Well Child / Immunization Program Form

ChildrenFirst
A Good Health Rewards Program
by Community Health Plan of Washington™

COMMUNITY HEALTH PLAN of Washington™

As a Community Health Plan of Washington (CHPW), member your child is eligible to receive a reward for getting care.

To be eligible, your child must:

- See his/her provider for the scheduled Well Child exam; AND
- Be current on all scheduled immunizations; AND
- Be a CHPW member on the appointment date and when the provider submits the form.

Please check the a box for one (1) of the following FREE rewards.

Infancy (newborn – 11 months):		**Early Childhood (12 months – 4 years):**	
☐ Baby Grooming Kit	☐ Diapers*	☐ Bike Helmet*	☐ Diapers*
☐ Car Seat*	☐ Thermometer	☐ Children Books	☐ Dental Care Pack
☐ Cupboard Locks*		☐ Cupboard Locks*	☐ Thermometer
Middle Childhood (5 years – 10 years):		**Adolescence (11 years – 13 years):**	
☐ Backpack*	☐ Clothes*	☐ Backpack*	☐ Dental Care Pack
☐ Bike Helmet*	☐ Dental Care Pack	☐ Bike Helmet*	☐ School Supplies*
☐ Booster Seat*	☐ School Supplies*	☐ Clothes*	

Please Note: Rewards with a star (*) are offered in the form of a gift certificate.

Please complete the following. Your provider's office will send this form to CHPW. **If you are eligible, you will receive your reward in the mail within 3 weeks. If you still have not received your reward after 3 weeks, or have any questions about this program, please call our Customer Service at 1(800) 440-1561 (TTY Relay: Dial 7-1-1), Monday – Friday, 8 a.m. to 5 p.m.**

I request and authorize the disclosure of protected health information, including protected health information about the HPV vaccine, to be released to CHPW to confirm eligibility for the Children First Well Child Program.

Member Name: _____

Member ID Number: _____ Child's Date of Birth: _____

Parent/Guardian Name (print clearly): _____

Parent/Guardian Signature: _____ Date: _____/_____/_____

Mailing Address: _____

City/State/Zip: _____ Phone Number: _____

This section to be completed by clinic staff only

Please attest that the patient named above is current on all immunizations as reccomended by the current CDC immunization schedule. ☐ Yes ☐ No

Please indicate which immunizations, if any, were given during today's visit: _____

Clinic staff signature: _____

Provider name: _____
(print)

Please send the completed form to:
Community Health Plan of Washington
ATTN: Children First Program
By Fax: (206) 652-7071
By Email: childrenfirst@chpw.org