Steve Shorr Insurance
Learn More==> https://wp.me/P50DOs-25r

Needs Assessment Worksheet

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Medicare Part A? _____ Effective Date: _____

Medicare Part B? _____ Effective Date: _____

If No, when will they become eligible? _____

Medicaid (Medi-Cal in CA)? _____

Age: _____

Living at Home or in a Facility? _____
County of Residence: _____
Zip Code: _____
Travel to other States or Countries during the year? _____

Current Medical Coverage Type:	Company Name:	Plan Name:	End Date:

Primary Care Physician:	Medical Group(s)	PCP ID #	Accepting New Patients?	Existing Only?	Closed?
			☐	☐	☐
			☐	☐	☐

Specialists: (Name and Specialty)	Medical Group(s)	In Network?

Preferred Hospital:

Steve Shorr Insurance

Learn More==> https://wp.me/P50DOs-25r

Needs Assessment Worksheet

Medications:	Dosage:	Frequency:	In Formulary?	Tier	Co-Pay

Current Pharmacy:_____ In Network? _____

Transportation? _____

Diabetic Supplies Needed? _____

Hearing Aids? _____

Durable Medical Equipment Needs:

Oxygen?_____

Wheelchair?_____

Walker?_____

Other? _____

Chronic Illness? _____