



Name: _____
(First) (MI) (Last)

Home Address: _____
(Street)

(City) (State) (Zip)

Telephone: (_____) _____ Best Time to Call: _____

Date of Birth: ____/____/____ Social Security Number: ____-____-____

- | | | |
|--|------------------------------|-----------------------------|
| 1. Do you currently need or receive assistance or supervision performing everyday living activities, such as walking, bathing, dressing, eating, transferring or toileting? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Are you currently confined to a hospital, nursing home, assisted living facility or are you receiving any type of care or assistance in your home? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Do you use oxygen continuously or a walker or a wheelchair more than once per week? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Have you ever been diagnosed with or treated for: | | |
| a) Mental Retardation, Alzheimer's Disease, Dementia, Senility or any other type of Organic Brain Syndrome or Disorder, Schizophrenia, or consulted a physician about memory loss, forgetfulness or confusion? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b) Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c) ALS (Amyotrophic Lateral Sclerosis or Lou Gehrig's Disease), Cerebral Palsy, Charcot Marie Tooth, Cystic Fibrosis or Muscular Dystrophy? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Have you ever tested positive for Huntington's Chorea? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

IF ANY OF THE ABOVE QUESTIONS ARE ANSWERED YES, THIS FORM SHOULD NOT BE SUBMITTED.

PRODUCER CERTIFICATION

By signing below, I certify to the Company that:

- I personally spoke to the above-named client on ____/____/____ by phone in person.
- I have completed this form accurately and completely, based upon information obtained directly from the client.
- I have advised the client that:
 - this is **not** an application for insurance.
 - his or her eligibility for coverage will be evaluated through an in-home health interview performed by a Registered Nurse and medical records.
 - he or she will be contacted to schedule a face-to-face health interview, which will be conducted in his/her home.
- I am familiar with, have observed and fully complied with all applicable laws, regulations, rules, and requirements, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA), Gramm-Leach Bliley Act (GLB), "Do Not Call" and privacy.

Producer's Signature Date

Producer's Name (please print) Producer's Number

Annual Budget Preference: _____

Plan Preference: Comprehensive Stand Alone HHC Stand Alone Facility