THE Great-West Life ASSURANCE COMPANY

Great-West Life Centre
100 Osborne Street N
Winnipeg MB R3C 1V3

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,

Your Claim Service Representative

The Great-West Life Assurance Company

THE Great-West Life ASSURANCE COMPANY

NURSING CARE HEALTH ASSESSMENT FORM

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:
204.946.7838
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 _____ Sex: ☐ Male ☐ Female
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 Practioner 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 _____

Clear