



Enrollment Form



The Primary Care Health Home Enrollment Form must be completed in full. Please complete the form, save a copy, and submit in an encrypted email to the Enrollment Coordinator, Marcia.seabourne@dmh.mo.gov. Indicate "PCHH ENROLLMENT" in the subject line of the email.

PART 1
PART 2
PART 3
PART 4

Health Home: HH Provider #:

Date: MO HealthNet ID/DCN#: Date of Birth:

Participant Name:

First MI Last

Mailing Address:

Street

City

State

Zip Code

Does the participant have a Guardian/Parent? Yes No *If no, skip to Part 4

If yes, name of Guardian/Parent:

Guardian/Parent Address:

(if different from participant)

Street

City

State

Zip Code

Has the Guardian/Parent agreed to the enrollment: Yes

Please check all applicable diagnoses:

- COPD/Asthma
- Developmental Disability
- Obesity (BMI >25)
- Heart Disease
- Diabetes
- Tobacco Use

MO HEALTHNET USE ONLY:

Enrollment:	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Date Approved/Denied:	<input type="text"/>	Effective Date of Enrollment: <input type="text"/>
Not currently enrolled in HCH:	<input type="checkbox"/>	Verified current Medicaid Eligibility: <input type="checkbox"/>
Verified in DM 3700 cohort:	<input type="checkbox"/>	
Reason Enrollment Denied:	<input type="text"/>	
Request processed by:	<input type="text"/>	