

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 nam	ıe .
Address line 1	
Address line 2	2
City	e/Territory
Country Zip/	Foreign postal code
Gender Hon	ne phone-
Male Female	
	ne phone
Date of birth / / / /	
Month Day Year E- mail	EXTENSION
HERT N 1970M 1992 AV 1992M 199 199 199	A V B W V V V V V V V V V V V V V V V V V
	umber below if you do not have a Social Security e SSNs to obtain health information during the
claims process.	
Select your current status:	
	ceased; received ADL support services
Receiving support services for activities of	or to death
daily living (ADL)	te of birth / / /
Recovered; received ADL support services prior to recovery	Month Day Year



Personal information

Select yo	our l	iving	acc	omn	noda	atio	ns:																		
Home		Assist	ted liv	ving fa	cility		Nu	rsing	hom	e															
						Ĭ									T										
Facility's na	me (if	applic	cable)			1/2									100	-									
· ·					7															- 4				-	
Address lir	ne 1								-																
Address lir	ne 2																								
					T				7																
City											I	Stat	te/T	errit	ory										
													(24047)												
Country										-	1	Zip,	/For	eign	pos	stal	COC	le							
Married? Yes		No										ls y	our Yes	spoi	use	in b No		efits	or	initi	atin	ig be	enet	fits?	
Who is the If you select If you select Contact'	cted '	"mem "othe	ber,"	wher	e sho	ould		end b	enef		orr				? []Pri	ima	ry a	ddr	ess] Fai	cilit	y ac	dress
Contact	S IIA	me			_	T		_		1											1			ľ	
First name									LA		Lac	t nan													
First name M.I. Last name Relationship to the member																									
		T														T									
Contact's s	treet	t addr	ess																						
					1					1						-				1					
City											L	State		L	Zip	cod	e								
Contact'	s pr	eferr	ed p	hone	e																				

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.



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? 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? If yes, what is the approximate date assistance began? 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? Result of a work-related injury? Yes Hospice services? Yes (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



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 Date of last visit Start of care date Month Day Year Month Day Year

Reason for last visit



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	~ / 1	
Name		
Street address		
City	State	Zip code
Phone	Fax	
Start of care date Month Day Year	Date of last visit	Month Day Year
Peason for last visit		



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) / Day Year						
Reason for last visit								
Are you currently receiving se	rvices? Yes No	If yes, are hospice servi	ces included? Yes No					
		Type of provider						
In you	r home		In a facility					
Informal caregivers Friend Family member Private caregiver	Formal caregivers Home care age Home health a Visiting nurse Hospice agence	agency association	Adult day care center Assisted living facility Nursing home					
Name Street address								
City		State	Zip code					
Phone		Fax						
Start of care date								
Are you currently receiving services? Yes No If yes, are hospice services included? Yes No Type of provider								
In you	r home	.c	In a facility					
Informal caregivers Friend Family member Private caregiver	Formal caregivers Home care age Home health a Visiting nurse	ency agency association	Adult day care center Assisted living facility Nursing home					
	Hospice agend	EY .						



Provider information for Home Care or Facility Care Name Street address City State Zip code Fax Phone End of care date Start of care date (if applicable) Month Day Year Month Day Year Reason for last visit Are you currently receiving services? Yes If yes, are hospice services included? Yes Type of provider In your home In a facility Informal caregivers Formal caregivers Adult day care center Assisted living facility Friend Home care agency Nursing home Family member Home health agency Private caregiver Visiting nurse association Hospice agency Name Street address Cîty State Zip code Fax Phone End of care date Start of care date (if applicable) Month Month Day Day Year Year Are you currently receiving services? Yes If yes, are hospice services included? Yes Type of provider In your home In a facility Informal caregivers Formal caregivers Adult day care center Assisted living facility Friend Home care agency Nursing home Family member Home health agency Private caregiver Visiting nurse association Hospice agency



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 Cedarhurst, 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

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 Cedarhurst, NY. 11516

or

Fax to: 800-984-5524