Horizon Blue Cross Blue Shield of New Jersey

1700 American Blvd.
Pennington, NJ 08534
HorizonBlue.com

Dear Valued Member:

Thank you for choosing Horizon NJ TotalCare (HMO SNP). We are committed to giving you access to quality health care and personal service.

To help you meet your health care goals, attached is a **Health Needs Survey**. The survey is a simple tool that allows us to help you identify health risks so we can give you feedback that can help your overall health.

During the next two weeks, please answer the questions in the survey, place it in the self-addressed, stamped envelope provided and mail it to the following address:

Horizon NJ TotalCare (HMO SNP)
Attn: DSNP Care Management
250 Century Pkwy
Mount Laurel, NJ 08054

The personal health information you provide is private and has no effect on your health care benefits.

Based on the health risks identified in your survey response, you may receive a phone call from one of our professional Care Managers to talk about how we can help you manage your health.

If you have any questions, please call **1-800-621-5894** (TTY/TDD **711**). We are available to assist you Monday through Friday, between 8 a.m. and 5 p.m., Eastern Time.

Sincerely,

Carol Smolij

Carol Smolij, BSN, RN, CPHQ
Director, Dual Special Needs Plan
Horizon NJ TotalCare (HMO SNP)

ENCLOSURE

Please detach Survey sheet, fold and place into self-addressed, stamped envelope provided and mail it to Horizon NJ TotalCare (HMO SNP).

Horizon NJ TotalCare (HMO SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-543-5656** (TTY/TDD **711**). This document is also available in other languages, as well as other formats, such as large print and Braille.

Spanish (Español): Para ayuda en español, llame al **1-800-543-5656** (TTY/TDD **711**).
Chinese (中文)：如需中文協助，請致電 **1-800-543-5656** (TTY/TDD **711**)。

Horizon Healthcare of New Jersey, Inc. ("HHNJ") has contracts with both CMS and the State of New Jersey Medicaid Program to provide a HMO Medicare Advantage Dual Special Needs plan. Enrollment in Horizon NJ TotalCare (HMO SNP) depends on contract renewal. Products are provided by HHNJ, however, communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. Both companies are independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® names and symbols are registered marks of the Blue Cross and Blue Shield Association. The Horizon® name and symbols are registered marks of Horizon Blue Cross Blue Shield of New Jersey.

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HEALTH NEEDS SURVEY

Member Information

Name:	Date:	
Horizon ID #:	Birth Date:	
Address:		
City:	Zip:	State:
Phone Number:	Cell Phone Number:	
Can we send you a text? ❑ Yes ❑ No		
Do you have a POA/Personal Representative? ❑ Yes ❑ No		
If yes, Name:	Phone:	
Doctor Name:	Phone:	

Health Information

How many times have you been admitted to the hospital in the last 6 months ?

❑ No Admissions
❑ 1 Admission
❑ 2 Admissions
❑ 3 or more Admissions

Comments: _____

How many Emergency Room visits in the last 6 months have you had that did not result in an inpatient hospital stay?

❑ 0 - 1 Visit
❑ 2 - 4 Visits
❑ 5 or more Visits

Comments: _____

Do you have any planned future admissions or surgeries? ❑ Yes ❑ No

If Yes, please describe: _____

_____

Rate your overall health: ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

Comments: _____

_____

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HEALTH NEEDS SURVEY

Do you have any of the following conditions? Check all that apply.

- ❑ Asthma
- ❑ COPD
- ❑ Tuberculosis
- ❑ Seizures
- ❑ Memory Problems
- ❑ Depression
- ❑ Schizophrenia
- ❑ Congestive Heart Failure
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Diabetes
- ❑ Kidney Failure
- ❑ On Organ Transplant List
- ❑ Paralysis
- ❑ Stroke
- ❑ Multiple Sclerosis
- ❑ HIV/AIDS
- ❑ Cancer with treatment
- ❑ Lead Poisoning
- ❑ Sickle Cell Disease
- ❑ Autism
- ❑ Hemophilia
- ❑ Pregnancy
- ❑ Cerebral Palsy
- ❑ Congenital Heart Anomalies
- ❑ Intellectually Challenged
- ❑ Stomach Ulcer

Comments: _____

_____

_____

_____

Do you use four or more prescribed medications? ❑ Yes ❑ No

List all prescriptions: (Put a line through prescriptions your doctor says you should take but are not taking.)

Prescription Medication	Dose	How Often?	How Taken?

Do you use any medical equipment or supplies (such as cane/walker/crutches) or diabetic supplies? ❑ Yes ❑ No

Comments: _____

_____

_____

Do you need help with Activities of Daily Living (such as bathing, dressing, toileting, feeding)? ❑ Yes ❑ No

Describe the help you need: _____

_____

_____