

**ILLINOIS
LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION**

P. O. Box 4198, Lisle, Illinois 60532
(773) 444-4071 eFax (773) 304-3559
ILClaims@illinoisga.org



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	Confined to a hospital.....From		To
what dates, if	Confined to a rehabilitation facility..... From		To
confined	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	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Toileting	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Dressing	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Bathing	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Ambulation	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Transfer	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Mobility	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance

Instrumental Activities of Daily Living

Housekeeping	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Meal preparation	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Shopping	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Transportation	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Managing Medicines	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance
Laundry	<input type="checkbox"/>	No Assistance	<input type="checkbox"/>	Standby Assistance	<input type="checkbox"/>	Hands On Assistance	<input type="checkbox"/>	Total Assistance

Bowel/Bladder	<input type="checkbox"/>	Continent	<input type="checkbox"/>	Incontinent	<input type="checkbox"/>	Foley Catheter	<input type="checkbox"/>	Ostomy	<input type="checkbox"/>	Other	
Vision	<input type="checkbox"/>	Normal/Corrected	<input type="checkbox"/>	Impaired	<input type="checkbox"/>	Blind	<input type="checkbox"/>	Glasses/Contacts			
Hearing	<input type="checkbox"/>	Normal/Corrected	<input type="checkbox"/>	Impaired	<input type="checkbox"/>	Deaf	<input type="checkbox"/>	Hearing Aids:	<input type="checkbox"/>	R <input type="checkbox"/>	L
Mental Status	<input type="checkbox"/>	Alert & Oriented	<input type="checkbox"/>	Forgetful*	<input type="checkbox"/>	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 or 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 activities: 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 _____