

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

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 _____

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 _____

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 _____

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

- Friend
- Family member
- Private caregiver

Formal caregivers

- Home care agency
- Home health agency
- Visiting nurse association
- Hospice agency

- Adult day care center
- Assisted living facility
- Nursing home

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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- Nursing home

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

Reason for last visit _____

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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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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 your 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 Cedarhurst, NY. 11516

or

Fax to: 800-984-5524