Manulife

Affinity Markets – In Home Nursing Care

1 Plan member information

Plan member's name (first, middle initial, last)	Plan number	Identification number

Your request for in home nursing coverage was received on _____ .

Please sign this authorization form and have your attending physician complete the Nursing Care Assessment questionnaire.

Manulife will not assume responsibility for any fee associated with the completion of these forms. Manulife requires that prior approval be obtained for any nursing coverage. Manulife reserves the right to deny payment of any nursing care claim(s) that was not submitted for prior approval, or does not meet contract provisions.

All completed forms can be mailed to the address below:

Manulife
Affinity Markets Health Claims
P.O. Box 670, Stn. Waterloo
Waterloo, ON N2J 4B8

2 Authorization

I _____ authorize the release of any medical information that is necessary to assess nursing care coverage for _____ .

I certify that the information in this form is true and complete, to the best of my knowledge, and does not contain a claim for any expenses previously paid for by any plan.

I authorize any person or organization who has information pertaining to this claim, including any health care provider, insurance company, any type of workers' compensation board and investigative agencies, to release and exchange such information requested by Manulife and/or its claims service providers for the purpose of plan administration including processing and investigating this claim.

I authorize Manulife and its claims service providers to collect, to use and to exchange with the persons or organizations listed above any information needed for the purpose of plan administration including processing and investigating this claim.

If this claim is made on behalf of my spouse and/or dependents, I am authorized to disclose information about them, for the purpose of plan administration including processing and investigating this claim.

If my social insurance number is used as my certificate number, I authorize its use for the identification and administration of my benefits.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Signature of patient		Date signed (dd/mmm/yyyy)
Signature of witness		Date signed (dd/mmm/yyyy)
If patient is unable to sign, please complete: Signature of Power of Attorney for personal care or statutory or court appointed guardian	Relationship to patient	Date signed (dd/mmm/yyyy)

Statement of confidentiality

The specific and detailed information requested on the In Home Nursing Care questionnaire form is required to process the insured person's claim request. To protect the confidentiality of this information, The Manufacturers Life Insurance Company (Manulife) will establish a "financial services file" from which this information will be used to process the application, offer and administer services and process claims. Access to this file will be restricted to those Manulife employees, mandataries, and administrators who are responsible for the assessment of risk (underwriting), marketing and administration of services and the investigation of claims, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in jurisdictions outside Canada, and subject to the laws of those foreign jurisdictions. Your consent to the use of personal information to offer you products and services is optional and if you wish to discontinue such use, you may write to Manulife at the address shown below. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Chief Privacy Officer. Manulife. P.O. Box 1602 Del Stn 500-4-A, Waterloo, Ontario N2J 4C6. A copy of our privacy policy is available on **manulife.ca.**

Accessibility statement

Manulife is committed to offering products and services to persons with disabilities, in ways that are consistent with the principles of dignity, independence, integration and equal opportunity. Manulife has a core belief that everyone should be treated with courtesy and respect and made to feel welcome. Manulife's accessibility policy allows you to receive this form in alternate formats upon request. Please contact us at accessibility@manulife.com, or call us at 1-855-891-8671, if you would prefer this document in an alternate format. If you would like more details about accessibility at Manulife, we would encourage you to visit our website at **manulife.com/accessibility**.

Manulife

Affinity Markets
Nursing Care Plan Member Questionnaire

3 Patient information
(to be completed by the plan member)

Patient's name (first, middle initial, last)			Date of birth (dd/mmm/yyyy)

If patient is not the subscriber, please provide the relationship to the subscriber

Address	City	Province	Postal code

Telephone number	Fax number	
( )	( )	

Contact name	Contact telephone number
	( )

Is Provincial Home Care or any other community organization involved in the care of this patient? ◯ Yes ◯ No

If *yes*, please indicate	Hours per week of service

Level of care provided:
◯ Registered Nurse ◯ Registered Practical Nurse ◯ Health Care Aide ◯ Personal Support Worker

If known, please provide the name and phone number of Home Care Coordinator/Case Manager:

Name	Telephone number
	( )

Please indicate whether the person requiring nursing care:

Has received reimbursement for nursing from Manulife previously? ◯ Yes ◯ No

If *yes*, please give approximate dates

Lives alone? ◯ Yes ◯ No

Has a care-giver present in the home? ◯ Yes ◯ No

Estimated number of hours per day care-giver is available

Please provide the name and telephone number of any physician active in the patient's care.

