Liberty HealthShare℠

A healthcare sharing ministry of Gospel Light Mennonite Church Medical Aid Plan, Inc.

Medical History Questionnaire

PLEASE FILL OUT IN ITS ENTIRETY

Answer each question for every person on the Application, including children, and for the entire period specified.
NOTICE: Liberty HealthShare relies on the information you provide in this Questionnaire to determine whether you are eligible for membership. You must provide truthful and complete answers to the following questions to the best of your ability. You must fully answer all health history questions. If Liberty HealthShare approves your application for membership and later discovers that you withheld material information that would have been a determinative fact, we may rescind your membership. "YES" answers will not necessarily cause an applicant to be denied membership, but may require further information to be provided on the Medical History Explanation section.

All questions must be answered or the application will be returned. If you cannot answer either "YES" or "NO" for a specific question, check the "NOT SURE" box. For example, you can check the "NOT SURE" box if you do not understand a medical term being used, are not sure whether you have or had a listed medical condition, cannot remember the exact time frame when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "YES" or "NOT SURE" please provide the information requested in the Medical History Explanation section. Liberty HealthShare may need to contact you and ask further questions regarding your "YES" or "NOT SURE" responses in order to process your application.

APPLICANT'S INFORMATION

Name: (First, Middle, Last)			
Birthdate: (Month/Day/Year)	Height:	Weight:	Gender: (*Circle*) M F
Street Address:	City:	State:	Zip:
Social Security Number: (*Optional*) - -	Employer Name:	Occupation/Title:	

MEDICAL HISTORY

1. Are you currently taking or have you been prescribed any type of medications, vitamins and/or supplements?	*Circle One:*	Yes	No	Not Sure
2. Within the past 60 days, have you seen a health care provider(s) for any reason, including any type of testing?	*Circle One:*	Yes	No	Not Sure
3. Within the past 36 months, have you been hospitalized or treated at an urgent care or emergency room for any reason?	*Circle One:*	Yes	No	Not Sure
4. Have you ever consulted with a health care provider or been diagnosed or treated for Amenorrhea (absense of menses)?(If you are male please select No)	*Circle One:*	Yes	No	Not Sure
5. Have you ever consulted with a health care provider or been diagnosed or treated for any gynecological abnormalities?(If you are male please select No)	*Circle One:*	Yes	No	Not Sure

Continued >

MEDICAL HISTORY *Continued*

6. Do you currently have Medical Insurance Coverage?	*Circle One:*	Yes	No	Not Sure
7. Do you currently have a Primary Care Physician?	*Circle One:*	Yes	No	Not Sure
8. Have you had a physical within the past 12 months?	*Circle One:*	Yes	No	Not Sure
9. Have you ever been diagnosed or treated for any type of cancer, leukemia, melanoma, or malignant tumor(s)?	*Circle One:*	Yes	No	Not Sure
10. Within the past 36 months, have you consulted with a health care provider or been diagnosed with any of the following? (angina, heart attack, irregular/increased rate, heart disease, hypertension, high cholesterol, phlebtis, stroke, circulatory, blood, or bleeding disorders, sleep apnea)	*Circle One:*	Yes	No	Not Sure
11. Within the past 36 months, have you consulted with a health care provider or been diagnosed with diabetes, thyroid, or any other endocrine disorders?	*Circle One:*	Yes	No	Not Sure
12. Within the past 36 months, have you consulted with a health care provider or been diagnosed with recurrent pain (including back) or joint disorders?	*Circle One:*	Yes	No	Not Sure
13. Within the past 36 months, have you consulted with a health care provider or been diagnosed with any neurological disorders (i.e. seizures or epilepsy)	*Circle One:*	Yes	No	Not Sure
14. Within the past 36 months, have you consulted with a healthcare provider or been diagnosed with any type of congenital heart disorders or birth defects?	*Circle One:*	Yes	No	Not Sure
15. Within the past 36 months , have you consulted with a healthcare provider or been diagnosed with liver, prostate or kidney disorders?	*Circle One:*	Yes	No	Not Sure
16. Have you ever participated in a treatment program, consulted with a health care provider or been diagnosed with or treated for any psychological, emotional or behavioral disorder or addiction?	*Circle One:*	Yes	No	Not Sure
	Date of last treatment:	/	/	
17. Have you ever been diagnosed or treated for any type of Hepatitis? If yes, please specify which type.	*Circle One:*	Yes	No	Not Sure

18. Have you ever been diagnosed with or treated for any of the following? *Check All That Apply.*

- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ AIDS Related Complex (ARC)
- ☐ Antiviral Therapy or Treatment
- ☐ Ankylosing Spondylitis
- ☐ Alzheimer's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Diverticulitis/Diverticulosis
- ☐ Emphysema
- ☐ Gaucher's Disease
- ☐ Hemophilia
- ☐ Kaposi Sarcome
- ☐ Lupus Multiple Sclerosis
- ☐ Lyme Disease
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Pneumocystis Carinii Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Scleroderma
- ☐ Ulcerative Colitis

19. Do you consume alcoholic beverages? If yes, how many do you consume per week on average? (one beverage equals 12 oz. beer, 4 oz. wine or 1 oz. liquor)	0-3 per week	4-7 per week	8-14 per week	15+ per week
20. Have you ever been on a waiting list, donated, or recieved an organ or a bone marrow transplant?	*Circle One:*	Yes	No	Not Sure
21. During the past 36 months, have you at any time smoked cigarettes, cigars, pipes, or used any other form of tobacco?	*Circle One:*	Yes	No	Not Sure
22. Within the past 36 months, have you had any type of surgeries?	*Circle One:*	Yes	No	Not Sure
23. Do you have any other medical condition(s) not previously listed?	*Circle One:*	Yes	No	Not Sure

MEDICAL HISTORY EXPLANATION

If you answered "YES" or "NOT SURE" to any questions in the Medical History Questionnaire, explain further using the space below. Include explanations for any applicant in this section by name for who you answered "YES" or "NOT SURE", including children. If extra space is needed, make a copy of this page and use as many separate pages as necessary. Please be complete in your responses.

