LiUNA!care

LOCAL 183 ™

MEMBER HEALTH MANAGEMENT SERVICES

APPLICATION FOR LONG TERM CARE BENEFITS

Local 183 Members' Benefit Fund – L183MLTC2401

Local 183 Retiree Benefit Trust Fund – L183RLTC2401

LiUNA!care LOCAL 183
MEMBER HEALTH MANAGEMENT SERVICES

Member Health Management Services
200 Labourers Way, Suite 5400 | Vaughan, ON | L4H 5H9
Tel: 416-240-2104 | Toll Free: 1-866-315-6011 | Fax: 416-240-7047
Email: memberhealthservices@liunacare183.com | liunacare183.com

Long Term Care Benefits

If you or your eligible spouse become unable to perform certain activities of daily living due to physical or cognitive impairment or require substantial supervision to protect your health and safety while covered and require support at home or at a long term care facility, you may be entitled to Long Term Care Benefits.

What are the eligibility requirements?

- You or your eligible spouse must have plan coverage under the Local 183 Members Benefit Fund or the Local 183 Retiree Benefit Fund on the date the need for long term care arose.
- You or your eligible spouse did not require long term care when your plan coverage started.
- You or your eligible spouse must be over the age of 18 when the need for long term care arose.
- You or your eligible spouse must be unable to perform at least two (2) of the six (6) listed ***activities of daily living*** without assistance due to a loss in functional capacity or you or your eligible spouse require ***substantial supervision*** to protect health and safety due to cognitive impairment.
- You or your eligible spouse must be in need of long term care for a period greater than 90 days to receive this benefit (waiting period).
- Care or treatment must be provided in Canada or the United States.
- A surviving spouse of an active member is eligible for a period of up to two (2) years from the member's date of passing while in benefit.

How to apply for Long Term Care benefits?

1. Ensure you meet the eligibility requirements for this benefit listed above.
2. Complete and sign the **Member / Claimant Statement** of the Long Term Care Application Form.

   An authorized representative may complete this form if you are unable to do so.
3. Attach copies of any Power of Attorney documents, if applicable.
4. Ensure the physician(s) overseeing your medical care completes the **Physician Statement**.
5. If you have or are incurring any long term care facility expenses, ensure the **Facility Care Provider Claim Form** is completed and enclosed with your application.
6. If you have or are incurring any home care or home health care expenses, the **Home & Community Care Provider Claim Form** must be completed and returned with your application.
7. The **Member / Claimant** and **Physician Statements** are required to begin assessing your claim.
8. Return the completed application to LiUNAcare Local 183 Member Health Management Services by

	Email:	**memberhealthservices@liunacare183.com**
	Mail:	**200 Labourers Way, Suite 5400 | Vaughan, ON | L4H 5H9**
	Fax:	**416-240-7047**
	Questions:	Email or call us at **416-240-2104** or **1-866-315-6011**

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Long Term Care Benefits

What are the Activities of Daily Living?

- (1) **Bathing** – washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- (2) **Continence** – the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- (3) **Dressing** – putting on and taking off all necessary items of clothing and any necessary braces, fasteners or artificial limbs.
- (4) **Eating** – feeding oneself by getting food, already prepared and made available, into the body from a receptacle (such as plate, cup or table) or by a feeding tube or intravenously.
- (5) **Toileting** – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- (6) **Transferring** – moving into or out of a bed, chair or wheelchair with or without the use of equipment.
- **Substantial Supervision** – continual supervision which may include cueing by verbal prompting, gestures or other demonstrations, by another person to protect the applicant from threats to health and safety.

What does the Long Term Care Benefit Cover?

