COLORADO
Department of Public Health & Environment

HCP Specialty Clinic
Family Information Questionnaire

HCP for Children and Youth with Special Health Care Needs

Child/Youth's First & Last Name _____ DOB _____ Age _____

School _____ Contact Name / Title / Number _____ Gender: ☐ Female ☐ Male

Language Spoken In Household (primary) _____ Interpreter Needed: ☐ Yes ☐ No

Child/Youth's Primary Care Provider (PCP) _____ PCP Phone _____

PCP Address _____ PCP City _____ PCP Zip _____

PARENT / GUARDIAN / CAREGIVER INFORMATION

Name	Relationship to Child/Youth	Birth Date	Employer / Work Phone Number	Guardian
				☐ Yes
				☐ Yes
				☐ Yes

PARENT / GUARDIAN / CAREGIVER CONTACT INFORMATION (primary)

Contact (name and relationship to patient):	**Home Phone:**
Mailing Address:	**Cell Phone:**
Home Address (if different from mailing address):	
E-mail:	
Emergency Contact (name & relationship to patient):	**Emergency Phone:**

INSURANCE (select all that apply)

☐ No Insurance

☐ Private Insurance Name _____

Insurance Number _____

☐ Check if this is your PRIMARY insurance.

☐ Medicaid Medicaid Number _____

☐ Straight ☐ Buy-In ☐ CHP+ ☐ SSI/SSDI ☐ HMO

☐ Check if this is your PRIMARY insurance.

HOUSEHOLD INFORMATION

(The following information is collected by the HCP program and is used in part to calculate the Specialty Clinic Fee. Families of children on Medicaid will not be charged a fee; however, we ask that you still complete the following information to the best of your ability.)

Hispanic Ethnicity of Child? ☐ Yes ☐ No ☐ Don't Know / Not Sure ☐ Refused

Single Parent Household? ☐ Yes ☐ No ☐ Don't Know / Not Sure ☐ Refused

Number of Persons in Child/ Youth'sHousehold? # _____ ☐ Don't Know / Not Sure ☐ Refused

Annual Income # _____ ☐ Don't Know / Not Sure ☐ Refused

Highest Education Level in Child/ Youth's Household? ☐ 8th grade or less ☐ Some high school ☐ High school graduate ☐ Some college ☐ College graduate ☐ Don't Know / Not Sure ☐ Refused

Age Range of Biological Mother at Child/Youth's Birth ☐ 16 years or younger ☐ 17 years or older ☐ Don't Know / Not Sure ☐ Refused

ADDITIONAL QUESTIONS

1a. During the past 6 months, has your [child/youth] seen a Specialist in Denver or the surrounding metro area?

◯ Yes ◯ No ◯ Don't Know / Not Sure ◯ Refused

1b. If yes, how many times in the past 6 months? #_____

1c. If yes, list specialty / specialties.

2a. During the past 6 months, has your [child/youth] gone to a hospital emergency room?

◯ Yes ◯ No ◯ Don't Know / Not Sure ◯ Refused

2b. If yes, how many times in the past 6 months? # _____

2c. How many times was [he/she] admitted to the hospital? # _____

3. During the past 6 months, about how many days did you or other household members miss work because of your [child/youth]'s special needs?

_____ days ◯ Don't Know / Not Sure ◯ Refused

Completed By (print name & relationship to child/youth): _____

Date _____