



Any person who knowingly presents a false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison."

**APPLICATION FOR LONG TERM CARE BENEFITS
TO BE COMPLETED BY THE ATTENDING PHYSICIAN**

1. Patient's Name:	Date of Birth:	Policy Number:
Patient's Address:		
2. Principal Diagnoses:		
ICD9 Code(s):	Date Diagnosed:	Recurring Condition(s)? () Yes () No
If Yes, please describe previous occurrences and dates.		
3. Is condition due to injury or sickness? ☐ Yes ☐ No Please explain.		
4. Has the patient been confined in a hospital or nursing facility within the past 5 years? () Yes () No		
If Yes, when and where:		
5. Is dependency in functional status due to organic mental impairment (i.e. Alzheimer's Disease or related disorders)?		
() Yes () No		
If Yes, please indicate how you arrived at the diagnosis (i.e. history, physical exam, diagnostic testing, mental status exam, and evidence from previous treatment):		
Type of mental status testing :		Score:
6. Is the patient competent to endorse checks or drafts and direct the use of the proceeds? () Yes () No		
If No, who handles their financial affairs?		
7. Patient Capabilities and Limitations. Indicate each activity of daily living the patient cannot perform without human assistance:		
A. Eating	☐	Date Capability Ended
B. Toileting	☐	Expected Recovery Date
C. Transferring	☐	
D. Bathing	☐	
E. Dressing	☐	
F. Continence	☐	

8. If patient is residing at home, what services are being provided (check appropriate box)?

A. Skilled Services	B. Support Services	C. Family/Informal	D. Equipment
() Nursing	() Home Health Aide		() Wheelchair
() Therapist	() Homemaker		() Cane
() Hospice	() Adult Day Care		() Prosthesis
() Other Specify _____	() Hospice (Palliative)		() Walker
	() Respite		() Other Specify _____
	() Emergency Response System		
	() Other Specify _____		

9. If the patient is confined in an institution, could the patient be cared for under Home Care? () Yes () No

10. Recommended Plan of Care (include any treatments or therapies prescribed, including expected duration) to improve or maintain current functional status:

11. Prognosis and Goals (check appropriate box):

- () Improvement in functional status expected – less than 3 months.
- () Improvement in functional status expected – 3 to 6 months.
- () No change in functional status expected.
- () Deterioration in functional status expected – less than 3 months
- () Deterioration in functional status expected – 6 to 12 months

Date _____ Physician's Name _____ Tax ID/SS # _____

Physician's Signature _____ Phone: (____)-____-____

Street Address _____ City _____ State ____ ZIP Code _____