LTC / STC PRE-SCREEN

LONG TERM CARE / SHORT TERM CARE

Phone: 402-352-6610
Fax: 888-959-1338

CLIENT INFORMATION:

Client's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ MALE ☐ FEMALE

DOB: ___/___/_____ Height: _____ Weight: _____

Tobacco User: ☐ YES ☐ NO

If *so, please indicate the type of frequency. If quit, indicate last use:* _____

_____

Spouse or Significant Other? ☐ YES ☐ NO

PLAN TYPE OPTIONS: *This gives us a better idea what you're looking for. It's okay if you don't know.*

Please let us know what options you are looking for: *Select all that apply.*

How many years of coverage: ☐ 1 year ☐ 2 years ☐ 3 years ☐ 5 years ☐ 6 years ☐ LIFETIME

Daily Benefit Amount: ☐ $100/day ☐ $150/day ☐ $200/day ☐ $250/day ☐ $300/day

Elimination Period/Waiting Period: ☐ 30 Days ☐ 90 Days ☐ 120 Days

Inflation Protection: ☐ YES ☐ NO

Other: _____

_____

MEDICAL QUESTIONS:

Have you ever been diagnosed with or treated for one of these conditions? *Check all that apply.*

- ☐ Diabetes requiring Insulin
- ☐ Peripheral Vascular Disease
- ☐ Carotid Artery Disease
- ☐ Skin Ulcers
- ☐ Stroke or Transient Ischemic Attack (TIA)
- ☐ Alzheimer's Disease, Lewy Body Disease, or Dementia
- ☐ Psychosis or Schizophrenia
- ☐ Mental Retardation
- ☐ Amyotrophic Lateral Sclerosis (ALS) or Myasthenia Gravis
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Post-Polio Syndrome
- ☐ Demyelinating Disease
- ☐ Lupus (SLE)
- ☐ Mixed Connective Tissue Disease
- ☐ Scleroderma
- ☐ Muscular Dystrophy
- ☐ Amputation-Due to Disease
- ☐ Double Heart Valve Replacement
- ☐ Organ or Bone Marrow Transplants
- ☐ Kidney Disease or Polycystic Kidney Disease
- ☐ Cirrhosis of the Liver
- ☐ Hepatitis B, C, D or E
- ☐ Hemachromatosis
- ☐ Metastatic Cancer
- ☐ Multiple Myeloma
- ☐ Brain or Spinal Cord Tumors
- ☐ AIDS
- ☐ Neurological Conditions affecting the brain or spinal cord
- ☐ Muscular conditions causing Functional Limits

MEDICATIONS:

Record all medications you currently take including **prescription medications** and any **over the counter drugs.**

MEDICATION	DOSAGE	FREQUENCY	# OF YEARS TAKING	REASON FOR TAKING

HAVE YOU BEEN PRESCRIBED ANY MEDICATIONS YOU ARE NOT TAKING? ☐ **YES** ☐ **NO**

If YES - provide details (i.e. name of medication, who prescribed, for what condition, why not taking:

_____

_____

DO YOU HAVE ANY SURGERIES PLANNED OR RECOMMENDED?

☐ **YES** ☐ **NO** Provide details of Type of Surgery and when it is scheduled:

_____

_____

WHEN WAS THE LAST TIME YOU SAW YOUR PRIMARY PHYSICIAN AND WHY?

Date last seen: _____

Reason: _____

_____

LIST ANY SPECIALISTS YOU HAVE SEEN IN THE LAST 5 YEARS.

	Type of Specialist:	Month/Year last seen:	Reason for Visit:
1.			
2.			
3.			

Additional info: _____

_____

HAVE YOU EVER BEEN ON DISABILITY?

☐ **YES** ☐ **NO** Please provide details:

_____

_____

DO YOU HAVE A HANDICAPPED PARKING TAG?

☐ **YES** ☐ **NO** Please provide details:

_____

_____

HAVE YOU EVER BEEN TURNED DOWN FOR ANY INSURANCE COVERAGE?

☐ **YES** ☐ **NO** Please provide details:

_____

_____

HAS A BIOLOGICAL MOTHER, FATHER, OR SIBILING BEEN DIAGNOSED WITH CORONARY HEART DISEASE OR ANY FORM OF DEMENTIA (e.g. ALZHEIMER'S DISEASE)?

Family Member:	Condition:	Age of Diagnosis:
1.		
2.		
3.		

CANCER HISTORY

Check here if there's no cancer history: ☐

Type: _____

Date of Dx: _____

Treatment: _____

_____

Stage: _____

Grade: _____

Lymph Node Involvement: ☐ **YES** ☐ **NO**

Date of last Treatment: _____

Any Recurrence? ☐ **YES** ☐ **NO**

If prostate cancer, please include:

Pre-PSA: _____

Current PSA: _____

Gleason Score: _____

HEART DISEASE HISTORY

Check here if there's no heart disease history: ☐

Heart Attack: ☐ **YES** ☐ **NO**

If yes, please provide dates: _____

_____

Stroke: ☐ **YES** ☐ **NO**

If yes, please provide dates: _____

_____

TIA: ☐ **YES** ☐ **NO**

If yes, please provide dates: _____

_____

Bypass Surgery? ☐ **YES** ☐ **NO**

If yes, please provide dates: _____

Angioplasty? ☐ **YES** ☐ **NO**

If yes, please provide dates: _____

☐ Pacemaker or ☐ Defibrillator? ☐ NONE

If yes, please provide dates: _____

DIABETES HISTORY

Check here if there's no diabetes history: ☐

☐ Type 1 ☐ Type 2

Date Diagnosed: _____

Medications: _____

AIC: _____

Any complications (retinopathy, neuropathy, nephropathy): _____

_____

MENTAL ILLNESS/DEPRESSION HISTORY

Check here if there's no mental illness/ depression history: ☐

Name of condition: _____

Date Diagnosed: _____

Severity: _____

Treatment: _____ _____

_____

Seeing a psychiatrist/psychologist? _____

Attempted suicide? If yes, date(s): _____

Hospitalization due to depression? ☐ YES ☐ NO

LUNG DISORDER HISTORY

Check here if there's no lung disorder history: ☐

Type of Disorder (asthma, bronchitis, COPD, emphysema, etc.): _____

_____

Severity: _____

Treatment: _____ _____

_____

Frequency of attacks: _____

Dates of hospitalization/ER visits: _____

BONE, JOINT, OR MUSCULAR PROBLEMS:

1. Surgery/joint replacements or recommended surgery in the past 5 years? ☐ **YES** ☐ **NO**
2. Any history of joint injections in the last 5 years? ☐ **YES** ☐ **NO**
3. Do you have any joint deformities? ☐ **YES** ☐ **NO**
4. Are you currently in physical therapy or using any medical equipment (i.e. cane, walker, crutches)? ☐ **Y** ☐ **N**

ADDITIONAL INFORMATION

Please include any Health History that was not covered in above areas. Also, include any additional information that you may have regarding the above areas. If this is a rush, please indicate when needed by. For certain risk assessments, we are at the mercy of the carriers to get back to us. Please allow extra time so we can find you the best carrier given the information provided.

Thank you for taking your time to complete this.
Our goal is to find you the most cost-effective coverage!

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