

Dear Plan Member,

To establish the amount of coverage available for nursing care under your group benefit plan, Great-West Life requires you to apply for a pre-care assessment. A pre-care assessment should be applied for before nursing care begins. To apply for a pre-care assessment, the enclosed Nursing Care Health Assessment form must be completed in full and sent to Great-West Life.

If you have not done so already, you will need to apply for your provincial health care plan for home care services. You will also need to advise the provincial home care case coordinator / manager assigned to your case that you are applying to your private health care benefits plan for supplemental nursing benefits and authorize the provincial health care plan to exchange information with Great-West Life.

Step 1: The Nursing Care Health Assessment form is divided into four parts. To help avoid a delay in the completion of the pre-care assessment, please be sure to write legibly and complete the entire form as follows:

- Part 1: Patient information - **to be completed by the plan member**. Please note that your Plan Number and Plan I.D. Number must be indicated on the form.
- Part 2: Current medical information - **to be completed by the patient's physician**.
- Part 3: Confirmation of eligibility and coverage for provincial home care - **to be completed by the provincial home care case coordinator / manager**.
- Part 4: Authorization - **to be completed by the plan member and the patient**.

Step 2: Once Great-West Life receives the Nursing Care Health Assessment form completed in full, we will review the medical information, contact your provincial home care case coordinator / manager to confirm the services you are receiving, and review your coverage to determine the amount of nursing care coverage available under your group plan.

Step 3: Once we have completed the pre-care assessment, we will let you know in writing what amount, if any, of nursing care coverage you are eligible for reimbursement under your group plan.

If you have any questions about nursing services, please check your employee benefits booklet or call our line toll-free at .

Sincerely,

The Great-West Life Assurance Company

Once complete, return this form to:

Mail to: Nursing Specialist, Medical and Dental Services
Group Health and Dental Benefits
The Great-West Life Assurance Company
PO Box 6000 Station Main
Winnipeg MB R3C 3A5

**IF REQUEST IS URGENT, PLEASE FAX TO:
204.938.2820
Attention: Nursing Specialist
(please send original to follow)**

INSTRUCTIONS FOR COMPLETION

This form **must be completed in full** to avoid a delay in assessing the claim. Once we have all the required information and have assessed the claim, we will notify the claimant in writing regarding plan coverage and the number of eligible hours.

Fees for providing medical information are not payable by your plan.

If you have questions, please refer to your Great-West Life employee benefits booklet or call 1.800.957.9777.

Part 1 PATIENT INFORMATION to be completed IN FULL by plan member

Plan Number: _____ Plan Member I.D. Number: _____

Patient Name: _____ Phone Number: _____
Last name First name

Patient Address _____
Number and street Apt. number City or town Province Postal Code

Date of Birth _____
Month Day Year

Language preference: English French

Correspondence preference: Letter mail
 Email

Email address: _____@_____ (illegible writing will default communication to letter mail)

Has a previous application for nursing benefits or health assessment form been submitted? Yes No

Other Insurance? Yes No

If "Yes", name of insurance company _____ Plan number _____

If you have been approved for nursing under another plan/government program aside from provincial home care; please provide us with a copy of this approval.

Part 2 CURRENT MEDICAL INFORMATION to be completed by physician (please print clearly)

(If additional space is required, please attach a separate sheet. Ensure writing is legible)

Current Diagnosis _____

Past Medical History _____

Prognosis _____

Surgical procedures and dates _____

Condition classified as Acute Chronic Convalescent Palliative PPS Score _____

Condition classified as Unstable/unpredictable Stable/predictable

Level of Care recommended

- RN (Physician must specify details in nursing treatments section)
- RPN / LPN (Physician must specify details in nursing treatments section)
- HCA / PSW (Describe below)
- Homemaker (Describe below)

Part 2 CURRENT MEDICAL INFORMATION to be completed by physician (please print clearly) (Con't)

Details of HCA / PSW / Homemaker requirements (non-nursing duties)

Details of nursing (RN/RPN/LPN/RNA) treatments: dressings, injections, etc. (must be specific to nursing care requested)

