

ATTN: Claims Department

FACILITY CERTIFICATION OF CARE

INSTRUCTIONS FOR CLAIMANT:

1. Please read and sign. (Use blue or black ink only.)
2. Give this form to the Long-Term Care Facility for completion.

Claimant Name _____ Policy Number _____

Signature of Claimant _____ Date _____

INSTRUCTIONS FOR THE LONG-TERM CARE FACILITY:

1. Please complete this form, and attach a copy of:
 - 1) Physician's signed plan of care – including the diagnosis and treatments prescribed.
 - 2) Initial assessment.
 - 3) Copy of the license for the unit where the Insured is confined.
 - 4) Narrative charting, nurses notes and CNA flow sheets.
2. Please return the completed form and copies to the address above.

Name of Long-Term Care Facility _____

Facility Address _____

Telephone Number (_____) _____ Number of Beds _____

Initial Admission Date _____

Discharge Date _____

Subsequent Admission(s) _____, _____, _____

Patient admitted from: Residence Hospital Other _____

Diagnosis on Admission _____

Secondary Diagnosis _____

Name of Attending Physician _____

Is Patient's Stay Medicare-Approved? Yes No If yes, list dates approved _____

FACILITY'S EVALUATION OF PATIENT'S LEVEL OF CARE:

	FROM	TO		FROM	TO
<input type="checkbox"/> Skilled	/ /	/ /	<input type="checkbox"/> Independent Living	/ /	/ /
<input type="checkbox"/> Intermediate	/ /	/ /	<input type="checkbox"/> Retirement Facility	/ /	/ /
<input type="checkbox"/> Assisted Living	/ /	/ /	<input type="checkbox"/> Other	/ /	/ /

Please return the completed forms promptly to the address above.

FACILITY CERTIFICATION OF CARE, continued

PATIENT'S NAME _____ Policy # _____

MENTAL AND COGNITIVE STATUS:

Describe client's assistance with medications:

Facility policy to administer Client self-administers Assistance provided

Describe _____

Does your facility document in a clinical record? Yes No If yes, how often? _____

Does the facility maintain control and records of medications given? Yes No

ACTIVITIES OF DAILY LIVING [ADLs]:

[ADLs]	Performs Completely Independently	Performs Independently Using Assistive Device	Able to Complete Only with Cueing or Supervision of Another Person	Requires Some Human Assistance with Certain Elements of Task	Requires Substantial Assistance with Another Person to Complete
Bathing/Showering/Sponge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence Bladder/Bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Record details of any assistance needed, including type of assistance, how often it is provided, and who provides the assistance _____

If more space is needed, attach a signed and dated sheet and check this box .
 (check only if additional sheet is submitted)

List any assistive devices used by patient (wheelchair, walker, cane, etc.) _____

FACILITY INFORMATION:

Does the facility have a Medical Director or MD available to furnish medical care in case of an emergency? Yes No

If yes, Name _____ Employee of facility? Yes No

Is there a nurse supervising care? Yes No

If yes, how often is the nurse physically present at the facility? _____ hrs/day _____ days/week

How often is nurse on call? _____ hr/day _____ days/week

Is this care provided under a physician's plan of care? Yes No

If yes, how often is the POC updated? _____

Signature of Director of Nursing or Nurse Manager _____

Title _____ Date _____

For Your Protection State Insurance Laws require the following to appear on this form:

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