

**HealthLink Miami Valley Questionnaire**

HealthLink Miami Valley is a program to identify people who may not have health insurance coverage or a usual place to get medical care in order to help them connect to health care or other services. The information asked for below will help HealthLink Miami Valley to know more about insurance and health needs in our community. The information will be kept confidential. Choosing not to answer these questions will have no effect on services you may be eligible to receive. You can contact Ms. Kimberly Conner at 775-1121 if you want more information or have questions about HealthLink Miami Valley or this questionnaire.

**1. Do you have health insurance?**

<input type="checkbox"/> NO health insurance	<input type="checkbox"/> YES, what kind? <input type="checkbox"/> Anthem <input type="checkbox"/> Medicare <input type="checkbox"/> Military/CHAMPUS <input type="checkbox"/> Medicaid/CareSource/CHIPS/Healthy Start Healthy Families <input type="checkbox"/> United Health Care <input type="checkbox"/> Other _____
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**2. Do you have children living with you?**       NO (Skip next 2 questions)       YES

**3. Are your children covered by health insurance?**

<input type="checkbox"/> NO health insurance	<input type="checkbox"/> YES, what kind? <input type="checkbox"/> Anthem <input type="checkbox"/> Medicare <input type="checkbox"/> Military/CHAMPUS <input type="checkbox"/> Medicaid/CareSource/CHIPS/Healthy Start Healthy Families <input type="checkbox"/> United Health Care <input type="checkbox"/> Other _____
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**4. Do any of your children under age 18 wheeze or have asthma?**       NO       YES

**5. Which BEST describes where you usually get health care? (please choose ONLY ONE)**

- Family doctor       Clinic, which one? \_\_\_\_\_  
 Emergency room       Urgent Care       I do not know where to go

**6. Do you get prescriptions filled when you should?**       YES       NO, why not? \_\_\_\_\_

**7. Do you have high blood pressure?**       NO       YES       DON'T KNOW

**8. Would you like to be contacted with more information on health care programs and services?**

- YES       NO

Name: (Please Print) \_\_\_\_\_

Client Address: \_\_\_\_\_

Phone/Contact Number: \_\_\_\_\_

Best time to contact: \_\_\_\_\_

I agree to allow the information on this form to be given to HealthLink Miami Valley.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_