If you or your eligible spouse meet the eligibility requirements, you may be eligible for the following benefits:

- A maximum **Daily Indemnity Benefit** of up to $50 per day if you qualify as needing long term care.
- A maximum **Additional Daily Reimbursement Benefit** of up to $100 per day towards the actual incurred costs of **home care** or **home health care** services provided by a licenced agency, **hospice care**, and **long-term care facility**.
  - **home care services provided by a licensed agency** for the purpose of providing assistance with the activities of daily living and to allow you or your eligible spouse to remain safely at home,
  - **home health care services provided by a licensed agency** for medically necessary services such as nursing, physical therapy, and occupational therapy, provided in the member or eligible spouse's home.
- A maximum **Respite Care Benefit** of up to $100 per day if receiving the Daily Indemnity Benefit for a maximum of 21 days in each 12-month period following the date of the claim for actual costs incurred for additional home care or home health care services provided by a licenced agency when the insured person's primary unpaid caregiver requires relief from providing such care. Unused portions of this benefit cannot be carried forward.
- A maximum **Home Modification Reimbursement Benefit** of up to $1,000 per period of care for the actual incurred costs for the installation of safety equipment such as safety handrails, grab bars and ramps provided that the costs are incurred within 60 days of the date of eligibility.
- A maximum **Grief Counselling Reimbursement Benefit** of up to $2,000 per period of care for the actual costs of incurred within 365 days of the death of the insured person, for grief counselling for the surviving spouse, caregiver and/or dependent children.
- The **lifetime maximum benefit is $300,000 per person**.

There are certain exclusions and limitations – please refer to the benefit plan booklet for greater detail.

Application for Long Term Care Benefits

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MEMBER / CLAIMANT STATEMENT

All sections of this application must be completed, signed, and submitted to initiate your claim for long term care benefits. If any section of this application is not completed or portions are not answered fully, the assessment of your claim may be delayed. An authorized representative may complete this form if the member or eligible spouse is unable to do so. Attach copies of any Power of Attorney documents, if applicable. Please return to completed application to LiUNAcare Local 183 Member Health Management Services.

MEMBER / CLAIMANT INFORMATION

Member's Name		Union ID Number
Applicant ☐ Member ☐ Member's Spouse	Claimant Name (If not the Member)	
Date of Birth (mm/dd/yyyy)	Primary Telephone Number	Alternate Telephone Number
Address		
Is the Member / Claimant currently residing at the address listed above? ☐ Yes ☐ No		
With whom does Member / Claimant live? ☐ Alone ☐ Spouse ☐ Family Member ☐ Facility		
If Member / Claimant is not residing at the address at the top of this page: Where is the insured currently residing?		
Facility or Relative Name		Telephone Number
Facility or Relative Address		Email Address

AUTHORIZED CONTACT INFORMATION

Name of Authorized Contact filing claim		Relationship to Member / Claimant
Telephone Number	Email Address	Are you the primary contact for questions regarding this claim? ☐ Yes ☐ No
Alternative Authorized Contact person		Relationship to Member / Claimant
Telephone Number	Email Address	Are you the primary contact for questions regarding this claim? ☐ Yes ☐ No

POWER OF ATTORNEY (POA) or LEGAL GUARDIAN

Does Member / Claimant have a Power of Attorney (POA) or Legal Guardian? ☐ Yes ☐ No	POA / Legal Guardian Name	
Relationship to Member / Claimant or Title	Telephone Number	Email Address
Address		Fax Number

A COPY OF POWER OF ATTORNEY DOCUMENTS MUST BE SUBMITTED WITH THIS FORM

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Member / Claimant Name	Union ID	Date of Birth

CLAIM INFORMATION

What is the cause, condition or physical dependency that required the Member / Claimant to seek long term care services?

What is the date the Member / Claimant first sought treatment for this condition?

Are the following expenses being incurred:

☐ Long Term Care Facility or Hospice ☐ Home Health Care ☐ Home Care ☐ Other (Please describe)

Please attach Explanation of Benefits from your other insurer for any services you are also claiming under this Long Term Care Plan.

