Aetna Better Health® of Ohio, MyCare Ohio (Medicare-Medicaid Plan)

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: _____

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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

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
☐ Diabetes
☐ HIV / AIDS
☐ Cancer Type: _____
☐ Organ transplant Type: _____
☐ Chronic obstructive pulmonary disease (COPD)
☐ Congestive heart failure (CHF)
☐ Coronary artery disease (CAD)
☐ Substance abuse needs
☐ Mental health needs
Describe
☐ Other:

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

Please complete and return in the addressed envelope to:
Aetna Better Health of Ohio
Attn: Care Management
7400 W. Campus Rd.

Aetna Better Health® of Ohio, MyCare Ohio (Medicare-Medicaid Plan)

New Albany, OH 43054-8725

Questions?
Call toll-free **1-855-364-0974 (TTY: 711)** or visit **www.AetnaBetterHealth.com/Ohio**.

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.

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-855-364-0974 (TTY:711), 24 hours a day, 7 days a week. The call is free.

ATTENTION: If you speak Spanish or Somali, language assistance services, free of charge, are available to you. Call 1-855-364-0974 (TTY: 711), 24 hours a day, 7 days a week. The call is free.

ATENCIÓN: Si habla español o somalí, tiene a su disposición servicios de idiomas gratuitos. Llame al 1-855-364-0974 (TTY: 711) las 24 horas del día, los 7 días de la semana. Esta llamada es gratuita.

FIIRI: Haddii aad ku hadasho Isbaanish ama Soomaali, adeegyada lluqadda, oo bilaash ah, ayaa laguu heli karaa adiga. Wac 1-855-364-0974 (TTY: 711), 24 saacadood maalintii, 7 maalmood todobaadkii. Wicitaanku waa bilaash.