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LONG-TERM CARE – DAILY VISIT NOTES AND CARE LOG

The Company You Keep®

NEW YORK LIFE LONG-TERM CARE INSURANCE
PO Box 64670, St. Paul, MN 55164-0670
Phone: 800-224-4582 Fax: 908-840-3043

Return Completed Form and Invoice To:	**Claimant Information:**
New York Life Long-Term Care Insurance Attn: Claims Department PO Box 64670 St. Paul, MN 55164-0670 Fax: 908-840-3043 E-Fax: claimsfax@newyorklifeltc.com	Last Name First Name MI Policy Number Claim Number

HOW TO COMPLETE THIS FORM – Instructions to the Caregiver

This form is to be used after New York Life Insurance Company has determined eligibility under the Home and Community-Based Care Benefit and after the claimant has begun to receive home care services from an eligible provider.

1. If daily visit notes or a daily log **is not already completed by your care provider**, please have your provider complete this *Daily Visit Notes and Care Log* for each day of services and submit it on a weekly basis with the weekly care invoice for ongoing claims.
2. The care provider must record the home health care services provided for each day and **complete the entire form**.
3. Indicate the date of service under each day of the week.
4. Indicate under Activities of Daily Living and Instrumental Activities of Daily Living whether the care provided is hands-on assist **(HOA)**, standby assist within arms length **(SBA)**, or not provided **(N/P)**.
5. **For Cognitive Impairment Claims Only:** Indicate if supervision is provided due to a severe cognitive impairment by checking the box on those days supervision is provided. Also indicate in the ADLs and IADLs section if cueing **(CUE)** is required for the claimant to complete the ADLs or IADLs.
6. The **claimant** (or legal representative if required) and **caregiver** must sign and date this form.
7. Return this *Daily Visit Notes and Care Log* and the weekly care invoice(s) to the address above or send it via fax to 908-840-3046 or e-fax to claimsfax@newyorklifeltc.com.

HOME CARE PROVIDER INFORMATION (To be completed by the Caregiver – Please Print)

Full Name of Caregiver providing care:		
Name and Credentials/Title of Caregiver's Supervisor:		
Name of Home Care Agency:		
Street Address:		
City:	State:	Zip Code:
Phone #:	Fax #:	

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CARE LOG

Date (indicate under each day)	**Sunday** ___/_ /_ __	**Monday** __ _/___/_ __	**Tuesday** ___/_ /_ __	**Wednesday** ___/_ /_ __	**Thursday** ___/_ /_ __	**Friday** __ _/___/_ __	**Saturday** ___/___/___
Time In (specify am/pm)							
Time Out (specify am/pm)							
Activities of Daily Living Indicate HOA (hands-on assist) or SBA (standby assist within arms reach) or N/P							
Bathing							
Dressing							
Toileting							
Transferring							
Incontinence Care							
Eating (feeding - not meal prep)							
Ambulation, including walking							
Instrumental Activities of Daily Living Complete as instructed above							
Medication Administration							
Meal Preparation							
Laundry							
Housekeeping							
Transportation							
Supervision for Safety/Fall Risk							
Cognitive Impairment Use if claimant is on claim due to a cognitive impairment – Indicate by check if supervision was provided for safety due to cognitive impairment – elaborate in notes							
Supervision for Safety due to Cognitive Impairment							
Total Hours Per Day:							

Additional Services/Notes (attach additional sheets if needed)**:**

I hereby certify that the Home Care services listed above were provided to me, the claimant, on the dates indicated above. I further understand that benefit payments will be made payable to me.

Claimant Signature:_____ Date: _____

Caregiver Signature:_____ Date: _____

PLEASE NOTE: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement is guilty of insurance fraud.