ACTIVITIES OF DAILY LIVING & SUPERVISION

Please check all Activities of Daily Living for which the Member / Claimant requires assistance and provide details:

Activity	Who provides assistance?	Describe the type of assistance provided:
☐ Bathing		
☐ Continence		
☐ Dressing		
☐ Eating		
☐ Toileting		
☐ Transferring		
☐ Substantial Supervision		

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Member / Claimant Name	Union ID	Date of Birth

CAREGIVER INFORMATION

List all caregivers who currently provide support (include licensed caregivers as well as friends and family members who have been providing assistance). Copy this page to submit additional caregivers or continue on a separate sheet if needed.

1. Agency/Person Name		Relationship to Member / Claimant
Is agency/person a licensed health care professional? ☐ Yes ☐ No	Date Services started (mm/dd/yyyy)	Telephone Number
Address		Fax Number
Describe services provided		

2. Agency/Person Name		Relationship to Member / Claimant
Is agency/person a licensed health care professional? ☐ Yes ☐ No	Date Services started (mm/dd/yyyy)	Telephone Number
Address		Fax Number
Describe services provided		

3. Agency/Person Name		Relationship to Member / Claimant
Is agency/person a licensed health care professional? ☐ Yes ☐ No	Date Services started (mm/dd/yyyy)	Is agency/person a licensed health care professional? ☐ Yes ☐ No
Address		Fax Number
Describe services provided		

4. Agency/Person Name		Relationship to Member / Claimant
Is agency/person a licensed health care professional? ☐ Yes ☐ No	Date Services started (mm/dd/yyyy)	Is agency/person a licensed health care professional? ☐ Yes ☐ No
Address		Fax Number
Describe services provided		

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PRIMARY PHYSICIANS

List all physicians consulted for condition and Primary Care Physician(s) consulted in the **past 5 years**. Copy this page to submit additional physicians or continue on a separate sheet if needed.

1. Physician Name and specialty		
Date first consulted (mm/dd/yyyy)	Date last consulted (mm/dd/yyyy)	Physician Telephone Number
Address		Physician Fax Number

2. Physician Name and specialty		
Date first consulted (mm/dd/yyyy)	Date last consulted (mm/dd/yyyy)	Physician Telephone Number
Address		Physician Fax Number

3. Physician Name and specialty		
Date first consulted (mm/dd/yyyy)	Date last consulted (mm/dd/yyyy)	Physician Telephone Number
Address		Physician Fax Number

HOSPITALIZATIONS / NURSING FACILITY CONFINEMENTS

Please provide details for all hospitalizations/nursing facility confinements in the **1 past year**. Copy this page to submit additional hospitalizations or continue on a separate sheet if needed.

1. Facility Name		
Date admitted (mm/dd/yyyy)	Date discharged (mm/dd/yyyy)	Telephone Number
Address		Fax Number

2. Facility Name		
Date admitted (mm/dd/yyyy)	Date discharged (mm/dd/yyyy)	Telephone Number
Address		Fax Number

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Member / Claimant Name	Union ID	Date of Birth

MEMBER / CLAIMANT (OR POWER OF ATTORNEY) DECLARTION

I certify that the information presented is true, correct, and complete. I understand that for the duration of this claim, I must immediately notify LiUNAcare Local 183 Member Health Management Services and LifePlans LTC Services Inc. of any change in the member's / claimant's status as it relates to their entitlement to long term care benefits.

