Lifeline Alliance HealthShare

LTCBP Benefits Initiation Form

This form is used to initiate the benefits process. Please provide accurate and complete information to the best of your knowledge and ability. Any failure to do so could jeopardize your benefits. Note: Form completion does not guarantee benefits approval and/or benefit reimbursement

Personal information

☐ Mr. ☐ Mrs. ☐ Ms.

Members's name

First name

M.I.

Last name

Address line 1

Address line 2

City

State/Territory

Country

Zip/Foreign postal code

Gender

☐ Male ☐ Female

Home phone - -

Date of birth / /

Month Day Year

Home phone - -

Extension

E- mail

Social Security number - -

Please call us at the number below if you do not have a Social Security number (SSN). We use SSNs to obtain health information during the claims process.

Select your current status:

☐ Assistance is needed

☐ Receiving support services for activities of daily living (ADL)

☐ Recovered; received ADL support services prior to recovery

☐ Deceased; received ADL support services prior to death

Date of birth / /

Month Day Year

Personal information

Select your living accommodations:

☐ Home ☐ Assisted living facility ☐ Nursing home

Facility's name (if applicable)

Address line 1

Address line 2

City

State/Territory

Country

Zip/Foreign postal code

Married?

☐ Yes ☐ No

Is your spouse in benefits or initiating benefits?

☐ Yes ☐ No

Who is the contact for the benefits? ☐ Member ☐ Other

If you selected "member," where should we send benefits correspondence? ☐ Primary address ☐ Facility address

If you selected "other," please complete the contact information below:

Contact's name

First name

M.I.

Last name

Relationship to the member

Contact's street address

City

State

Zip code

Contact's preferred phone

_ _ _ - _ _ _ - _ _ _ _

You, the member, are required to complete and sign all benefits forms. However, if you wish to authorize someone to make decisions on your behalf, the designated person must be named on a copy of your durable financial power of attorney or guardianship papers. Once we process this legal documentation, your representative will then have the right to complete forms related to your benefits.

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Benefits information

1. Briefly explain why benefits are being filed.

2. Are you currently in need of assistance with at least two of the following activities: bathing, continence, dressing, eating, toileting, or transferring? ☐ Yes ☐ No

If yes, what is the approximate date the assistance began? ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

If yes, what type of assistance do you need?

- ☐ getting into or out of a tub or shower ☐ washing your body or hair
- ☐ putting on and taking off all clothing items and any necessary braces, fasteners, or artificial limbs
- ☐ getting into and out of bed ☐ getting into or out of chair ☐ getting into or out of wheelchair
- ☐ getting on and off the toilet ☐ performing the associated personal hygiene
- ☐ maintaining control of bladder function ☐ maintaining control of bowel
- ☐ when unable to control bowel or bladder, performing associated personal hygiene, including caring for a catheter or colostomy bag
- ☐ feeding yourself by getting food into your mouth from a container (such as a plate or cup) or by a feeding tube or intravenously

3. Is this request for benefits being opened because you need substantial supervision due to a severe cognitive impairment, such as Alzheimer's disease or dementia? ☐ Yes ☐ No

If yes, what is the approximate date assistance began? ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

Please note that in this case a legal representative will be required.

4. Is this request for benefits being opened for any of the following reasons:

Result of injuries sustained due to a motor vehicle accident? ☐ Yes ☐ No

Result of a work-related injury? ☐ Yes ☐ No

Hospice services? ☐ Yes ☐ No

(If you receive hospice services, please list this information in the Provider Information section.)

5. If you are currently in a skilled nursing facility, please provide the expected discharge date (if known):

☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

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Insurance information

Please provide the name of any medical insurance you have, including Medicare

Medical insurance carrier's name

If you are covered by a long term care insurance policy, please provide the following information:

Long term care insurance carrier's name

Phone ___ - ___ - ____

☐ Individual policy ☐ Group policy

Policy ID number

Policy effective date __ / __ / __
Month Day Year

Residence information

Who is currently living with you in your home?

