Medicare Needs Assessment

Note to Brokers:

This tool is intended to help identify and understand:

- The client's current situation
- The client's ultimate needs and budget

Once you have determined the client's needs and budget, present the product solution that best meets their needs.

Needs Assessment Questionnaire

Demographics

Client Name ____

Permanent Address ____

City ______________________________________State___________ Zip Code_________________

Mailing Address ____

City ______________________________________State___________ Zip Code_________________

Phone _____________________________________Email_______________________________________

Emergency Contact Name___________________________Relationship___________________________

Phone _____________________________________Email_______________________________________

Medicare Eligibility

Are you a current Medicare beneficiary or new to Medicare? CURRENT NEW

Effective Date Part A_______________________ Effective Date Part

B____________________________ Why do you want to change your coverage now?

Aging in Moving Change in Finances Annual Review Other ______________________

Do you have a Healthcare POA or someone who helps with medical decisions? POA Helper

Name____________________________________ ______Relationship__________________________

Phone_____________________________________Email_______________________________________

Current Coverage

ACA Cobra VA Tricare Original Medicare Med-Supp PDP

Company-Provided Plan (currently working) Company-Provided Retirement Plan

Medicare Advantage Medicare Advantage Special Needs Plan

Dental Vision Hearing

Carrier: ___________________ Plan: _________________________ Premium: __________

Carrier: ___________________ Plan: _________________________ Premium: __________

Carrier: ___________________ Plan: _________________________ Premium: __________

Carrier: ___________________ Plan: _________________________ Premium: __________

Carrier: ___________________ Plan: _________________________ Premium: __________

Fact Finding

This guide is provided by CareFree Insurance Services for use during the sales process by a licensed insurance agent. Information contained in this questionnaire will be protected under the federal Protected Health Information guidelines. The information contained in this questionnaire will not be used for any other purpose or shared with any other entities.

How do your monthly premiums fit into your budget? ____

Would you like information about programs that may help cover costs? Yes No

What is prompting you to review your coverage today? ____

If you could change anything about your healthcare coverage what would it be?

Premium Cost Copay/Coinsurance Costs Providers Benefits Plan Structure
Other____

What parts of your current coverage do you like? ____

Do you currently have a Primary Care Physician (PCP)?Yes No

If so, who? Name__________________________________Location___________________________

Would you consider changing your Primary Care Physician if it meant getting into a plan that better suits your needs? Yes No

Do you understand how networks (i.e., provider and/or pharmacy) work? Yes No

How do you feel about physician referrals for certain services?________________________________

Are there any prescriptions that need to be included in a plan, that you'd like to preview the cost?

Prescription(s)____

What do you consider to be the most important aspects of medical coverage? (Select any that apply)

Providers

Prescription Inclusion and Cost

Premium and Copay/Coinsurance Cost

Plan extras, like Gym Membership, Transportation, Dental, Vision, an Over the Counter benefit (depending upon local availability)?

Anything else? ____

Would you like information about any plans in the area that may offer special coverage for beneficiaries with certain medical conditions, including diabetes, heart conditions, or Chronic Obstructive Pulmonary Disease (COPD) (depending upon local availability)? Yes No

Are you concerned about paying for things like copays, deductibles, and coinsurance? Yes No

What coverage do you have to help pay for what your Medicare plan does not pay? _______________

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Coverage Decision Grid

Note to Broker: After analyzing the client's needs, complete this form with the client and explain the options presented. Complete a full and compliant benefits presentation on the client's preferred plan.

Decision Drivers	Option 1 Plan Name: ____________ Plan Type: _____________	Option 2 Plan Name: ____________ Plan Type: _____________	Option 3 Plan Name: _____________ Plan Type: ______________
Premium/Costs for each option			
Provider/ Prescription for each option			
Important Plan Benefits for each option			
Other Factors for each option			

Plan Choice (circle one)	Option 1	Option 2	Option 3
Client Signature			

Future Consent to Contact

I am not interested in a plan at this time. If I chose to complete the information below, I agree to allow this agent to contact me within the timeframe below about health plans, services and/or education information related to health care.

Client Signature			
Date			
Select contact method(s)	**Phone #** ______________	**Text #** _________________	**Email** __________________
Select contact time frame	**For a period of one month from today**	**To review next year's choices (10-1 to 12/7)**	**Other (please specify)** ________________________

To contact a client in AEP, the AEP box must be checked and form signed & dated by the client. Agents must save this form as back-up documentation for contact verification.

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