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

LiUNAcare Local 183 is administered by Benefit Plan Administrators Ltd (BPA) on behalf of the Local 183 Members' Benefit Fund and Local 183 Retiree Benefit Trust Fund (Benefit Trust Funds). LifePlans LTC Services Inc., a third-party provider, has been appointed by LiUNAcare Local 183 to review and assess this claim to determine entitlement to long term care benefits under the Benefit Trust Funds. As an eligible member or eligible spouse of the Benefit Trust Funds, I hereby consent to LiUNAcare Local 183 and LifePlans LTC Services Inc.'s collection, use, and disclosure of my personal information for purposes related to determining my eligibility and entitlement to long term care benefits under the Benefit Trust Funds. I hereby authorize the following uses and disclosures of health information about me:

1. The health information that I am authorizing to be used or disclosed consists of all of the following information:

My medical records and medical history; and other information that relates to:

• The diagnosis of any physical or mental condition,

• The treatment or prognosis of any physical or mental condition,

Whether such treatment is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug use; and communicable or infectious conditions.

2. The following persons or entities are authorized to disclose health information about me to LiUNAcare Local 183 and LifePlans LTC Services Inc. and their service providers, agents, and representatives.: A doctor; medical practitioner; hospital; clinic or medical or medically related facility; pharmacy or pharmacy benefit manager; or any other organization, institution, or person having health information about me.

3. Health information about me may be exchanged between LiUNAcare Local 183 and LifePlans LTC Services Inc.

4. Health information about me may be used or disclosed to evaluate or process any claim for long term care benefits or to service my long term care benefit coverage. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, we may be obligated to disclose health information to government, regulatory, and law enforcement entities.

5. LiUNAcare Local 183 and LifePlans LTC Services Inc. are authorized to disclose health information about me to the individuals designated below. (You should consider listing your spouse, partner, children, and/or any other family member or friend with whom you may want LiUNAcare Local 183 and LifePlans LTC Services Inc. to discuss your claim.)

Print Name: _____ Relationship: _____ Phone: _____

Print Name: _____ Relationship: _____ Phone: _____

Print Name: _____ Relationship: _____ Phone: _____

6. I understand that:

• If I do not sign this Authorization, LiUNAcare Local 183 may decline to pay any claim for long-term care benefits.

• I may withdraw this authorization at any time by providing written notice to LiUNAcare Local 183. Although an authorization may generally be revoked by sending a written request to LiUNAcare Local 183, there is no right to revoke this Authorization if my claim for benefits may be contested by LiUNAcare Local 183 or if LiUNAcare Local 183 has already relied and acted upon this Authorization.

• A copy of this Authorization is as valid as the original.

• I may request a copy of this Authorization.

LiUNAcare Local 183 is committed to protecting and maintaining the confidentiality of all personal information collected. All information will be handled in accordance with applicable privacy laws and LiUNAcare Local 183 's internal data protection policies, ensuring secure handling and storage.

By signing below, I consent to the collection, use, and disclosure of my personal information as outlined above.

Member / Claimant or Power of Attorney (POA) - If this authorization is signed by a POA, a copy of the POA must be included.

Member / Claimant or Power of Attorney (POA) Signature	Date

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PHYSICIAN STATEMENT

Member / Claimant: Please provide this form to the physician most familiar with your current condition for completion. Your assistance will expedite the claim process as you or your Power of Attorney will be able to sign any required medical release authorizations. If multiple physicians are involved in your care, you may copy this document as needed to assure all pertinent information is obtained.

Physician: Please complete all information requested on this form. The purpose of this document is to provide basic medical information for a long term care benefit claim about the claimant and assist the claims examiner to assess your patient's eligibility for long term care benefits. Please complete this form and return to the patient or email to memberhealthservices@liunacare183.com or fax to 416-240-7047. Any fees associated with the completion of this form is the responsibility of the applicant.

MEMBER / CLAIMANT NAME	UNION ID	DATE OF BIRTH

MEDICAL INFORMATION (to be completed by Physician)

Patient's Name	Date of Birth (mm/dd/yyyy)

What is the primary condition(s) causing the loss: Please list all diagnoses that have resulted in the need for long term care:

Primary Diagnoses	Date of Onset (mm/dd/yyyy)

Secondary Diagnoses	Date of Onset (mm/dd/yyyy)

Is there a diagnosis of cognitive impairment? ☐ Yes ☐ No	If yes, please provide a specific diagnosis
Date of Cognitive Test (mm/dd/yyyy)	Cognitive Testing Results (Please attach test documents and results)
Last time you saw the patient?	What was the nature of the visit? (primary complaint)

Please attach all pertinent medical records that will allow us to evaluate the cause, condition, or physical dependency that required the patient to seek long term care services.

