LONG TERM CARE FACTFINDER

Client Name: _____ Spouse: _____

Date of Birth: _____ Date of Birth: _____

Smoker: _____ Smoker: _____

Height: _____ Weight: _____ Height: _____ Weight: _____

HEALTH QUALIFICATION:

1) Have you been treated for any medical conditions in the past 5 years? Please List, including dates.

_____ _____

_____ _____

_____ _____

_____ _____

2) Are you currently taking any medication? Please list medication, dosage, date prescribed, reason for drug:

_____ _____

_____ _____

_____ _____

_____ _____

3) Have you been hospitalized in the past 5 years? Please list dates and reasons.

_____ _____

_____ _____

_____ _____

_____ _____

PLAN DESIGN (Please Check One)

☐ Partnership ☐ Traditional

NURSING HOME AMOUNT (Please Check One)

☐ Daily ☐ Monthly $ Amount _____ # of Years _____ Waiting Period _____

PLEASE FAX COMPLETED FACTFINDER TO SPECIFIC SOLUTIONS AT 716-632-6051 OR EMAIL mtomaka@specificsolutions.com

For questions, please contact Margaret Tomaka at 716-632-7777 or 1-800-873-2345

AGENT _____

Fax or email _____