

# 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

<b>POLICYHOLDER NAME</b>			<b>POLICY #:</b> _____
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 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 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