

**TO BE COMPLETED BY NURSING STAFF:**

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. Thank you for your time.

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:
- 0 = Independent
  - 1 = Stand-by Assistance on a regular basis (to qualify, stand-by assistance must be within *one arm's length* during the entire activity)
  - 2 = Hands On, Physical Assistance or Total Dependency on a regular basis

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** by staff? \_\_\_\_\_  
 If administered by staff, are medications administered because this resident requires that assistance or because you provide this assistance 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? \_\_\_\_\_
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 this individual's plan of care document that resident is not permitted to leave premises without escort?  
 \_\_ Yes \_\_ No
9. Does the resident drive? \_\_\_\_\_

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

\_\_\_\_\_  
 Signature Date

\_\_\_\_\_  
 Please print name and title