Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Dear Member:

We are committed to helping you and your family stay healthy. This health assessment will help us learn about your health and coordinate your care in a way that meets your personal needs.

Please take the time to answer the questions as best as you can. **If you have questions about the assessment or would like to complete it over the phone, please call us** at 1-844-533-1994, ext. 35566, (TTY 711) from 8:30 a.m. to 5 p.m., Eastern Time Monday through Friday.

After you've finished the assessment, return it to us in the self-addressed envelope we've included. The information you share with us will not be shared with anyone who does not need to know.

If you lose the envelope, you can mail the completed health assessment to us at:

Anthem HealthKeepers Plus
Outreach Department
VA2002-N800
P.O. Box 27401
Richmond, VA 23286-8708

Call toll free for translation or oral interpretation at no cost/Llame a la línea gratuita para servicios de traducción o interpretación sin cargo: 1-800-901-0020 (Medallion Medicaid, FAMIS); 1-855-323-4687 (CCC Plus); TTY 711.

**www.anthem.com/vamedicaid**

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**Health assessment**

Please read each question. Please circle the answer that best describes you or the member. If the question asks you to fill in the blank, please write your answer in the space provided.

Today's date: _____

Name of person completing form: _____

Relationship to member(s) _____

Street address:

_____

City: _____State: _____ ZIP: _____

Home phone: (_____) _____Cell phone: (_____) _____

May we send you text messages and continue to call you on your cell phone? Please circle one: ☐Yes ☐No

Email address: _____

What is the best phone number to reach you? Please circle one: ☐Home ☐Cell ☐Other

If other, please write the number: (_____) _____

By providing us this phone number, you are giving us consent to call this phone number.

| **Member name** | **Medicaid or FAMIS ID #** | **Anthem HealthKeepers Plus member ID #** (nine digits) ___ ___ ___ ___ ___ ___ ___ ___ ___ |
|---|---|---|

1. Do you have a primary care provider (PCP) who you see when you are sick or need regular checkups?
   ☐Yes ☐No ☐I don't know
2. Are you seeing any specialists on a regular basis?
   ☐Yes ☐No ☐I don't know
3. Have you been in the hospital within the past year, or do you have any procedures planned in the hospital in the next 60 days?
   ☐Yes ☐No ☐I don't know
4. Are you taking any prescription or over-the-counter medications?
   ☐Yes ☐No ☐I don't know

7. Do you have health care needs we can help you with?
   ☐Yes ☐No ☐I don't know
   7a. Please describe the health care needs in the space below.
8. Do you have additional health care needs such as prescription assistance, durable medical equipment, etc.?
   ☐Yes ☐No ☐I don't know
   8a. Please describe the additional health care needs in the space below.

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| | |
|---|---|
| 5. Have you been diagnosed with a behavioral health condition, or do you have a history of a behavioral health condition?<br>☐ Yes ☐ No ☐ I don't know<br><br>6. Are you receiving additional interventions such as special services through school, nursing care, day support or personal assistance?<br>☐ Yes ☐ No ☐ I don't know | 9. Do you need help with referrals for other health care or social services such as shelter, food or clothing?<br>☐ Yes ☐ No ☐ I don't know<br>9a. Please describe the needs in the space below.<br><br>10. For female members only: Are you pregnant?<br>☐ Yes ☐ No ☐ I don't know |