Transition of Care Assessment

Thank you for choosing Optima Health for your 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 approximately five 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.

If you would like to download, print, and complete, surveys can be mailed or faxed to:

Optima Health Plan
Clinical Care Services
Attn: Tamika Lane
4417 Corporation Lane
Virginia Beach, VA 23464
Fax Number (757) -552-8823 Attn: Tamika Lane

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

_____

First Name *Middle Initial* *Last Name* *Date of Birth*

ii. **Required** Please provide names and dates of birth of all individuals being added to the plan:

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

Covered Person	Primary Care Physician	Physician's Office

Transition of Care Assessment

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?	◯	◯	
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?	◯	◯	
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?	◯	◯	

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?	◯	◯	◯ Oxygen ◯ CPAP ◯ Diabetes supplies ◯ Other
B) If you answered YES for part A, please list the names of covered persons who need 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	
Emphysema or Chronic Bronchitis	No	Yes	
Heart Failure (CHF)	No	Yes	
High Blood Pressure or Hypertension	No	Yes	

Transition of Care Assessment

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	○	○	
Feeling down, depressed, or hopeless	○	○	

vii. Are you or anyone covered under the health plan currently seeing a behavioral health care provider?

Behavioral Health…	No	Yes	Name of Covered Person(s)
	○	○	

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
	○	○	○	○
	○	○	○	○
	○	○	○	○
	○	○	○	○

Transition of Care Assessment

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 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 data 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.