Facility: Resident/Claimant: Policy #

Please answer the questions below. This information is necessary for the processing of the above named resident's long term care insurance claim. Please answer the questions thoroughly and attach a ***current medication list and a copy of your facility's license***. THIS FORM IS TO BE COMPLETED BY NURSING OR SOCIAL SERVICES STAFF

1. Please indicate the current level of services with the following Activities of Daily Living. Use the following guide to indicate the level of services being received on a regular basis:
   - 1 = Independent, does not require assistance from anyone
   - 2 = Independent, only requires equipment to complete ADL
   - 3 = Needs reminders/cueing to initiate or complete ADL due to memory loss
   - 4 = Stand-by Assistance (person within arm's reach) required to complete ADL
   - 5 = Hands-on assistance required from another to complete some or all of ADL
   - 6 = Unable to participate in any part of ADL at all

ACTIVITIES OF DAILY LIVING	LEVEL		ACTIVITIES OF DAILY LIVING	LEVEL
Bathing			Dressing	
Eating			Toileting	
Incontinence			Transfers	
Mobility/Ambulation (indoor)				

2. Are the resident's medications being **administered (facility stores, sets up dispenses and maintains Medication Administration Record)** by staff? Yes ☐ No☐

   If administered by staff, are medications administered because this resident requires that assistance or because you provide this assistance to all residents? Resident Requires ☐ Medication assistance is provided to all residents ☐

   If required: Why?_____

   If not administered by staff, please indicate the current medication arrangement (e.g., resident administers own medication, staff does medication reminders, staff sets up meds, family does medication set-ups, etc.)

   _____

3. Does the resident have a cognitive impairment? Yes ☐ No☐

   If so, how was that cognitive impairment confirmed (by testing, physician diagnosis, etc.)?_____

   Does the resident take any dementia medication? Yes ☐ No☐

   If so, what medication(s)? _____

4. Is the resident's room/unit/apartment:

   ☐ on a locked or secured unit? ☐ on an Alzheimer's or Dementia unit?

   ☐ on the Assisted Living unit ? (non-secured) ☐ on the Independent Living unit?

5. Does the resident wear a wander guard bracelet or similar device? Yes ☐ No☐
6. Is there a physician order in place to ensure resident does not leave premises without escort? Yes ☐ No☐
7. If not on a secured unit, does the resident leave the facility? Yes ☐ No☐

   If so, does the resident leave facility without escort ? Yes ☐ No☐

   If only with escort, with whom? _____
8. Does the plan of care document that resident is not permitted to leave premises without escort? Yes ☐ No☐
9. Does the resident continue to drive? Yes ☐ No☐
10. During the most recent month, was the resident absent from the facility? Yes ☐ No☐

    If yes, what dates? _____ and for what reason?_____

I verify that, to the best of my knowledge, the above information is accurate and correct.

Name and Title:_____Date:_____