LiUNA! care
LOCAL 183
BUILDING HEALTHY FUTURES

NURSING CARE

Industrial Division

Members Benefit Fund

Policy Nº - 158000

LiUNA!care LOCAL 183
MEMBER HEALTH MANAGEMENT SERVICES

Member Health Management Services
200 Labourers Way, Suite 5400 | Vaughan, ON | L4H 5H9
Tel: 416-240-2104 | Toll Free: 1-866-315-6011 | Fax: 416-240-7047
Email: memberhealthservices@liunacare183.com | liunacare183.com

Nursing Care

If you or an eligible dependent require nursing, you may be eligible for nursing care services.

Eligibility Requirements

- You must be a Member or an eligible dependent with plan coverage.
- Nursing Services must be ordered by a licensed physician (M.D.) in Canada as medically necessary for a medical condition(s) that requires the specialized training of a nurse.
- Home nursing care must be performed by a legally qualified Registered Nurse (R.N.), Registered Nursing Assistant (R.N.A.), Registered Practical Nurse (R.P.N.), or Victorian Order Nurse (V.O.N.) in Canada.
- Your nurse cannot be related you by blood or marriage, or be a member of your family, or normally reside in your home.

Benefit

- Nursing care services will be eligible up to a maximum lifetime benefit of $5,000.

Application Instructions

1. Ensure you meet the eligibility requirements for this benefit listed above.
2. Patient to complete Part 1 of the Nursing Care Health Assessment Form.
3. Plan Member and Patient to complete Part 4 of the Nursing Care Health Assessment Form.
4. Physician to complete Part 2 of the Nursing Care Health Assessment Form.
5. Homecare Case Coordinator/ Manager to complete Part 3 of the Nursing Care Health Assessment Form.
6. Include any supporting medical records.
7. Return the completed application to LiUNAcare Local 183 Member Health Management Services by

	Email:	**memberhealthservices@liunacare183.com**
	Mail:	**200 Labourers Way, Suite 5400 | Vaughan, ON | L4H 5H9**
	Fax:	**416-240-7047**
	Questions:	Email or call us at **416-240-2104** or **1-866-315-6011**

8. Keep a copy of the completed application for your records to substantiate your claim.

NURSING CARE HEALTH ASSESSMENT FORM

Once complete, return this form to:

Mail to: LiUNAcare Local 183
200 Labourers Way, Suite 5400
Vaughan, ON. L4H 5H9
Email: memberhealthservices@liunacare183.com
Fax: 416-240-7047
Tel: 416-240-2104

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 Canada Life employee benefits booklet.

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 _____
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 (< 3 months) ☐ Convalescent (3-6 months) ☐ Chronic (>12 months)
☐ Palliative (end of life) ☐ PPS Score _____

Condition classified as ☐ Unstable/unpredictable ☐ Stable/predictable

Level of Care recommended (Coverage will be based on plan design)

☐ RN (Physician must specify details in nursing treatments section)

☐ RPN / LPN (Physician must specify details in nursing treatments section)

☐ HCA/ / PSW

Part 2 CURRENT MEDICAL INFORMATION to be completed by physician (please print clearly) (Con't)

Details of Health Care Aid / Personal Support Worker requirements (non-nursing duties)

_____

_____

Details of nursing (RN/RPN/LPN) treatments: dressings, injections, etc. (must be specific to nursing care requested)
***Reminder: These duties cannot be those which can be completed by (HCA/PSW). Frequency and length of treatment required.**

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 Canada 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

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

At Canada 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. I authorize Canada Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Canada 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 also consent to the use of my personal information for Canada Life and its affiliates' internal data management and analytics purposes.

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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

Plan Member Name _____ Signature _____

Patient Name _____ Signature _____

Date _____