DECLARATION

I certify that the information above is accurate and complete to the best of my knowledge:

Physician's Name and Specialty	Telephone Number
Address	Fax Number
Physician's Signature	Date

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FACILITY PROVIDER CLAIM FORM

Member / Claimant: Please complete the Member / Claimant Details and provide this form to your facility provider for completion. If multiple facility providers are involved in your care, you may copy this document and present to each provider for completion.

Facility Provider: Please complete this form and return to the Member / Claimant or email to memberhealthservices@liunacare183.com or fax to 416-240-7047. Any fees associated with the completion of this form is the responsibility of the applicant.

MEMBER / CLAIMANT NAME	UNION ID	DATE OF BIRTH

CARE INFORMATION (to be completed by FACILITY PROVIDER)

Claimant's / Resident's Name	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)

1. Admission Date (mm/dd/yyyy)		Discharge Date (mm/dd/yyyy)	

2. Indicate the admission and discharge date from each level of care the Claimant/Resident has utilized:

☐ Skilled Care	From (mm/dd/yyyy):		To (mm/dd/yyyy):	
☐ Intermediate Care	From:		To:	
☐ Custodial Care	From:		To:	
☐ Memory Care	From:		To:	
☐ Assisted Living	From:		To:	
☐ Independent Living	From:		To:	
☐ Other:	From:		To:	

3. Is this facility licensed or certified by your province to provide care?	☐ No ☐ Yes
If "NO", explain why not	

4. List absences from Facility (including hospitalizations) since Admission Date:

Reason:			
From (mm/dd/yyyy):		To (mm/dd/yyyy):	
Reason:			
From:		To:	
Reason:			
From:		To	

5. Has any portion of this confinement been covered by other insurance?	☐ No ☐ Yes
If "YES" list dates and provide name of payer:	
6. Does this facility have 24-hour on-sit staff to provide care?	☐ No ☐ Yes
7. Does this facility maintain daily care documentation?	☐ No ☐ Yes
8. Does this facility have established procedures for obtaining appropriate aid in a medical emergency?	☐ No ☐ Yes

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Member / Claimant Name	Union ID	Date of Birth

CARE INFORMATION continued (to be completed by Facility Provider)

9. Has the Plan of Care for this Claimant/Resident been ordered and approved by a physician?	☐ No ☐ Yes
10. Does this facility have services performed by or under the continual supervision of a Registered Nurse, licensed practical nurse or licensed vocational nurse, on-site 24 hours per day	☐ No ☐ Yes
11. Was the Claimant/Resident confined to another facility or hospital prior to this admission?	☐ No ☐ Yes, If "YES":

Facility Name:			
Reason:			
From:		To:	
Facility Name:			
Reason:			
From:		To:	
Facility Name:			
Reason:			
From:		To:	

A COPY OF THE FOLLOWING MUST ACCOMPANY THIS FORM (WHEN APPLICABLE):

- ☐ **ITEMIZED BILL AND FEE SCHEDULES**
- ☐ **INITIAL ASSESSMENTS**
- ☐ **RESIDENT'S AGREEMENT**
- ☐ **MINIMUM DATA SET**
- ☐ **APPROPRIATE LICENSE(S)/CERTIFICATE(S)**
- ☐ **INITIAL PLAN OF CARE/SERVICE PLAN**
- ☐ **PHYSICIAN ORDERS**

Facility Name	BN/SIN
Address	Telephone Number
Email Address	Fax Number

DECLARATION

I certify that the information above is accurate and complete to the best of my knowledge:

