Individual Long Term Care
Alternate Plan of Care Request Form

INSTRUCTIONS: *1. You must complete this form in full.*
2. Print or type all information except where a signature is required
3. Your Physician must review and complete the certification section below
4. Return the completed form to: CNA Insurance Companies,
P.O. Box 64912, St. Paul, MN 55164-0912

Name of Insured:_____
Policy Number of Insured:_____ Social Security Number _____

1. Primary Diagnosis:_____ Date of Diagnosis:_____
2. Please state the reason for your Alternate Plan of Care Request (attach additional sheets as necessary)
_____
_____
3. Please indicate what activities the caregiver will be assisting you with and the level of assistance you require.

	Independent	Supervision / Cueing	Physical Assistance	Totally Dependent
Eating	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Transferring	☐	☐	☐	☐
Continence	☐	☐	☐	☐
Ambulating	☐	☐	☐	☐
Manage Medications	☐	☐	☐	☐
Housekeeping	☐	☐	☐	☐
Meal Preparation	☐	☐	☐	☐

4. Is continuous supervision required due to a cognitive impairment? ☐ Yes ☐ No
5. Do you receive any type of in home care (formal or informal)? ☐ Yes ☐ No
6. How many hours per day do you receive assistance? _____
7. How many days per week do you receive assistance? _____
8. From whom do you receive the assistance? _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I KNOW IT IS A CRIME TO COMPLETE THIS FORM WITH INFORMATION I KNOW IS FALSE OR TO OMIT ANY FACTS I KNOW ARE IMPORTANT

Person Submitting the Request _____ Relationship to Insured _____

Signature of Person Submitting the Request _____ Date_____

PHYSICIAN CERTIFICATION

I, Dr. _____ have reviewed the Alternate Plan of Care Request for *(Patient)*_____. I agree with the care enumerated above and certify the need for care for a six month period beginning *(Start Date)*_____ through *(End Date)*_____.

Signature of Physician_____ Date_____

Physician Address:_____
Telephone Number:_____ Fax Number: _____