



**Chronic Illness Pre-Enrollment  
Qualification Assessment**

**Erickson<sup>®</sup> Advantage Champion Plan**



# Chronic Illness Pre-Enrollment Qualification Assessment

Applicant Name: \_\_\_\_\_ Medicare ID#: \_\_\_\_\_

Below are the Clinical Qualifying Questions for the Erickson Advantage® Champion Plan. Yes to any one question, unless noted differently, will pre-qualify the beneficiary for the plan.

**HEART: Congestive Heart Failure (CHF), Cardiovascular Disease, Coronary Artery Disease (Heart Attack)**

1. Have you ever had a heart attack?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
2. Have you ever had cardiac bypass surgery (open heart surgery)?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
3. Have you ever had an angioplasty or stent?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
4. Have you been told by a doctor or clinic that you have heart failure (weak heart)?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
5. Have you ever had valve replacement surgery?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
6. Have you had a cardiac arrest?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
7. Do you have a pacemaker and/or defibrillator?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
8. Have you ever had an operation to get rid (ablation) of a heart arrhythmia?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
9. * Do you have a heart arrhythmia (funny rhythm) which requires you to take medication?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
10. * Have you ever experienced chest pain (angina) and was told by your doctor or clinic it was heart-related?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure

\* "Yes" to question 9 or 10 only requires further verification.

**LUNG: Chronic Obstructive Pulmonary Disease (COPD), (Chronic Lung Disease, Emphysema, Asthma, Asthmatic Bronchitis)**

1. Have you ever been told by a doctor or clinic that you have COPD (chronic), chronic Bronchitis, emphysema and/or chronic asthma?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
2. Do you suffer from chronic coughing or shortness of breath for which you have been prescribed or are taking medicine?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
3. Have you smoked for 20 years or more and, if so, do you have a chronic cough or shortness of breath?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
4. Have you been prescribed or are you taking a medication or oxygen for any chronic lung disease such as COPD (chronic obstructive pulmonary disease), chronic Bronchitis, emphysema and/or chronic asthma?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure

**DIABETES: Diabetes (Sugar Diabetes, Sugar)**

1. Have you ever been told by a doctor or clinic that you have diabetes (too much sugar in the blood)?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
2. Have you been prescribed or are you taking insulin or an oral medication that is supposed to lower the sugar in your blood?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure

**HIGH BLOOD PRESSURE: Hypertension (High Blood Pressure)**

1. Have you been diagnosed by your doctor as suffering from “hypertension” or “high blood pressure?”	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
2. Do you take medication regularly to control hypertension or high blood pressure?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure

**ARTHRITIS: Rheumatologic Disease (Arthritis)**

1. Have you been diagnosed by your doctor as suffering from arthritis or rheumatism?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
2. Have you had joint replacement surgery for arthritis; or do you take medication for arthritis?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure

**DEMENTIA: Dementia (Senile Dementia, Senility, Alzheimer’s disease, Vascular or Multi-Infarct Dementia, Parkinson’s Dementia)**

1. Does the applicant have memory loss that interferes with daily activities?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
2. Has the applicant been told by a doctor or clinic that they have any form of dementia or Alzheimer’s disease?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
3. *Is the applicant taking either Namenda® or Aricept® for Alzheimer’s disease?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure

\* A “yes” answer requires further verification.

**Important: Health Risk Assessment Questions**

**Completion of this section is not required for enrollment in the plan.** *Answers to the questions in this section will assist Erickson in understanding your health care needs better. This information will help us make sure you get access to appropriate care management as quickly as possible.*

**Which of the following statements fits you best in terms of health?**

- Must stay in bed all or most of the time
- Must stay in the house all or most of the time
- Need the help of another person in getting around inside or outside the house
- Do not need the help of another person or a special aid but have trouble getting around freely
- Not limited in any of these ways
- Not sure

**Do you need help at home because of health problems and unable to get help?**  Yes  No

**In the previous 12 months have you stayed overnight as a patient in a hospital?**  Yes  No

If Yes, please check frequency:  1 time  2-3 times  4 or more times

**Are you currently being treated for or do you have serious memory loss?**  Yes  No



Open to complete the Chronic Illness  
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