Name

Relationship

How long have they been living with you?

Name

Relationship

How long have they been living with you?

Name

Relationship

How long have they been living with you?

Medical information

Please provide the requested information for all physicians (including your primary care physician) that you may have seen in the last 12 months, as well as any hospitals or rehabilitation facilities you may have visited that relate to your need for long term care assistance.

Name

Street address

City

State

Zip code

Phone

Fax

Start of care date __ / __ / __
Month Day Year

Date of last visit __ / __ / __
Month Day Year

Reason for last visit

Lifeline Alliance®
HealthShare

Medical information

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ☐☐ / ☐☐ / ☐☐ (Month / Day / Year) | Date of last visit ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

Reason for last visit

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ☐☐ / ☐☐ / ☐☐ (Month / Day / Year) | Date of last visit ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

Reason for last visit

Lifeline Alliance®
HealthShare

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ☐☐ / ☐☐ / ☐☐ (Month / Day / Year) | Date of last visit ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

Reason for last visit

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Provider information for Home Care or Facility Care

Please share information regarding any care you have received in the past 12 months. The provider may be an individual or an organization. Be sure that information for each provider is complete and accurate in order to help avoid processing delays.

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

End of care date (if applicable) ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

Reason for last visit

Are you currently receiving services? ☐ Yes ☐ No

If yes, are hospice services included? ☐ Yes ☐ No

Type of provider

In your home		In a facility
Informal caregivers	**Formal caregivers**	☐ Adult day care center
☐ Friend	☐ Home care agency	☐ Assisted living facility
☐ Family member	☐ Home health agency	☐ Nursing home
☐ Private caregiver	☐ Visiting nurse association	
	☐ Hospice agency	

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

End of care date (if applicable) ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

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Provider information for Home Care or Facility Care

Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

End of care date (if applicable) ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

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Name

Street address

City | State | Zip code

Phone | Fax

Start of care date ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

End of care date (if applicable) ☐☐ / ☐☐ / ☐☐ (Month / Day / Year)

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☐ Private caregiver	☐ Visiting nurse association	☐ Nursing home
	☐ Hospice agency	

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Agreement and Acknowledgment

I am requesting a determination for benefit eligibility under the **Long Term Care Benefits program (LTCBP)**. All of the answers and explanations I have provided are accurate and complete to the best of my knowledge and ability. I understand that medical records or answers to any questions that a care coordinator may have will also be considered.

If there are any changes to my health, treatment, or provider, I agree to immediately notify Lifeline Alliance 456 A Central Ave, Suite 157 Cederhurst, NY. 11516, in writing.

Caution: If you are approved for benefit eligibility, but you should not have been because one or more of your answers or explanations are incorrect or untrue, or fails to include all material information requested, we may have the right to deny a benefits. Any person who, with an intent to defraud or knowing that he or she is facilitating a fraud against an LTCBP, submits an application, or files for benefits containing a false or deceptive statement is guilty of LTCBP fraud and may be subject to criminal and civil penalties.

Before we can process you benefits eligibility, you must certify by signing below that the information you have provided on this form is accurate and complete to the best of your knowledge and ability.

☐ I wish to open a request for LTCBP benefits.

Signature (number or legal representative) ______________________________

Date signed ______/______/______
(Required: mm/dd/yy)

Print name ______________________________

Note: If any form is signed by the durable power of attorney designee, guardian, or executor, please submit the appropriate documents with this claims initiation form. If the Medical Release is signed by someone other than the insured, a copy of the durable financial power of attorney, or guardianship papers, may be required.

Remember to complete and sign:

- Medical Release
- Form W-9 Request for Taxpayer Identification Number and Certificate

These forms are required to process this benefits initiation. In order for us to discuss your coverage with another person designated by you (including your spouse), who is not your durable power of attorney designee or guardian, please complete the Authorization for Disclosure attached at the end of this form.

Mail to : Lifeline Alliance 456 A Central Ave, Suite 157 Cederhurst, NY. 11516

or

Fax to : 800-984-5524