About Me and My Health Form

Select HEALTH
VNS Health

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? _____
   (Number of T-cells in your immune system)
   Viral load? _____
   (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.)

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

**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	☐ Yes	☐ No
Taking daily medications	☐ Yes	☐ No
Seeing your Primary Care Physician	☐ Yes	☐ No
Seeing your Specialist	☐ Yes	☐ No
Drugs or Alcohol	☐ Yes	☐ No
Getting or preparing healthy food	☐ Yes	☐ 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
PO Box 18023
Hauppauge, NY11788-9876

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