***Reminder: These duties cannot be those which can be completed by (HCA / PSW / Homemaker)**

1. _____
2. _____
3. _____
4. _____

Current medications: route, dose, frequency

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

CHECK OR COMMENT ON ALL THAT APPLY:

Vital signs: BP _____ Pulse _____ Resp. _____ Temp _____ O2 sats _____

Pain/discomfort Location 1: _____ **Pain/discomfort Location 2:** _____

Frequency _____ Frequency _____

Duration _____ Duration _____

Alleviated by _____ Alleviated by _____

Precipitating factors _____ Precipitating factors _____

Integument

No skin problems Lesion Rash Callous Bruise Ulcer Discharge Varicosity Skin breakdown

If yes, explain _____

Oral cavity Special diet Yes No Type: _____

No reported concerns Difficulty chewing Difficulty swallowing Dentures: Upper Lower

Other _____

Neurological/cognitive levels Level of consciousness Alert Altered

Seizures Fainting MMSE Score: _____ Date: _____ Tremors Spastic

Cognition/Orientation: Difficulty Yes No If yes, please explain: _____

Other _____

Respiratory/cardiovascular

S.O.B. Rest or activity Orthopnea Cough: Non-productive Productive

Cyanosis Wheezes Crackles Oxygen use Continuous Intermittent Rate _____

Nebulization Ventilator Tracheotomy

Other _____

Cardiovascular - Chest pain? Yes No (If yes, please explain) _____

History of: Hypertension Hypotension Dizziness

If yes, explain aggravating factors / remarks: _____

Circulation Difficulty? Yes No (If yes, please explain) _____

Edema: Pitting Dependent Right Left Bilateral

Gastrointestinal system

Bleeding Ostomy GI upset Diarrhea Appetite Good Poor

Constipation Nausea/vomiting Gastrostomy/enteral tube

Other _____

Vision

No reported visual loss Blind Cataracts Partially impaired (details) _____

Hearing/ears

No hearing loss Hearing device Deaf Partially impaired (details) _____

Musculoskeletal

No reported concerns

Coordination/Balance _____ Swollen joints _____

Prosthesis R/L _____ Limited R.O.M. _____

Amputation R/L _____ Other _____

Genital/Urinary

Full control _____ Frequency _____

Incontinence _____ Blood in urine _____

Difficulty urinating _____ Nocturia _____

Indwelling catheter _____ Other _____

Activities of daily living

Adaptive Equipment used at Home:

Cane Wheelchair Hospital bed Eating aids Standard walker Wheeled walker Commode Toilet aids Lift

Tub aids None Other _____

Independent _____

Requires assistance with: Mobility Feeding Hygiene Dressing Toileting Other

Assistance provided by: _____

Physician name (print) _____ Phone number _____

Address _____
Number and street City or town Province Postal Code

Signature _____ Date _____

Part 3 CONFIRMATION OF PROVINCIAL HOME CARE ENTITLEMENT to be completed by provincial coordinator

Please be advised that this document will enable the nursing specialist at Great-West Life to expedite your claim in an efficient and accurate manner. Please have your homecare case co-ordinator / manager fill this out.

Patient Name: _____

Great-West Life Policy Number: _____ Great-West Life ID Number: _____

Homecare Manager Name: _____ Phone Number: _____

Case Manager: Please provide the current level of care patient is receiving.

Home Support Workers (*Circle HCA PSW HOMEMAKERS) - hourly

Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? Yes No

Nurse Practitioner Visits

Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? Yes No

Nursing (*Circle RN LPN RPN RNA)

Home visits only - Frequency _____ Focus of intervention _____

Shifts in home - Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? Yes No

Palliative Pain & Symptom Management

Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? Yes No

Case Manager Signature _____ Date _____

Part 4 AUTHORIZATION to be completed by the plan member and patient

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to www.greatwestlife.com.

I authorize Great-West Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life, located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. I certify that the information given is true, correct, and complete to the best of my knowledge.

Plan Member Name _____ Signature _____

Patient Name _____ Signature _____

Date _____