Ohio Department of Job and Family Services
Healthchek and Pregnancy Services Assessment

Healthchek information has been given to me_____
(Name)

_____ _____ _____
(Address) (City/State) (Zip)

_____ _____ _____ _____
(Case Number) (Social Security Number) (Optional) (Telephone) Eligibility Date

I request the following services for my children and/or myself:
(Please check all the services you need.)

☐ Health Screening Services (Including physical exams)
☐ Vision Services
☐ Hearing Services
☐ Dental Services
☐ Name of Doctor
☐ Name of Dentist
☐ Help in making Medical or Dental Appointments
☐ Transportation to Medical or Dental Appointments

Child's name	Birth date	SSN or Medicaid Billing Number

Please answer the following questions:

Are your children's immunizations and well child exams up-to-date? ☐ **YES** ☐ **NO**

Please give us the names of your children's current doctor_____and dentist_____.

Is anyone in your family (including yourself) pregnant? ☐ **YES** ☐ **NO** If YES, give the name(s) of the pregnant woman_____. If known, give the date(s) the baby is due: _____
(Month and Year)

Is the pregnant woman now going to a doctor or clinic for the pregnancy? ☐ **YES** ☐ **NO**
If YES, give the name of the doctor or clinic.

Do you need other social services? ☐ **YES**, Specify:_____ ☐ **NO**

Are you currently enrolled in a Managed Care Plan or HMO?
☐ **YES**_____ ☐ **NO**
(Name of Plan or HMO)

(NOTE: • Before you enroll in an HMO, be sure that your doctor or clinic is on the HMO's list.
• If you enroll in an HMO in the future, be sure to tell the HMO staff about the services you would like to get.

I agree that I and/or my children may receive any of the services listed above. If release of medical information is required, I understand that I will be asked to sign a release form.

Recipient's Signature_____ Date_____

For office use:
Case worker_____ Date_____

Healthchek or Pregnancy Services worker_____ Date_____

☐ No services requested at this time ☐ Face to Face ☐ Mailed ☐ Telephone

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