WellCare®
Beyond Healthcare. A Better You.

MEMBER INFORMATION

Please fill out this form and return it in the enclosed envelope.

Date completed: ____

Member name*(last, first, middle initial):__________________________

Member address: ____

City:________________________________State:________ZIP: ________

Member phone: ________________

Member date of birth*:_____________________Age: ________________

Member ID number: ____

Emergency contact name:___________________Phone: ________________

Who is completing this form for you? ______________________________

HEALTH ASSESSMENT *All Required

1. What is your gender? ☐ Male ☐ Female

2. What language do you prefer to use at home?
   ☐ English ☐ Spanish ☐ Other: _____________

3. What is your living situation?
   ☐ Own ☐ Rent ☐ Live with family ☐ Live with friends ☐ Homeless
   ☐ Other ________________

4. What is your race or ethnicity?
   ☐ African American ☐ American Indian
   ☐ Asian ☐ Native Hawaiian or Pacific Islander
   ☐ White Non-Hispanic ☐ Multicultural
   ☐ Other: ________________

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5. What is your highest level of education?
   - ☐ Elementary school (K–5)
   - ☐ Middle school (6–8)
   - ☐ High school (9–12)
   - ☐ High school graduate
   - ☐ Some college
   - ☐ College graduate
   - ☐ Graduate school
   - ☐ N/A

6. How often do you exercise? ☐ 2–3 times per week ☐ Once per week ☐ Rarely ☐ Never

7. In general, how would you rate your overall health?
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
   - ☐ N/A

8. Compared to one year ago, my health is worse. ☐ Yes ☐ No

9. Has a doctor ever told you that you have the following?
   - ☐ Diabetes
   - ☐ High blood pressure
   - ☐ Heart disease
   - ☐ Kidney disease
   - ☐ Cancer
   - ☐ Asthma
   - ☐ COPD
   - ☐ Allergies
   - ☐ HIV/AIDS
   - ☐ Hepatitis
   - ☐ Depression
   - ☐ N/A

10. Are you currently pregnant? ☐ Yes ☐ No

11. Do you currently take prescription medicine? ☐ Yes ☐ No

12. Do you currently use any of the following?
    - ☐ Hearing aids
    - ☐ Glasses or contacts
    - ☐ Wheelchair or walker
    - ☐ Other Assistive devices

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13. Have you received dental care in the past year? ☐ Yes ☐ No

14. Have you been to the emergency room in the past three months?
    ☐ Yes ☐ No ☐ N/A

15. Do you use tobacco or tobacco products? ☐ Yes ☐ No
    ☐ I would like help quitting ☐ N/A

16. How often do you use alcohol?
    ☐ Everyday ☐ Two or more days per week
    ☐ Rarely ☐ Never

17. Do you need help with any of the following? (Mark all that apply)
    ☐ Food ☐ Clothing
    ☐ Housing ☐ Employment
    ☐ Mobility ☐ Getting to medical appointments
    ☐ Safety

18. Do you need help performing any of the following daily activities?
    ☐ Accessing medication ☐ Bathing
    ☐ Eating ☐ Dressing
    ☐ Shopping ☐ Managing finances

19. Would you like your health plan to contact you about any other health concerns? ☐ Yes ☐ No

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Si el español es su lengua materna, podemos brindarle servicios de traducción. También podemos proporcionarle esta información en otros formatos. Estos incluyen Braille, audio o letra de imprenta grande. Simplemente llámenos sin cargo al **1-877-389-9457**. Para TTY llame al **1-877-247-6272**.

如果中文是您的母語，我們可以為您翻譯。我們也可以用其它格式為您提供資訊。這些格式包括布萊葉文、音頻及大字體。僅需撥打我們的免費電話。您可以撥打 **1-877-389-9457** 聯絡我們。TTY 用戶請撥打 **1-877-247-6272**。

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