OhioHealthy

Transition of Care Assessment

Thank you for choosing OhioHealthy 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.

Completed surveys can be emailed to caremanagement@ohiohealthyplans.com.

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 inidividuals 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

OhioHealthy

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 healthcare providers?	◯	◯	

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	No	Yes	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	

OhioHealthy

Transition of Care Assessment

End Stage Renal Disease	No	Yes	
High Cholesterol	No	Yes	
Diabetes	No	Yes	
Stroke	No	Yes	
Athritis	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 healthcare 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
	◯	◯	◯	◯
	◯	◯	◯	◯
	◯	◯	◯	◯
	◯	◯	◯	◯

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****Required** Authorization**

As a new OhioHealthy enrollee, I understand that OhioHealthy 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 OhioHealthy to share the information collected about my health or the health of my dependents with Care Management teams, my assigned OhioHealthy Plan physician, and OhioHealthy's pharmacy team to assist with continuity of care under my new OhioHealthy plan. I understand that my health information will be entered into a secured medical record. Any information received by OhioHealthy 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.

Information disclosed from records is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

_____

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 you care, email caremanagement@ohiohealthyplans.com.