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Supplement to ConnectiCare® SOLO Application
MENTAL HEALTH QUESTIONNAIRE

Name of primary applicant: _____ ID/SSN:

Name of person related to condition: _____

1. Please check off one of the following conditions that best applies to you:

- | | | |
|---|---|---|
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Major/Minor Depression | <input type="checkbox"/> Anorexia/Bulimia |
| <input type="checkbox"/> OCD | <input type="checkbox"/> Stress/Anxiety | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Situational Depression | <input type="checkbox"/> Manic Depression | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Other: _____ | | |

1. Please check all of the symptoms you have experienced related to your condition:

- | | | |
|---|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Inability to concentrate | <input type="checkbox"/> weight loss/gain |
| <input type="checkbox"/> Heart palpitations | | |
| <input type="checkbox"/> Other: _____ | | |

2. When were you diagnosed? _____. Date of your last symptom? _____.

3. Please check off your treatment type from the following (if more than one type indicate so):

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Inpatient therapy | <input type="checkbox"/> outpatient therapy |
| <input type="checkbox"/> Counselor | | |
| <input type="checkbox"/> Other _____ | | |

4. When did your treatment begin? _____ Has your treatment stopped? Yes or No _____. If yes, when did the treatment stop? _____. If no, how often did this treatment take place? _____

5. If your treatment is medication, please provide the name of the medication, the dosage and the frequency with which you take it. _____
Have you had any medication changes in the past 6 months? Yes or No: _____. If yes, please explain(when, what from-what to, any plans for further changes, etc.):

6. Have you been hospitalized for this, or a similar condition? Yes No. _____. If yes, provide complete details regarding date(s) of hospitalization, duration of stay and name of facility:

7. When you experience symptoms for this condition, How do they impact your activities of daily living? _____

Please provide the name, address, and phone number of the most recent treating physician or health care practitioner seen for this condition:

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (or parent/guardian if under 18): _____

Today's Date: _____