Illinois Life and Health Insurance Guaranty Association
Relating to Penn Treaty, in Liquidation

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# Monthly Care Certification

*This form must be completed by facility staff only.*

## Resident and Facility Information

1. Resident name:________________________________________ Policy: ____________________
2. Facility Name:____________________________________________________________________
3. Contact person: ______________________________________ Title: ______________________
   Tel: _______________________________ Fax: __________________________________

## Confinement Information

All of the following questions must be completed for each month being claimed for benefits. Please attach and submit the billing statement from the facility **for the dates covered in this certification** with this form to one the preferred methods above. Do not submit until after month's end.

4. This form is submitted for service dates:_______________through________________
   Discharge date: _____________________________
5. Was the resident out of the facility overnight? Yes No if yes, complete the following:
   Left on:________Returned on:__________Due to: Hospital Other _______________
   Left on:________Returned on:__________Due to: Hospital Other _______________
   Left on:________Returned on:__________Due to: Hospital Other _______________
6. Care level: Skilled Intermediate Assisted Living Other _________________
7. Current Diagnosis: ___________________________________________________________

**Please indicate with a check mark the level of assistance provided by the facility staff with the following activities:**

| Activities of Daily Living (ADLs) | Bathing/ Showering | Indoor mobility/walking | Getting in/out of bed/chair | Continence care bladder/bowel | Eating | Toileting | Dressing | Medication |
|---|---|---|---|---|---|---|---|---|
| Independent | | | | | | | | |
| Supervision | | | | | | | | |
| Standby Assistance | | | | | | | | |
| Hands-On Assistance | | | | | | | | |

***(Cognitively Impaired resident only***

8. Was prompting, cueing or supervision provided? Yes No
9. Does the resident use any of the following?
   Cane Walker Wheelchair Other ____________________
10. Are any of the dates above covered by Medicare Medicare Advantage Plan
    Yes No If yes, list Paid-In Full and Coinsurance dates: ________________________
11. Does the resident receive Medicaid assistance? Yes No
12. Bed hold charge? Yes No

If the facility statement does not reflect payments made by Medicare, Medicaid or other sources for the same period that reduces the resident's liability for charges, please attach payment information for the dates in this submission.

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.

Signed________________________________Title:________________Date: ______________