Disability and Health Information Questionnaire

Applicant Name: _____

Applicant Birth Date: _____

To understand your immediate health needs and better coordinate your health care once you are enrolled in PHP (HMO SNP), we would like to ask you the following questions about your health history. This information will be used by your Registered Nurse Care Manager to assess your health. Any information you provide on this form will not affect your current or future enrollment in the plan. If you choose not to complete this questionnaire, your current or future enrollment in the plan will also not be affected.

1. Did you become eligible for Medicare because of a disability?
   - ☐ Yes *If "yes," please skip to question 3.*
   - ☐ No

2. Did you become disabled *after* you became eligible for Medicare?
   - ☐ Yes
   - ☐ No *If "no," skip to question 5.*

3. What health condition caused you to become disabled? _____

   _____

   _____

4. On what date did you become disabled? _____
   (month/year)

5. For which health condition(s) are you being treated by your doctors? _____

   _____

   _____

   _____

6. What medications are you currently taking? _____

   _____

   _____

   _____

PHP is an HMO plan with a Medicare contract. Enrollment in PHP depends on contract renewal.