Preventive Care Health Information Form

summit DD
Developmental Disabilities Board

Directions for Participant: Bring this form with you to your preventive care visit and have your healthcare provider complete the form.

PARTICIPANT NAME: _____
Last Name *First Name*

DOB *(mm/dd/yyyy):*_____/_____/_____ **GENDER:**_____

STEP 1: PREVENTIVE CARE CONFIRMATION (REQUIRED)

Provider: I hereby acknowledge that the undersigned patient is up-to-date with recommended preventive care.

_____ _____ _____
Provider Signature | License # | Date (mm/dd/yyyy)

_____ _____
Provider Name (Printed) | Provider Phone Number

STEP 2: BIOMETRIC VALUES (OPTIONAL)

Directions for Provider: Complete biometric values for the participant listed below from current bloodwork dated after 12/02/2023.Please return the completed form to participant to upload to the PeopleOne Health portal.

BIOMETRIC VALUE GOALS

Health Measures	Health Goals	
BMI	< 27.5 kg/m^2	
Waist Circumference	Male	Female
	< 40 in.	< 35 in.
Blood Pressure	< 120/80 mmHg	
Fasting Glucose	< 100 mg/dL	
HDL	Male	Female
	≥ 40 mg/dL	≥ 50 mg/dL
Triglycerides	< 140 mg/dL	

PARTICIPANT BIOMETRIC VALUES

Height _____ ft. _____ in. Weight _____ lbs. BMI _____
(measured to nearest 1/4 in.) *(measured to nearest 1/2 lb.)*

Waist Circumference *(measured to nearest 1/4 in.)*	_____ in.
Blood Pressure	_____/_____ mmHg
Fasting Glucose	_____ mg/dL
HDL	_____ mg/dL
Triglycerides	_____ mg/dL

PARTICIPANT SIGNATURE (REQUIRED)

Participant: I hereby certify that the information on this form is accurate to the best of my knowledge and I authorize this data to be provided to PeopleOne Health for the purpose of administering the sponsored wellness program. I authorize Summit County Developmental Disabilities Board, PeopleOne Health and/or other partners engaged in my health plan to conduct services in connection with the Program. Biometric measures are not required to participate in the Program. My results will be securely and confidentially handled by PeopleOne Health. I authorize the use and disclosure of my health and personal information for purposes of participation in the Program. I understand Summit County Developmental Disabilities Board may determine my incentives and/or rewards based on my participation in the Program. This Program is not a diagnostic tool; it does not provide, nor is it a substitute for, professional medical advice, diagnosis or treatment. The information provided by the Program is for educational purposes only and should not be interpreted as a diagnosis or as a recommendation for a specific treatment plan, product or course of action. This authorization will expire 12 months from the date of my new medical plan year or one year from date of this document, whichever is later. Refer to Summit County Developmental Disabilities Board for more information to determine the impact on your health plan payroll contributions, incentives and/or rewards. I understand that it is my responsibility to make sure PeopleOne Health receives my completed form.

_____ _____
Participant Signature | Participant Name (Printed)

Upon obtaining your primary care provider's signature, please sign and return this form to PeopleOne Health for confidential tracking. The validity of this form may be verified for authenticity. Falsification of information will be subject to disciplinary actions consistent with employee guidelines. If you have any questions, please speak with your Human Resources representative.

All completed forms must be submitted to PeopleOne Health by 12/01/2024. Do not return this form to your employer.