

Transition of Care Assessment

Thank you for choosing Optima Health for your 2019 health coverage! By giving us information about your health conditions and medications, we will be able to aid in your continuity of care and ensure a smooth transition to your new health plan.

The assessment will take at least 5 minutes to complete.

Completion of the survey is voluntary. You will not be denied health plan coverage or treatment under your new plan if you do not complete the survey.

- i. Please provide your FULL government name and date of birth (**Required**):**

First Name Middle Initial Last Name Date of Birth

- ii. Please provide the names and dates of birth of all individuals you will be adding to the plan (**Required**):**

First Name	Last Name	Date of Birth

- iii. Please provide the best phone number, email address, and mailing address to reach you, in case one of our Case Managers needs to follow-up with you.**

Phone Number	
Email Address	
Mailing Address	

- iv. Please provide the name of the primary care physician of each person covered under the health plan (**Required**):**

Covered Person	Primary Care Physician	Physician's Office

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Appointments...	No	Yes	Name of Covered Person(s)
Do you or anyone covered under your health plan have an upcoming appointment with any of your health care providers?	<input type="radio"/>	<input type="radio"/>	
Prescriptions...	No	Yes	Name of Covered Person(s)
Do you or anyone covered under your health plan expect to have any prescriptions filled or refilled within 30 days of new enrollment?	<input type="radio"/>	<input type="radio"/>	
Medical Equipment...	No	Yes	Name of Covered Person(s)
Do you or anyone covered under your health plan use medical equipment for mobility and/or for use in day to day tasks?	<input type="radio"/>	<input type="radio"/>	

Medical Equipment... (cont'd)	No	Yes	Select the type of medical equipment needed:
A) Do you or anyone covered under the health plan anticipate needing to receive any medical equipment within 30 days of new enrollment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Oxygen <input type="radio"/> CPAP <input type="radio"/> Diabetes supplies <input type="radio"/> Other
B) If you answered YES for part A, please list the names of covered persons needing the equipment:	Name of Covered Person : _____ needs Oxygen/CPAP/Diabetes supplies/Other Name of Covered Person : _____ needs Oxygen/CPAP/Diabetes supplies/Other Name of Covered Person : _____ needs Oxygen/CPAP/Diabetes supplies/Other		

v. **(**Required**)** Have you or anyone covered under the health plan ever been diagnosed with any of the following conditions? *Circle the appropriate answer.*

Condition	If yes, name of person(s) diagnosed with condition	
Asthma	No	Yes
Heart Disease (Coronary Artery Disease, Angina, Heart Attack, A Fib)	No	Yes
Chronic Obstructive Pulmonary Disease (COPD)	No	Yes

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Emphysema or Chronic Bronchitis	No	Yes	
Heart Failure (CHF)	No	Yes	
High Blood Pressure or Hypertension	No	Yes	
End Stage Renal Disease	No	Yes	
High Cholesterol	No	Yes	
Diabetes	No	Yes	
Stroke	No	Yes	
Arthritis	No	Yes	
Depression, Anxiety, or other Behavioral Health diagnoses	No	Yes	
Osteoporosis	No	Yes	
Cancer	No	Yes	
Alzheimer's or Dementia	No	Yes	

vi. Have you or anyone covered under the health plan experienced any of the following in the last two weeks?

Mood...	No	Yes	Name of Covered Person(s)
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	
Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	

Behavioral Health...	No	Yes	Name of Covered Person(s)
vii. Are you or anyone covered under the health plan currently seeing a behavioral health care provider?	<input type="radio"/>	<input type="radio"/>	

viii. Describe your general overall health and the health of anyone else covered under the plan:

(Check only one per person)

Name of Covered Person(s)	Excellent	Good	Fair	Poor
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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(**Required**) Authorization

As a new Optima Health enrollee, I understand that Optima Health would like to collect some limited information about my health conditions and medications prior to the start of my new 2019 health plan coverage.

I authorize Optima Health to share the information collected about my health or the health of my dependents with Care Management teams, my assigned Optima Health Plan physician, and Optima's pharmacy team to assist with continuity of care under my new Optima Health plan.

I understand that my health information will be entered into a secured medical record.

Any information received by Optima Health is subject to restrictions on disclosure to others as set forth under state and Federal laws. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I understand that I or my authorized legal representative may receive a copy of this Authorization upon request and I agree that a photographic copy of this Authorization shall be as valid as the original.

I understand that this Authorization is valid for three (3) months from the date shown.

Signature of Applicant or *print and sign name of Legal Representative*

(mm/dd/yyyy)

Thank you for completing this survey! If you would like to talk to one of our Case Managers about your care, please contact us at: 1-866-503-2730.