

About Me and My Health Form



Fill out and return this form in the envelope provided and you will earn \$10 in rewards*. No stamp needed.

Questions?

Call your Care Team at 1-866-469-7774 (TTY: 711) Monday - Friday, 8 am - 6 pm

Please tell us about your health.

1. How would you describe your overall health?
(Check one.) Excellent Very Good Good Fair Poor
2. Do you smoke? Yes No
3. Do you have permanent or stable housing? Yes No
4. Do you have any health concerns? Yes No
If yes, please call us at 1-866-469-7774 and ask to speak with your care manager.

For members living with HIV.

5. If you are living with HIV, are you currently taking HIV medication? Yes No
6. What is your most recent CD4 count? Viral load?
(Number of T-cells in your immune system) (Amount of HIV in your blood)

Let us know how you are managing your health.

7. How confident are you that you can manage most of your health problems? (Check one.)
 Very Confident Somewhat Confident Not Very Confident Need Help
8. Are you currently receiving any of these services? (Check all that apply.)

<input type="checkbox"/> HASA (NYC – HRA Public Assistance Program)	<input type="checkbox"/> Home Care (Home attendant services or nursing assistance)	<input type="checkbox"/> Behavioral Health Services
<input type="checkbox"/> “Health Home” or Care Coordination Services	<input type="checkbox"/> Methadone Maintenance Program	<input type="checkbox"/> Nutrition/Pantry Services
<input type="checkbox"/> Other Case Management or Social Work Services	<input type="checkbox"/> Treatment Adherence Program	<input type="checkbox"/> Legal Services
	<input type="checkbox"/> Harm Reduction Program	<input type="checkbox"/> Transportation
	<input type="checkbox"/> Transgender Health Care Services	
	<input type="checkbox"/> Adult Day Treatment Program	

*By sharing this information with us, you can earn up to \$40 a year.

Let us know about how you are managing your health. (Continued)

9. Do you have problems with any of the following? (Check one answer for each item.)

- | | | |
|------------------------------------|------------------------------|-----------------------------|
| Filling prescriptions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Taking daily medications | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seeing your Primary Care Physician | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Seeing your Specialist | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Drugs or Alcohol | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Getting or preparing healthy food | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Almost done! Please enter the information and sign below. Then mail the form back to us in the postage-paid envelope and you will earn \$10 in Steps rewards.

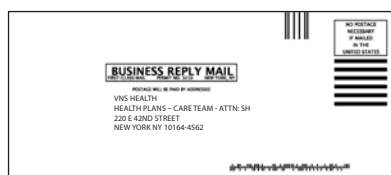
Last Name		First Name and Middle Initial	
Medicaid CIN#	Member ID (V#)	Area Code and Telephone #	
Address		Apt #	City
State NY	Zip Code	Email	
Signature		Date	

What is the best way to contact you? Email Text Phone

What is the best time to contact you? Morning (9 am – 12 pm) Afternoon (12 pm - 3 pm)
 Early Evening (4 pm - 6 pm)

Are you interested in attending a Member Advisory Meeting? Yes No

If yes, what is the best time for you to attend? Morning (9 am – 12 pm) Afternoon (12 pm - 3 pm)
 Early Evening (4 pm - 6 pm)



Missing your envelope? Mail this form back to:
VNS Health
Health Plans – Care Team - Attn: SH
220 East 42nd Street
New York, NY 10017

The information in this form will become part of your SelectHealth health care plan.