ROBUST INITIAL INQUIRY FORM FOR BROKERS AND IOAs

BROKER / IOA INFORMATION

Name:

Email:

Broker NPI number:

FMO Name:

Phone Number:

Agency: *(if any)*

Notes:

PROCEED TO PG. 2

PROSPECTIVE PARTICIPANT DEMOGRAPHICS

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First name: _____ **Middle name:** _____

Last name: _____ **Email:** _____

Date of Birth: _____ **Age:** _____ **Gender at birth:** _____

Preferred telephone #: _____ **Best Time to Call:** _____ _____

Social Security Number: _____ **Copy of card:** ◯ **Yes** ◯ **No**

(Request a copy of the card via email or fax)

Preferred Language: _____ **Secondary Language:** _____

Facility / Center Name: _____

Address Street: _____ **Bldg/Apt#:** _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____ **Country:** USA

US Citizen? ◯ **Yes** ◯ **No** **Does the Participant receive mail at this address?** ◯ **Yes** ◯ **No**

How long has the Participant lived at this address? _____

If lived at this address > 6 mos. Where did they live before, how long and why moved?

If you live with a family/caregiver, who is it? *(Names, relationship)*

Has anyone ever told you that your living situation seems unsafe? ◯ **Yes** ◯ **No**

If "Yes", what are concerns: _____

Do you plan on living in your home after PACE enrollment? ◯ **Yes** ◯ **No**

Are there any discussions or plans of moving from your home to memory care or skilled nursing? ◯ **Yes** ◯ **No**

LIVING SITUATION *(Check where applicable)*

- ☐ **Private Home/Apt**
- ☐ **Assisted Living**
- ☐ **Residential Care Facility (RCFE)**
- ☐ **Board and Care**
- ☐ **Homeless**
- ☐ **Alone**
- ☐ **With family/caregiver**
- ☐ **With Roommates**
- ☐ **Skilled Nursing Facility (SNF)**
- ☐ **Other** _____

PROCEED TO PG. 3

DECISION MAKING AUTHORITY

DECISION MAKING AUTHORITY / ADVANCED DIRECTIVE

Do you have someone who makes healthcare decisions for you, if someone other than yourself? ◯ **Yes** ◯ **No**

Name: _____

Relationship: _____ **Phone #:** _____

Do they have documented Power of Attorney for Health Care and/or Finances? ◯ **Yes** ◯ **No**

DPOA for Health Care: _____

Name: _____

Relationship: _____ **Phone #:** _____

DPOA for Finance: _____

Name: _____

Relationship: _____ **Phone #:** _____

**Notify prt and DPOA that a copy will be needed by fax or email (or at the HV if other methods are unavailable)*

Do you have an Advanced Directive in case of emergency? ◯ **Yes** ◯ **No**

Do you have any plans to leave the area in the next 30- 60 days? *(vacation, move, leave the country)* ◯ **Yes** ◯ **No**

If "Yes", provide date: _____

PROCEED TO PG. 4

MEDICAL ELIGIBILITY SCREENING

MEDICAL ELIGIBILTY SCREENING

Please describe your current health and medical conditions:

Diabetes: **Heart problems:**

Dialysis: **High Blood Pressure:**

COPD: **Pain Issues:**

Oxygen use: **Memory Problems:**

Mental Health: *(depression, anxiety, bipolar)*

How many falls in the last Month / Year?

Worsening? ◯ **Yes** ◯ **No** **Have You Seen an Increase in Falling?** ◯ **Yes** ◯ **No**

Do you walk unassisted? ◯ **Yes** ◯ **No** **Are you using a motorized/electric wheelchair?** ◯ **Yes** ◯ **No**

What medications are taken on a regular basis? *(list all including over the counter?)*

Are you taking any medications that were not prescribed specifically for you? *(pain pills, uppers, sleeping pills, etc.)*
How much, how often?

Do you take or use any illicit drugs? *(marijuana, cocaine, methamphetamines)* ◯ **Yes** ◯ **No**

How much? **How often?** **When was the last time you used?**

Do you receive any help at home? ◯ **Yes** ◯ **No** **Hours per week:**

Type: **How many hours?** **Who is the IHSS provider?**

Name: **Phone #:**

Other notes:

What kinds of help do you receive?

☐ **Bathing** ☐ **Dressing** ☐ **Eating** ☐ **Meals** ☐ **Toileting** ☐ **Ambulation**

☐ **Transferring** ☐ **Medication management** ☐ **Shopping** ☐ **Other:**

Willing to change home care providers to PACE: ◯ **Yes** ◯ **No**

Do you use assistive devices to walk, bathe, shower, get out of a chair or bed? ◯ **Yes** ◯ **No**

☐ **Walker** ☐ **Cane** ☐ **Lift** ☐ **Scooter** ☐ **Tub grab bars**

☐ **Shower chair, Shower** ☐ **Lifting recliner chair** ☐ **Other:**

Are there firearms in the home? ◯ **Yes** ◯ **No** **Locked up and away from ammunition?** ◯ **Yes** ◯ **No**

Are there pets in the home? *(Dogs / Cats / Reptiles / Birds)* ◯ **Yes** ◯ **No**

If vicious how are they secured?

PROCEED TO PG. 5

PCP / SPECIALIST INFO

CURRENT PRIMARY CARE PROVIDER / SPECIALIST INFO

Are you willing to receive care from a new Primary Care Provider? ◯ **Yes** ◯ **No**

Current PCP Name: _____ **Phone:** _____

Current PCP Address: _____ **Fax:** _____

Are you seeing a specialty provider? ◯ **Yes** ◯ **No** **If so, Specialty Type:** _____

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

Reason for seeing this provider? _____

Are you seeing another specialty provider? ◯ **Yes** ◯ **No** **If so, Specialty Type:** _____

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

Reason for seeing this provider? _____

Are you seeing another specialty provider? ◯ **Yes** ◯ **No** **If so, Specialty Type:** _____

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

Reason for seeing this provider? _____

Do you have a Psychiatrist or Therapist? ◯ **Yes** ◯ **No**

Name: _____ **Phone:** _____

Address: _____

Reason for seeing this provider? _____

PROCEED TO PG. 6
FINANCIAL ELIGIBILITY SCREENING

FINANCIAL ELIGIBILITY SCREENING

How is your name listed on your Medi-Cal/ Medi-Care Card?

Medi-Cal eligibility active date: **Medi-Cal#:** **Social Security#:**

Provide details of any pending issues with Medi-Cal:

Does this prosect need help with Medi-Cal applications? ◯ **Yes** ◯ **No**

If "Yes", were all documents collected? ◯ **Yes** ◯ **No**

Are you in the renewal process for Medi-Cal? ◯ **Yes** ◯ **No**

Is there Share of Cost (SOC) for Medi-Cal? ◯ **Yes** ◯ **No**

Willing to pay SOC? ◯ **Yes** ◯ **No**

Amount of SOC:

Is your Medi-Cal in another county? ◯ **Yes** ◯ **No**

Medicare Eligible: Medicare#:

Name of other insurance provider:

To be completed by the Benefits Enrollment Coordinator:

Date of Verification:

Medi-Cal verified? ◯ **Yes** ◯ **No**

Medicare verified, if eligible? ◯ **Yes** ◯ **No**

☐ **Provide printed AVES report to assigned marketing team member**