ILLINOIS
LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION

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FACILITY CARE RECERTIFICATION

BY FURNISHING THIS BLANK AND INVESTIGATING THE CLAIM, THE COMPANY SHALL NOT BE HELD TO ADMIT VALIDITY OF ANY CLAIM OR TO WAIVE ANY OF ITS RIGHTS OR ANY OF THE CONDITIONS OF THE POLICY

POLICYHOLDER NAME **POLICY #:** _____

NAME ADDRESS

CITY STATE ZIP PHONE#

PHYSICIAN'S SUPPLEMENTARY REPORT

1. What is the policyholder's current prognosis or condition ? _____
2. Has there been a change in your health condition?

3. State between what dates, if confined	Confined to a hospital……..……From	To	
	Confined to a rehabilitation facility…..…….…….…… From	To	
	Confined to a skilled nursing unit or facility……..……..… From	To	

If confined, please provide details regarding the facility:

NAME _____ ADDRESS _____ PHONE _____

NAME _____ ADDRESS _____ PHONE _____

NAME ADDRESS PHONE

4. Past Medical History including diagnosis with date of onset: _____
   What complications, if any, have arisen? (Describe fully) _____
5. Diagnosis for Facility Care: _____
6. Please tell us why this patient would require Facility Care for the above diagnosis: _____

CHECK the level of assistance you patient requires with the following activities:

Standby- Must have verbal guidance and partial or intermittent hands- assistance from another person.
Hands On- Must have assistance from another person with all or most of the activity.
Total- Does not participate in the activity and must be totally continuously cared for by another person.

Activities of Daily Living

Eating	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Toileting	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Dressing	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Bathing	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Ambulation	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Transfer	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Mobility	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance

Instrumental Activities of Daily Living

Housekeeping	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Meal preparation	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Shopping	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Transportation	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Managing Medicines	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Laundry	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance

Bowel/Bladder	☐	Continent	☐	Incontinent	☐	Foley Catheter	☐	Ostomy	☐ Other
Vision	☐	Normal/Corrected	☐	Impaired	☐	Blind	☐	Glasses/Contacts	
Hearing	☐	Normal/Corrected	☐	Impaired	☐	Deaf	☐	Hearing Aids: ☐ R	☐ L
Mental Status	☐	Alert & Oriented	☐	Forgetful*	☐	Confused*			

7. What equipment does this patient use?: ☐ Cane ☐ Walker ☐ Bedside Commode ☐ Wheel Chair ☐ Hospital Bed ☐ Seat Lift Chair ☐ Hoyer Lift ☐ Raised Toilet Seat

8.What level of care does this patient require:

☐ Assisted Living ☐ Independent ☐ Memory Care ☐ Shelter Care

Please explain: _____

9. How long do you anticipate this level of care will last? _____

10. Is this care medically necessary? ☐ YES ☐ NO

11. Is this care in lieu of a hospital or nursing confinement? ☐ YES ☐ NO

12. Is this care to provide personal or medical care to patient? ☐ YES ☐ NO

13. Date care started or should start: _____ Date care should end: _____

COGNITIVE CAPACITY *(if applicable)*

Please provide your opinion below as to what cognitive impairment, if any, your patient has experienced. We have provided a definition of cognitive impairment below for your reference.

Cognitive Impairment – An insured has suffered a deterioration of loss in their intellectual capacity which requires another person's assistance or verbal cueing to protect them or other as measured by clinical evidence and standardized tests which reliably measure impairment in the following areas:

(a) short or long-term memory:
(b) orientation as to person (such as who they are), place (such as their location) and time (such as day, date, year):
(c) deductive or abstract reasoning

*** Such loss intellectual capacity can result from Alzheimer's disease or similar forms of cognitive impairment.*

14. Does your patient have a cognitive impairment: ☐ YES ☐ NO

15. What is the cognitively impairing diagnosis (please be specific): _____

16. When was your patient first seen for cognitive issues and by whom? (mm/dd/yy): _____

17. Has any cognitive testing been completed? ☐ YES ☐ NO If yes, please attach testing with this form.
If no cognitive testing has been performed, please attach clinical findings that support a cognitive impairment

18. Is your patient's cognitive impairment to the degree that it puts him/her at risk for health and safety? ☐ YES ☐ NO

If yes, when did the cognitive impairment begin to impair your patient judgement? (mm/dd/yy) _____

19. If yes, please indicate why supervision is needed as well as what activities your patient needs assistance/supervision with?

Why: ☐ Short-Term memory loss ☐ Long-Term memory loss ☐ Poor Judgement ☐ Wandering Behavior
☐ Impaired executive function ☐ Impaired orientation to person/place ☐ Confusion

What activties: ☐ Managing Finances ☐ Managing Medications ☐ Using telephone/devices
☐ Handling Transportation ☐ Shopping ☐ Preparing Meals ☐ Housework/Home Management

20. Do you know whether or not your patient is still driving? ☐ YES ☐ NO ☐ UNK

21. If your patient is driving, do you agree that he/she should be driving? ☐ YES ☐ NO

PHYSICIAN RECERTIFICATION STATEMENT

I, recertify that the above service are required and authorized by myself with a written plan for treatment which will be periodically reviewed by myself. This patient is under my care and is in need of intermittent skilled nursing care and/or physical or speech therapy or has been furnished home health services based on such a need.

Signature **Date**

Print Physician/Practice Name Phone

Street City State Zip