Facility Authorized Person's Name	Telephone Number
Facility Authorized Person's Title	Fax Number
Facility Authorized Person's Signature	Date

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Member / Claimant Name	Union ID	Date of Birth

MEDICAL INFORMATION (to be completed by PHYSICIAN, NURSE, OR SOCIAL WORKER WHO IS MOST FAMILIAR WITH THE CLAIMANT'S / RESIDENT'S CARE NEEDS)

ORIENTATION/EXECUTIVE FUNCTIONING

13. Claimant/Resident is oriented to (*check all that apply*): ☐ Self ☐ Place ☐ Time ☐ Family ☐ Caregivers ☐ None

14. Is Claimant/Resident able to be left alone for periods of time? ☐ No ☐ Yes

If Yes, How many consecutive hours:_____ Frequency Claimant is alone:_____

15. Claimant ☐ Does not Drive ☐ Drives: Frequency:_____ Distance Claimant drives: _____

16. Claimant ☐ Manages medications independently ☐ Requires Medication Monitoring: _____

17. Claimant makes needs known: ☐ Verbally ☐ Unable ☐ Alternative method: _____

SYSTEM REVIEW

18. Skin: ☐ Intact ☐ Open areas/wounds: Describe: _____

19. Vision: ☐ Adequate ☐ Corrected with Glasses ☐ Impaired ☐ Blind

20. Hearing: ☐ Adequate ☐ Corrected with Aides ☐ Impaired ☐ Deaf

21. Bowels: ☐ Continent ☐ Incontinent: [Frequency: ☐ Occasional ☐ Frequent ☐ Total] ☐ Colostomy assist

22. Bladder: ☐ Continent ☐ Incontinent: [Frequency: ☐ Occasional ☐ Frequent ☐ Total] ☐ Catheter assist

23.Respiratory: ☐ Short of breath on exertion ☐ Treatment: Type: _____ ☐ Oxygen use: frequency: _____

ACTIVITY OF DAILY LIVING REVIEW

24. Eating: ☐ Independent ☐ Set Up ☐ Supervision ☐ Partial Assist ☐ Total Assist/Feeding Tube/other

25. Bathing: ☐ Independent ☐ Set Up ☐ Supervision ☐ Partial Assist ☐ Total Assist

26. Dressing: ☐ Independent ☐ Set Up ☐ Supervision ☐ Partial Assist ☐ Total Assist

27. Toileting: ☐ Independent ☐ Total Assistance ☐ Occasional Assistance

Describe assistance provided: _____

28. Transfers: ☐ Independent ☐ Stand-by Assist ☐ 1-Person Assist ☐ 2-Person Assist ☐ Gait Belt

29. Mobility: ☐ Independent ☐ Stand-by Assist ☐ 1-Person Assist ☐ 2-Person Assist ☐ Gait Belt

30. Equipment: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Geri-Chair ☐ Other: _____

31. Limitations: ☐ Deformities ☐ Hemiparesis ☐ Other: _____

DECLARATION

I certify that the information above is accurate and complete to the best of my knowledge:

Name	Telephone Number
Title	Fax Number
Signature	Date

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HOME & COMMUNITY CARE PROVIDER CLAIM FORM

Member / Claimant: Please complete the Member / Claimant Details and provide this form to your Home or Community Care Provider for completion. If multiple providers are involved in your care, you may copy this document and present to each provider for completion.

Home and Community Care Provider: Please complete this form and return to the patient or fax to 416-240-7047 or email to memberhealthservices@liunacare183.com. Any fees associated with the completion of this form is the responsibility of the Member / Claimant.

