Lead and Asthma Program Screening

Fill this form out if you feel like you and/or your child would benefit from our free home visiting services.

Requirements:

* Resident of Harford County
* Enrolled in/Eligible for Medicaid
* Be under the age of 19
* Have a blood Lead Level of 5µg/dL and 🡩

and/or

* Have a medical diagnosis of Asthma

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| **PATIENT INFORMATION** | | |
| Child Name: (Last, First) | Gender: M/F | Date of Birth: |
| Address: | | Apartment #: |
| City: | State: MD | Zip: |
| Phone Number: | Other Contact Number: | |
| Parent/Primary Caregiver Name: | | |
| Interpreter Needed?  Yes  No If *yes,* what language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Insurance Information  Medical Assistance Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Patient screening or Navigation for Asthma  Patient screening or Navigation for Lead  Patient screening or Navigation for Asthma and Lead | | |
| Do you agree to be contacted by the Harford County Health Department:  yes (Required) | | |

Please send completed form to the name and address listed below, or email completed form to/or call:

Zachary Macas

Program Supervisor - LAP

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