



**Patient/Clinician Health Improvement Plan for Enhanced Medicaid Benefits
Child/Adolescent**

Patient's Name: _____ Medicaid ID Number: _____

Date of Birth: _____ Medicaid Home: _____

1. Please indicate how often you and this patient have agreed that he/she will be seen at health center (medical home) this year (**choose one**):

- One visit to the primary care provider this year
- Three** visits to the primary care provider this year (approximately every 4 months)
- Quarterly** visits to the primary care provider this year (approximately every 3 months)
- Monthly** visits to the primary care provider this year
- Other** as per EPSDT periodicity schedule # _____ visits

2. Please mark any of following preventive and/or chronic illness care tests/procedures you would recommend for this patient **in the next 12 months**:

- Age appropriate immunizations Lipid screening
- Lead Screening Glucose level
- Other _____ Dental Check-ups

3. Health Education Classes. Please place a check mark in the appropriate box indicating if this patient needs education on any/all of the listed topics:

Nutritional Education ()	Weight Management ()	Diabetes Education ()	Tobacco Cessation Education ()
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I do not wish to sign the Member Agreement or to work with my medical home to develop a health improvement plan.

Signature _____ Date _____
(Parent or Guardian)

Witness _____ Date _____