brand new day Health Maintenance Organization Special Needs Plan	**Pre-Qualification Assessment for Congestive Heart Failure (CHF)**

Name: ____
first *middle* *last*

Gender: ☐ Male ☐ Female Date of birth: __________

Address: ____

City: ________________________ State: ______Zip:________

Is this a licensed nursing home: □ yes □ no
Do you receive SSI or SDI: □ yes □ no

Medicare

Do you have Medicare Part A? □ yes □ no ☐ not sure

Do you have Medicare Part B? □ yes □ no ☐ not sure

(If the answer is "No" to either question, the beneficiary does not qualify. If not sure, then the candidate's name will be sent for an eligibility check.)

Clinical Qualifying Questions
(If any of the following are checked, candidate pre-qualifies)

Have you ever been told by a doctor that you have any of the following illnesses?
(Check all that apply)

□ Congestive Heart Failure
□ "CHF"
□ Heart Failure (of any kind)
□ Hypertensive Heart with Chronic Kidney Disease
□ Hypertensive Heart (of any kind)
□ Hypertension / High Blood Pressure (Stage A CHF)

Medication Questions

1. Are you now or have you ever taken medication for an illness listed above?
2. What medications are you currently taking? ________________________

____

Primary physician:

____
Name of physician and his/her clinic or location / phone number

Cardiologist / Heart Doctor:

____
Name of specialist and his/her clinic or location / phone number

______________	________	______________	______________
Candidate Signature	*Date*	*Agent Signature*	*Agent #/Printed Name*