA#: Private Ins.: <input type="checkbox"/> No <input type="checkbox"/> Yes Martial Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Unknown If Interpreter is needed specific language:	Race: <input type="checkbox"/> African-American/Black <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> More than one race <input type="checkbox"/> Unknown Caregiver/Emergency Contact: Relationship: Phone:
FOLLOW-UP FOR: (Check all that apply) <input type="checkbox"/> Child under 2 years of age <input type="checkbox"/> Child 2 – 21 years of age <input type="checkbox"/> Child with special health care needs <input type="checkbox"/> Pregnant EDD: ____ / ____ / ____ <input type="checkbox"/> Adults with disability(mental, physical, or developmental) <input type="checkbox"/> Substance use care needed <input type="checkbox"/> Homeless (at-risk)	RELATED TO: (Check all that apply) <input type="checkbox"/> Missed appointments: ____ #missed <input type="checkbox"/> Adherence to plan of care <input type="checkbox"/> Immunization delay <input type="checkbox"/> Preventable hospitalization <input type="checkbox"/> Transportation <input type="checkbox"/> Other:
Diagnosis:	
Comments:	

MCO:	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) _____ # Face to Face _____	<input type="checkbox"/> Unable to Locate <input type="checkbox"/> Contact Date: / / <input type="checkbox"/> Advised <input type="checkbox"/> Refused
Comments:	
Contact Person: Phone: Fax:	Provider Name: Provider Phone:

Local Health Department (County)	Date Received: / /
Document Outreach: # Letter(s) _____ # Phone Call(s) _____ # Face to Face _____	<input type="checkbox"/> No Action (returned) Reason for return:
Contact Person: Contact Phone:	Disposition: <input type="checkbox"/> Contact Complete: Date: / / <input type="checkbox"/> Unable to Locate: Date: / / <input type="checkbox"/> Referred to: Date: / /
Comments:	