AETNA BETTER HEALTH® OF OHIO

Transition of Care form

Please complete this form and return it in the envelope provided.

Member information

Name: _____ Date of birth: _____
Member ID#: _____ Phone number: _____
Street address: _____ City, State, Zip: _____
Your name (if you are not the member): _____

Current care

1. Have you chosen a doctor? ☐ Yes ☐ No
   If yes, doctor's name _____ Phone number _____
2. Have you scheduled an appointment with your doctor? ☐ Yes ☐ No
3. What other doctors do you see?
   Doctor's name _____ Phone number _____
   See this doctor for _____ Phone number _____
   Doctor's name _____ Phone number _____
   See this doctor for _____ Phone number _____
4. Are you pregnant or have you had a baby in the last 30 days? ☐ Yes ☐ No – skip to question 6
   If "yes," when are you due or when did you deliver? _____
5. Do you have a doctor for this pregnancy? ☐ Yes ☐ No
   Doctor's name _____ Phone number _____
6. Are you currently getting any services in your home? ☐ Yes – list service & Agency ☐ No
   ☐ Home Health Agency: _____
   ☐ Personal Care or Homemaker Agency: _____
   ☐ Physical, speech or occupational therapy Agency: _____
   ☐ Services from a nurse Agency: _____
7. Are you currently using durable medical equipment (like a wheelchair, oxygen or breathing machine)?
   ☐ Yes Do you ☐ own or ☐ rent the equipment? Agency: _____
   ☐ No
8. Are you scheduled for or receiving any of the following outside of the home? ☐ Yes ☐ No
   ☐ Mental health treatment ☐ Physical, speech or occupational therapy ☐ Cancer treatment
   ☐ Rehabilitation therapy ☐ Other supports/services in your home ☐ Adult Day Health
   ☐ Transportation services ☐ Substance abuse treatment ☐ Elective surgery
   ☐ Dialysis ☐ Other
   Notes/Providers of the above services: _____

Medications

1. Are you taking medications or using any injectable medication(s), other than insulin? ☐ Yes ☐ No
2. Do you expect any problems getting your prescription(s) filled over the next 90 days? ☐ Yes ☐ No

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Health Information History

1. How many times have you been treated in the emergency room in the past six months? _____
2. How many times have you been in the hospital in the past six months? _____
3. Have you been told you have any of the following? (Please check all that apply.)
   - ☐ Asthma ☐ Chronic obstructive pulmonary disease (COPD) ☐ Substance abuse needs
   - ☐ Diabetes ☐ Congestive heart failure (CHF) ☐ Mental health needs
   - ☐ HIV / AIDS ☐ Coronary artery disease (CAD)
   - ☐ Cancer Type: _____
   - ☐ Organ transplant Type: _____
   - ☐ Other Describe:
4. Are you or a dependent enrolled in special programs, such as HCBS or home care waiver? (Please check all that apply.)
   - ☐ Waiver for a person over the age or 60 or 65
   - ☐ Waiver for a person with a physical disability (PD)
   - ☐ Waiver for a person with an Intellectual/Developmental Disability (IDD)
   - ☐ Other waiver/program Describe: _____
5. Are you having problems getting care that you need? ☐ Yes ☐ No
6. Do you have any concerns where you may need help from a case manager or a counselor? ☐ Yes ☐ No
   If yes, what is the best way to reach you? _____
7. What is your language preference? ☐ English ☐ Spanish ☐ Other: _____
   Please describe any other communication needs: _____
   Do you speak and understand English well? ☐ Yes ☐ No

You can get this information for free in other languages. Call 1-855-364-0974, TTY 711, 24 hours a day, 7 days a week. The call is free.

Puede obtener esta información en otros idiomas de manera gratuita. Llame al 1-855-364-0974 y TTY al 711, 24 horas al día, siete días de la semana. Esta llamada es gratuita.

Aetna Better Health of Ohio is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

Please complete and return in the addressed envelope to:
Aetna Better Health of Ohio
Attn: Care Management
7400 W. Campus Rd.
New Albany, OH 43054-8725

Questions? Call toll-free **1-855-364-0974 (TTY: 7-1-1)** or visit **www.aetnabetterhealth.com/ohio**.