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Long Term Care Request Form

Date of This Request: ________/________/_________ LTC Applicant: New Lead Existing Client

PLEASE FILL OUT THIS LTC REQUEST FORM AS THOROUGHLY AS POSSIBLE TO ENSURE ACCURATE QUOTES. THANK YOU.

Agency Information

Agency Name: ______________________________ Your Name: ______________________________

Address: ______________________________ State: __________ Zip Code: __________

Phone #: ____________________ FAX: ____________________ Mobile: ____________________

Email: ____________________ License #: ____________________ Are you currently LTC Certified? (For CA and WA Only) YES NO

Activities of Daily Living

Please confirm which activities client is currently able to perform:

Answer Telephone	Yes	No
Do Finances	Yes	No
Perform Housework	Yes	No
Do Own Laundry	Yes	No
Transportation	Yes	No
Do Own Shopping	Yes	No
Prepare Own Meals	Yes	No

Eligibility for home care benefits are usually based on the inability to perform certain "activities of daily living" (ADLs), or an impairment of cognitive ability. ADLs include: Bathing, Dressing, Continence, Toileting, Transferring, Eating, and Ambulating.

Please Note: If 2 or more activities are checked "No", you should not proceed with LTC Request Form.

Does client use a walker? Yes No If Yes, what kind of walker? ______________________________

Does client use a wheelchair? Yes No If Yes, what kind of wheelchair? ______________________________

Applicant Information

Client Name: ______________________________ Spouse: ______________________________

Birthdate: __________ Height: ________ Weight: __________ Birthdate: __________ Height: ________ Weight: __________

State of Residence: __________ Currently Has LTC Policy: YES NO Daily Benefit Amount: __________ Elimination Period: ________ DAYS

Benefit Duration: ___ of years - or - LIFETIME Tobacco Use: YES NO (Circle One) Is applicant part of an employer/association group we are quoting? YES NO

Inflation Protection: (Circle One) NONE SIMPLE COMPOUNDED Coverage Types: (Check All That Apply) ☐ Institutional ☐ Home Care

Special Requests, Riders, Etc. ____

____

(Over, please...)

Applicant Health Information

	Yes	No	If Yes, Medicine	Dosage	Freq	Diagnosis Date
Heart Disease	☐	☐				/ /
Coronary Artery Disease	☐	☐				/ /
Circulatory Disorders	☐	☐				/ /
High Blood Pressure	☐	☐				/ /
Leukemia	☐	☐				/ /
Lymphoma	☐	☐				/ /
Cancer	☐	☐				/ /
Paralysis	☐	☐			/	/
Stroke, TIA	☐	☐				/ /
Bowel Disorders	☐	☐				/ /
Bladder Disorders	☐	☐			/	/
Prostate Disorder	☐	☐			/	/
Kidney Disorder	☐	☐				/ /
Depression	☐	☐				/ /
Alcoholism	☐	☐				/ /
Liver Disorder	☐	☐				/ /
Osteoporosis	☐	☐				/ /
Arthritis	☐	☐			/	/
Reproductive Disorders	☐	☐				/ /
Respiratory Disorder	☐	☐				/ /
Parkinson's Disease	☐	☐				/ /
Seizure	☐	☐				/ /
Tremor	☐	☐				/ /
Diabetes	☐	☐			/	/
Dementia	☐	☐				/ /
Alzheimer's Disease	☐	☐				/ /
Memory Loss	☐	☐				/ /
Other	☐	☐				/ /

Within the last 5 years, has applicant been hospitalized, consulted or treated by a member of the medical profession for any reason not previously stated? YES NO

If Yes, Please Explain: ______

Does client currently use any assistive or mechanical devices? YES NO

If Yes, Please Explain: ______

Has client ever received home health care or been confined to a nursing home or rehabilitation facility? YES NO

If Yes, Please Explain: ______

Does client currently need or receive any help in doing any activities of daily living? YES NO

If Yes, Please Explain: ______

Request Quotes From The Following Companies

☐ MUTUAL OF OMAHA ☐ NATIONAL GUARDIAN

END OF LONG-TERM CARE REQUEST FORM.
When complete, please fax to 760-930-9495. Please allow 24 hours to process. Thank you!