CAREfidence

"Knowing a plan is there when it's time for care"

LTC PLANNING ASSESSMENT

CLIENT NAME	DATE OF BIRTH	NICOTINE USAGE (Yes or No & Type)	HEIGHT	WEIGHT
#1:				
#2:				

HEALTH STATUS & HISTORY

In the past 10 years, what conditions have you received medical advice, treatment, diagnosis, or consultation?

	#1 or #2	Provide details for any and all conditions, with details about the physician(s), surgery, treatments, therapy, planned follow-ups, or medications taken (including over-the-counter), with the drug name, reason, dosage, and frequency.	
Cancer (other than skin) *			
Cardiac/Coronary Issues *			
Diabetes *			
Atrial Fibrillation		CLIENT #1	CLIENT #2
Depression or Mental Disorder			
Chronic Pain or Disabling condition			
Epilepsy / Seizures			
Joint Replacement Surgery			
Osteoporosis / Osteopenia			
Rheumatoid Arthritis			
Strokes / TIAs			
Condition limiting motion			
A condition requiring adaptive device			
Other: _____			

** Provide details on page 2*

Authorization To Disclose Personal Medical Information

Under applicable state & federal law, including the Health Insurance Portability and Accountability Act (HIPAA), I give your firm and its agents/representatives access to and use of my protected health information for the purposes of the underwriting or administration of insurance coverage on my behalf. The information used in accordance with this authorization may be redisclosed by your firm and may no longer be protected by federal and state privacy laws.

By signing this form, I agree to the release, disclosure, and sharing of my medical information by your firm and its agents. I relieve them from all liability having to do with that disclosure. This authorization will expire 24 months from the date of your signature. I am entitled to a copy of this authorization form, and a digital copy of this authorization is as valid as the original.

I have the right to revoke this authorization, in writing, at any time, but the revocation will not affect any actions taken in reliance on this authorization or relating to the use or disclosure of the protected health and non-health information taken before the receipt of the notice.

Signatures of the insured, applicant, or legal representative	Date	Applicable State(s)	Phone Number

Cancer

Type, location and date of diagnosis: _____

Stage/Grade/Metastasis: _____

Dates/details of treatment and/or surgery: _____

Any recurrence: _____ Date of last follow-up: _____

Cardiac / Coronary Issues

Date of diagnosis/onset of chest pain: _____ Number of involved vessels: _____

Dates and details of treatment and/or surgery (e.g., angioplasty, bypass, etc.)

_____

Date of last testing (EKG, stress, stress echo, etc.): _____ Results: _____

Any symptoms since treatment/surgery: _____

Diabetes

Date of diagnosis: _____ Type ☐ I or ☐ II Date/result of last A1c: _____

Treatment: ☐ Insulin ☐ Diet ☐ Medications Type and dosage: _____

Has the proposed insured been diagnosed with any of the following: _____

1. Retinopathy 2. Kidney Disease 3. Neuropathy 4. Heart Disease 5. Hypertension 6. Insulin Reaction 7. Urine Protein/Microalbumin

Lifestyle and Family Dynamics

	CLIENT 1	CLIENT 2
Describe Your Build: Slim = 1 Athletic = 2 Muscular = 3 Oval/Pear = 4		
Ancestry: European = 1 Asia = 2 Africa = 3 India = 4 Latin America = 5 Middle East = 6 Other = 7		
How many times do you exercise 30+ minutes in a given week?		
How many servings of fruits and vegetables do you have every day?		
How many alcoholic drinks do you consume each day?		
Where do you turn for emotional support? Self = 1 Spouse = 2 Family = 3 Friends = 4 (Select all that apply)		
How many doctor/dentist visits do you have in a given year?		
Family History of Cancer? None = 1 Self = 2 Family = 3 (Select all that apply) Type: _____		
Family History of Alzheimer's or Dementia? None = 1 Self = 2 Family = 3 (Select all that apply)		
Family History of Diabetes? None = 1 Self = 2 Family = 3 (Select all that apply)		
Family History of Heart Disease? None = 1 Self = 2 Family = 3 (Select all that apply)		
Family History of Stroke? None = 1 Self = 2 Family = 3 (Select all that apply)		
Planned/Actual age of Retirement and State To Live During Retirement (Example 68 - FL)		
How many parents or grandparents lived to at least age 85:		

Plan Funding:

☐ Non-Qualified $ _____ ☐ One-Time ☐ 10–Pay ☐ Lifetime

☐ Qualified $ _____

☐ Cash Value in Annuity or Life Insurance: $ _____