Physician's name	Telephone number
	( )
Physician's name	Telephone number
	( )
Physician's name	Telephone number
	( )

4 Patient information

(to be completed by the attending physician)

Patient's name (first, middle initial, last)

Primary diagnosis

Secondary diagnosis - other medical conditions

Surgical intervention

Date of discharge from hospital (if applicable) (dd/mmm/yyyy)

Medications (include dose and route):

Drug	Dose	Route

Prognosis:

- ◯ Good complete recovery expected
- ◯ Condition chronic, unlikely to improve or deteriorate
- ◯ Patient is expected to deteriorate gradually, has a prognosis of greater than 3 months
- ◯ Patient is expected to deteriorate quickly, has a prognosis of less than 3 months
- ◯ Patient is terminal, and is not expected to live more than a few days

Level of care requested:

◯ Registered Nurse ◯ Registered Practical Nurse ◯ Health Care Aide ◯ Personal Support Worker

Why do you feel this level of care is most appropriate?

Please outline duties of caregiver

Please indicate number of shifts and duration of care requested:	Hrs/day	Days/week

5 Functional assessment

Mobility

- ◯ ambulates independently
- ◯ ambulates with assistance, unsteady on feet
- ◯ confined to wheelchair
- ◯ confined to bed

Continence

- ◯ full control of bowel and bladder
- ◯ occasional incontinence, requires routine toileting
- ◯ incontinent of bowel/bladder
  - ◯ foley catheter
  - ◯ supra-pubic catheter
  - ◯ ostomy - please specify _____

Wounds

- ◯ none
- ◯ clean post-op incision
- ◯ clean wound - non sterile
- ◯ clean wound - sterile
- ◯ dirty wound - sterile
- ◯ burn
- ◯ decubitus ulcer
- ◯ packing/debriding

Cognitive function

- ◯ normal
- ◯ impaired but cooperative and stable
- ◯ impaired - please explain _____

Level of consciousness

- ◯ alert
- ◯ semi-conscious
- ◯ unconscious/coma

Self-care/A.D.L.

- ◯ completely independent in self-care
- ◯ does all aspects of self-care with supervision
- ◯ unable to do some aspects of self-care - explain _____
- ◯ totally dependent for all aspects of self-care

Special needs (please check the items that apply to your patient)

- ◯ oxygen
- ◯ intravenous therapy/medication
- ◯ respirator
- ◯ percutaneous nephrostomy tube
- ◯ dialysis
- ◯ airway suctioning Frequency _____
- ◯ deep suctioning Frequency _____
- ◯ tracheostomy care
- ◯ portacath or subclavian line
- ◯ chemotherapy
- ◯ frequent injectable medications
- ◯ pain pump
- ◯ other - explain below:

5 Functional assessment *(continued)*

Does your patient have any of the following:

- ◯ spinal cord injuries
- ◯ respiratory difficulties
- ◯ unstable neurological condition:
  - ◯ epilepsy
  - ◯ frequent seizures
  - ◯ other - explain _____
- ◯ renal failure
- ◯ decompensated congestive heart failure, frequent BP, PR monitoring
- ◯ terminal cancer: prognosis, expected to live only a few days
- ◯ difficulty with pain control - needs frequent adjustment of analgesics, and frequent PRN analgesia
- ◯ risk of hemorrhage - explain _____
- ◯ high risk of developing a serious infection - explain _____
- ◯ has a life threatening or unstable condition - explain _____
- ◯ brittle diabetic

Additional information

Please provide any additional information you feel may be helpful in assessing your clients nursing care needs.

6 Doctor's information

Name (or office stamp)			
Address	City	Province	Postal code
Telephone number ( )	Fax number ( )		
Physician's signature		Date signed (dd/mmm/yyyy)	