PRE-ENROLLMENT QUALIFICATION ASSESSMENT TOOL DIABETES, CONGESTIVE HEART FAILURE (CHF), AND CARDIOVASCULAR DISEASE

Astiva Health offers a Chronic Special Need Plan (CSNP) for people with chronic conditions. You may be eligible to join Astiva Health's special needs plan for chronic conditions if you can answer "Yes" to any of the questions below.

Please complete this form and fax to 1-949-522-8553 or email to enrollment@astivahealth.com and return it to us with your enrollment application. It is important that all sections in this form are completed to accurately process your enrollment request. Astiva Health must confirm your chronic condition with your doctor within 30 days of the effective date of enrollment. If we are unable to verify your chronic condition, we need to disenroll you from this plan.

This form must be submitted with the enrollment application for Astiva Health C-SNP Savings (HMO) 007 and C-SNP Premium (HMO) 008.

First Name:	MI:	Last Name:
Gender: ☐ Male ☐ Female ☐ Non-Binary		DOB:

Clinical Pre-Qualifying Questions

If the applicant answers "Yes" or "Not Sure" to any of the following questions, then the beneficiary pre-qualifies for the SNP

Diabetes						
Have you been diagnosed with diabetes?	☐	Yes	☐	No	☐	Not Sure
Have you had problems with high blood sugar?	☐	Yes	☐	No	☐	Not Sure
Do you take medication and/or have you been put on a special diet to control your blood sugar?	☐	Yes	☐	No	☐	Not Sure
Do you check your blood sugar at home?	☐	Yes	☐	No	☐	Not Sure
Have you had problems with fluid retention in your lungs or swelling in your legs due to heart problems?	☐	Yes	☐	No	☐	Not Sure
Do you take medication to prevent fluid retention?	☐	Yes	☐	No	☐	Not Sure
Have you presented increased thirst, frequent urination, extreme hunger, unexplained weight loss, slow healing sores, or frequent urination?	☐	Yes	☐	No	☐	Not Sure
Cardiovascular Disorders						
Have you been diagnosed by your doctor or other licensed healthcare professional with cardiac arrhythmia, or coronary artery disease (Angina), blood clots or vascular disease of legs?	☐	Yes	☐	No	☐	Not Sure
Have you had or been told you're at risk of having a heart attack?	☐	Yes	☐	No	☐	Not Sure
Do you have swelling in the lower body?	☐	Yes	☐	No	☐	Not Sure
Have you had problems with chest pain or tightness, shortness of breath, heart attack, or stroke?	☐	Yes	☐	No	☐	Not Sure
Have you received a stent in your heart?	☐	Yes	☐	No	☐	Not Sure
Do you have a pacemaker, or do you take any medications for abnormal heart rhythm?	☐	Yes	☐	No	☐	Not Sure
Have you ever smoked?	☐	Yes	☐	No	☐	Not Sure

Chronic Heart Failure (CHF)						
Have you been diagnosed by your doctor or other licensed healthcare professional with chronic or congestive heart failure (CHF)?	☐	Yes	☐	No	☐	Not Sure
Do you have high blood pressure?	☐	Yes	☐	No	☐	Not Sure
Have you had problems with fluid retention in your lungs or swelling in your legs due to heart problem?	☐	Yes	☐	No	☐	Not Sure
Do you take medications to prevent legs or hand swelling?	☐	Yes	☐	No	☐	Not Sure
Do you feel fatigue when walking or doing physical activity?	☐	Yes	☐	No	☐	Not Sure
When you walk, do you need to stop and rest?	☐	Yes	☐	No	☐	Not Sure
Have you had problems with rapid, erratic heartbeats?	☐	Yes	☐	No	☐	Not Sure
Do you take a water pill due?	☐	Yes	☐	No	☐	Not Sure
Has a physician ever told you that you have a blood clots?	☐	Yes	☐	No	☐	Not Sure

Medication Questions

1. Are you now or have you ever taken medication for an illness listed above?
   Yes ☐ No ☐ Not Sure ☐
2. Have you ever taken or currently taking metformin or insulin injections?
   Yes ☐ No ☐ Not Sure ☐

Current Medications List

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med

Primary Physician: _____

Name of Physician

_____

Physician or Clinic location and phone number

Specialist: _____

Name of Specialist

_____

Specialist or Clinic location and phone number

Candidate Signature:_____ Date: _____

POST ENROLLMENT CONTINUITY OF CARE FORM

After you complete the Enrollment Packet, please complete the following information and fax to 1-949-522-8553 or email to enrollment@astivahealth.com

Member Name:_____Phone:_____Date: _____

Post Enrollment Questions

1. Are you currently using durable medical equipment or medical devices? ❑ Yes ❑ No

1a. If "Yes" Please specify which one of the following:	❑ Bath Chair ❑ Cane ❑ Catheters ❑ Commode ❑ CPAP machine /Sleep Apnea ❑ Diapers ❑ Hospital Bed	❑ Oxygen ❑ Pressure mattress ❑ Toilet seats ❑ Walker ❑ Wheelchair ❑ Other: _____ ❑ Other: _____
1b. If "Yes" Who is servicing the equipment or medical devices?	Name:_____ Phone:_____ Address: _____ _____	
2. Are you receiving active care from a medical specialist, or do you see a special doctor for treatment of cancer, a heart condition, diabetes, or other medical condition?	❑ Yes ❑ No (If yes, who?) Name:_____ Phone:_____ Address: _____ _____	
3. Are you currently receiving home health services?	❑ Yes ❑ No (If yes, who?) **Company:**_____ Phone:_____ Address: _____	
4. Do you need transportation to and from your appointments? * * Not all plans provide transportation coverage	❑ Yes ❑ No If no, please call Astiva Health Member Services at 1-866-688-9021, TTY 711	

Additional contact information: caretaker, relative(s) or support person(s)

Name:_____Phone:_____Relationship: _____