MEMBER / CLAIMANT NAME	UNION ID	DATE OF BIRTH

CARE INFORMATION (to be completed by HOME & COMMUNITY CARE PROVIDER)

Claimant's Name	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)
Agency Name		BN/SIN
Address		Telephone Number
Email Address		Fax Number

1. Type of care provided and details of care including dates:

Type of Care	Date Care initiated	Date Care Terminated	Number of days per week care provided	Number of hours per day care provided	Hourly Rate	Holiday Rate	Anticipated duration of services/discharge plan
☐ Adult Day Care							
☐ Home Health Care							
☐ Home Care Services							
☐ Hospice Care							
☐ Respite Care							
☐ Other:							

2. Is this facility licensed or certified by your province to provide care?	☐ No ☐ Yes

If "NO", explain why not

3. Please list all license(s) currently held by Provider and dates of license expirations:

Type of Licenses	Expiration Date

A COPY OF THE FOLLOWING MUST ACCOMPANY THIS FORM (WHEN APPLICABLE):

- ☐ **PHYSICIANS ORDERS**
- ☐ **LICENSE(S)/CERTIFICATE(S)**
- ☐ **ITEMIZED BILL/FEE SCHEDULES**
- ☐ **ASSESSMENTS**
- ☐ **INITIAL PLAN OF CARE/SERVICE PLAN**

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Member / Claimant Name	Union ID	Date of Birth

CARE INFORMATION (to be completed by Home or Community Care Provider)

ORIENTATION/EXECUTIVE FUNCTIONING

4. Claimant/Resident is oriented to (*check all that apply*): ☐ Self ☐ Place ☐ Time ☐ Family ☐ Caregivers ☐ None

5. Is Claimant/Resident able to be left alone for periods of time? ☐ No ☐ Yes

If Yes, How many consecutive hours:_____ Frequency Claimant is alone:_____

6. Claimant ☐ Does not Drive ☐ Drives: Frequency:_____ Distance Claimant drives: _____

7. Claimant ☐ Manages medications independently ☐ Requires Medication Monitoring: _____

8. Claimant makes needs known: ☐ Verbally ☐ Unable ☐ Alternative method: _____

SYSTEM REVIEW

9. Skin: ☐ Intact ☐ Open areas/wounds: Describe: _____

10. Vision: ☐ Adequate ☐ Corrected with Glasses ☐ Impaired ☐ Blind

11. Hearing: ☐ Adequate ☐ Corrected with Aides ☐ Impaired ☐ Deaf

12. Bowels: ☐ Continent ☐ Incontinent: [Frequency: ☐ Occasional ☐ Frequent ☐ Total] ☐ Colostomy assist

13. Bladder: ☐ Continent ☐ Incontinent: [Frequency: ☐ Occasional ☐ Frequent ☐ Total] ☐ Catheter assist

14.Respiratory: ☐ Short of breath on exertion ☐ Treatment: Type: _____ ☐ Oxygen use: frequency: _____

ACTIVITY OF DAILY LIVING REVIEW

15. Eating: ☐ Independent ☐ Set Up ☐ Supervision ☐ Partial Assist ☐ Total Assist/Feeding Tube/other

16. Bathing: ☐ Independent ☐ Set Up ☐ Supervision ☐ Partial Assist ☐ Total Assist

17. Dressing: ☐ Independent ☐ Set Up ☐ Supervision ☐ Partial Assist ☐ Total Assist

18. Toileting: ☐ Independent ☐ Total Assistance ☐ Occasional Assistance

Describe assistance provided: _____

19. Transfers: ☐ Independent ☐ Stand-by Assist ☐ 1-Person Assist ☐ 2-Person Assist ☐ Gait Belt

20. Mobility: ☐ Independent ☐ Stand-by Assist ☐ 1-Person Assist ☐ 2-Person Assist ☐ Gait Belt

21. Equipment: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Geri-Chair ☐ Other: _____

22. Limitations: ☐ Deformities ☐ Hemiparesis ☐ Other: _____

DECLARATION

I certify that the information above is accurate and complete to the best of my knowledge:

Name	Telephone Number
Title	Fax Number
Signature	Date