brand new day Health Maintenance Organization Special Needs Plan	**Pre-Enrollment Qualification Assessment Tool for Dementia**

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)*

☐ Dementia
☐ Parkinson's Disease
☐ Frontotemporal Dementia (FTD)
☐ Picks (PiD)
☐ Mild Cognitive Impairment (MCI)
☐ Dementia with Lewy Bodies (DLB)
☐ Alzheimer's disease
☐ Creutzfeldt-Jakob disease (CJD)
☐ Huntington's Disease (HD)
☐ Vascular Dementia
☐ Multi-Infarc Dementia (MID)
☐ Normal Pressure Hydrocephalus (NPH)

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

Specialist:

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

____________	______	____________	____________
Candidate Signature	*Date*	*Agent Signature*	*Agent Printed Name*