Question Number	First/Last Name of Person Affected	Describe Condition, Injury, Illness, Symptom or Diagnosis	Month & Year that It Started	Date of Complete Recovery (If Applicable)	Types of Treatment Given and Exact Name of Medications, Dosage and Frequency Prescribed

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Together, We're Changing Healthcare...For Good!

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I understand I understand that I have the right to revoke this authorization in writing unless Liberty HealthShare has taken any action in reliance upon it.

I understand that Liberty HealthShare has requested and will receive from me and my health care provider's protected health information prior to my enrollment in Liberty HealthShare. Liberty HealthShare will use this information to determine whether I am eligible to enroll. I further understand that Liberty HealthShare will protect the confidentiality of that information in the same manner as all other protected health information Liberty HealthShare maintains and, if I do not enroll, Liberty HealthShare will not use or disclose the information Liberty HealthShare obtained for any other purpose.

I understand that Liberty HealthShare will make disclosures of my protected health information as necessary for my treatment. A doctor or health facility involved in my care may request some of my protected health information that Liberty HealthShare holds in order to make decisions about my care.

I understand that Liberty HealthShare will make uses and disclosures of my protected health information as necessary for payment purposes. For instance, Liberty HealthShare may use information regarding my medical procedures and treatment to process and arrange for the payment of medical bills, to determine whether services are medically appropriate or to otherwise pre-authorize or certify services as eligible to be shared under the Guidelines. Liberty HealthShare may also forward such information to another health plan that may also have an obligation to process and pay expenses on my behalf.

I understand that Liberty HealthShare will use and disclose my protected health information as necessary for health care operations which include peer review, business management, accreditation and licensing, utilization review and management, quality improvement and assurance, enrollment, voluntary disclosure of health conditions, compliance, auditing, and other functions related to my healthcare management. Liberty HealthShare may also disclose my protected health information to another health care facility, health care professional or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has, or had, a patient relationship with me.

I understand that Liberty HealthShare may from time to time disclose my protected health information to family, friends, and others who are involved in my care or in payment for my care in order to facilitate that person's involvement in caring for me or paying for my care. If I am unavailable, incapacitated, or facing an emergency medical situation and Liberty HealthShare determines that a limited disclosure may be in my best interest, Liberty HealthShare may share limited protected health information with such individuals without my approval. Liberty HealthShare may also disclose limited protected health information to a public or protected entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for me.

I understand that certain aspects and components of Liberty HealthShare services are performed through contracts with outside persons or organizations, such as legal services, Member Stewardship Programs, Medical Discount Organizations, Pharmacy Managers, etc. At times it may be necessary for Liberty HealthShare to provide some of my protected health information to one or more of these outside persons or organizations who assist with health care operations. In all cases, Liberty HealthShare requires these business associates to appropriately safeguard the privacy of my information.

I understand that Liberty HealthShare may communicate with me regarding my medical expenses, share amount, or other matters related to my health. If I am endangered when all or part of the information being sent to me is viewed by another person, I understand that reasonable requests to receive communications regarding my protected health information by alternative means or at alternative locations will be accommodated by Liberty HealthShare.

I understand that Liberty HealthShare may, from time to time, use my protected health information to determine whether I might be interested in or benefit from treatment alternative or other health-related programs, products or services which may be available to me as a member. Liberty HealthShare may use my protected health information to identify whether I have a particular illness, and contact me to advise me that, as a member, a disease management and/or wellness program may help me manage my illness or health condition.

I understand that this authorization is voluntary, that I may revoke it at any time, and that I may get a copy of this form after signing it.

☐ **Parent(s)**

name	phone

☐ **Children**

name	phone

☐ **Spouse**

name	phone

☐ **Other**

name	phone

I Authorize the above release:_____ DATE: _____

With my signature below, I do hereby certify that I have provided truthful and accurate information to the best of my knowledge as directed on the Medical History Questionnaire and have provided truthful and accurate explanations as necessary on the Medical History Explanation page(s).

APPLICANT NAME (PRINT):_____

APPLICANT SIGNATURE: _____ DATE: _____

IF COUPLE OR FAMILY

SPOUSE NAME (PRINT): _____

SPOUSE SIGNATURE:_____ DATE: _____

MEDICAL HISTORY QUESTIONNAIRE CHECKLIST

COMPLETE EACH PAGE IN FULL. LEAVE NOTHING BLANK. INDICATE 'NOT APPLICABLE' (N/A) IF NECESSARY
EACH ADULT APPLYING MUST SIGN ALL SIGNATURE AREAS.

Mail completed application and annual membership dues to:

Liberty HealthShare
4845 Fulton Dr. NW • Canton, OH 44718
1-855-585-4237 *Phone* 216-456-8115 *Fax*

FOR OFFICE USE ONLY

Revd:____/____/____

Matched w/ Applicant: Y / N

N' fied: ____/____/____ A or D

Adults: #_____ Children: #_____