Individual Long Term Care Plan of Care Form

You must complete this form in full.
Please print or type all information except where signature is required.
Please return the completed form to the insured or authorized representative or to:
CNA Insurance Companies, P.O. Box 64912 St. Paul MN 55164-0912

Name of Insured	Policy Number	Social Security Number

Name of Licensed Health Care Practitioner: _____

Address: _____

Telephone Number: _____ Fax Number: _____

1. Plan of Care Certification Dates: From: _____ To: _____
2. Diagnosis causing the need for Long Term Care Services?
   Diagnosis _____ Approximate date of diagnosis _____
   Resulting Impairment _____
3. Co-Morbid diagnoses causing the need for Long Term Care Services?
   Diagnosis _____ Approximate date of diagnosis _____
   Diagnosis _____ Approximate date of diagnosis _____
   Diagnosis _____ Approximate date of diagnosis _____
4. Has the insured had any hospitalizations in the past 2 years? Yes_____ No_____
   Reason/Dx _____ Approximate Dates _____ Length of stay _____
   Reason/Dx _____ Approximate Dates _____ Length of stay _____
   Reason/Dx _____ Approximate Dates _____ Length of stay _____
5. Has any form of cognitive impairment been diagnosed? Yes_____ No_____ Diagnosis: _____
   Cognitive Testing: MMSE Score _____ Folstein Score _____ Other _____ Approximate Date tested _____
   Other Testing _____ Results _____ Approximate Date tested _____
6. Would the use of durable medical equipment such as grab bars reduce or eliminate the need for human assistance? Yes__ No_
   Please explain. _____
7. Would widening of one or more doorways to accommodate wheel chair access or other home modifications reduce or eliminate the need for human assistance? Yes_____ No_____
   Please explain and specify details _____
8. Do you have any financial interest in the entity that will be providing the care? Yes_____ No_____
   Please explain. _____
9. Attach a copy of your medical records (example: office visits, diagnostic studies, consults, etc.) for the past year along with a list of all medications to support the diagnosis and recommended care.

Please continue to the next page.

Functional Capacity

10. Please provide detailed information regarding the insured's functional capacity with the following Activities of Daily Living

Activity of Daily Living	Describe Insured's Functional Capacity to Perform	If you indicated any incapacity, how long do you anticipate the impairment to continue?
Eating – Feeding yourself by getting food into your body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously. (Does not include food preparation.)		
Bathing – Washing yourself by sponge bath; or in either a tub or shower, including the task of getting in or out of the tub or shower.		
Dressing – Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.		
Administration of Medication – Taking medication in the prescribed amounts and at the prescribed times.		
Toileting – Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.		
Mobility – Walking with or without the assistance of a mechanical device, such as a wheelchair, braces, a walker, a cane or other walking aid device.		
Transferring – Moving into or out of a bed, chair, or wheelchair.		
Continence - The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.		

11. Based upon the noted medical diagnoses and functional and/or cognitive deficits, please describe in narrative form:

- the frequency **(including recommended minimum number of days per week and hours per day that care is required)**,
- the intensity **(including recommended minimum skill level, training and/or certifications/designations of the caregivers who should provide the care)**, and
- the nature of Long Term Care services required **(including the appropriate care setting for such services).**

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I certify that the above information is accurate and true to the best of my knowledge. I KNOW THAT IT IS A CRIME TO COMPLETE THIS FORM WITH INFORMATION THAT I KNOW IS FALSE OR TO OMIT ANY FACTS.

Physician Signature _____ **Date**_____