

**CSA RETIREE WELFARE FUND  
HOME HEALTH AIDE CARE CLAIM FORM**

**TO BE COMPLETED BY PATIENT. (A DESIGNATED REPRESENTATIVE OF THE PATIENT MAY COMPLETE THIS PORTION OF THE FORM IF THE PATIENT IS UNABLE TO DO SO.)**

MEMBER : \_\_\_\_\_ SOCIAL SEC # : \_\_\_\_\_  
(Last, First, Middle Int)

ADDRESS: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_  
\_\_\_\_\_

NAME OF PATIENT (If not member): \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Last, First, Middle Init)

RELATION TO MEMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE#(\_\_\_\_) \_\_\_\_\_  
(if different from member) (Street, City, State, Zip)

WHERE IS PATIENT CURRENTLY RESIDING? \*

OWN RESIDENCE  RESIDENTIAL ASSISTED LIVING/PERSONAL CARE FACILITY  
 OTHER (EXPLAIN) \_\_\_\_\_

\*PATIENTS WHO ARE HOSPITALIZED, OR RESIDING IN A NURSING HOME /REHABILITATION CENTER ARE NOT ELIGIBLE FOR THIS BENEFIT.

IF OTHER THAN YOUR RESIDENCE, WHAT IS THE NAME, ADDRESS, TELEPHONE NUMBER AND DATE YOU ENTERED THIS LOCATION?

FACILITY: \_\_\_\_\_ DATE ENTERED \_\_\_\_/\_\_\_\_/\_\_\_\_ ADDRESS: \_\_\_\_\_

TEL. # : \_\_\_\_\_

IF PATIENT HAS BEEN HOSPITALIZED OR CONFINED TO ANY OTHER TYPE OF FACILITY WITHIN THE LAST YEAR, PLEASE COMPLETE THIS SECTION:

1. \_\_\_\_\_  
NAME OF HOSPITAL/ FACILITY: \_\_\_\_\_ ADDRESS: (City, State, Zip) \_\_\_\_\_ ADMITTED \_\_\_\_/\_\_\_\_/\_\_\_\_ DISCHARGED \_\_\_\_/\_\_\_\_/\_\_\_\_
2. \_\_\_\_\_  
NAME OF HOSPITAL/ FACILITY: \_\_\_\_\_ ADDRESS: (City, State, Zip) \_\_\_\_\_ ADMITTED \_\_\_\_/\_\_\_\_/\_\_\_\_ DISCHARGED \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE LIST THE PHYSICIANS PATIENT SEES ON A REGULAR BASIS OR HAS CONSULTED IN REGARD TO THIS CONDITION, ALSO INDICATE WHICH PHYSICIAN IS THE PRIMARY PHYSICIAN.**

1. \_\_\_\_\_  
NAME: \_\_\_\_\_ SPECIALTY \_\_\_\_\_ DATE FIRST SEEN \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE LAST SEEN \_\_\_\_/\_\_\_\_/\_\_\_\_  
ADDRESS: (Street, City, State, Zip) \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

2. \_\_\_\_\_  
NAME \_\_\_\_\_ SPECIALTY \_\_\_\_\_ DATE FIRST SEEN \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE LAST SEEN \_\_\_\_/\_\_\_\_/\_\_\_\_  
ADDRESS: (Street, City, State, Zip) \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

IS PATIENT CURRENTLY, OR HAS PATIENT RECENTLY, RECEIVED ANY OF THE FOLLOWING SERVICES?

HOME HEALTH SERVICES  PHYSICAL THERAPY  OCCUPATIONAL THERAPY  
 OTHER SERVICES \_\_\_\_\_

IF YES PROVIDE THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE AGENCY OR INDIVIDUAL PROVIDING THE SERVICE (S)

NAME / AGENCY \_\_\_\_\_ ADDRESS \_\_\_\_\_ TEL. NO \_\_\_\_\_

PRIMARY CONTACT (IF DIFFERENT THAN CLAIMANT): \_\_\_\_\_ RELATION: \_\_\_\_\_

ADDRESS (Street, city, State, Zip) \_\_\_\_\_ TELEPHONE \_\_\_\_\_

INDIVIDUAL COMPLETING THIS FORM: \_\_\_\_\_ RELATION: \_\_\_\_\_  
ADDRESS (If Different From Above) \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION:** The above statements are true and complete to the best of my knowledge I hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance company or government agency to disclose or furnish to the CSA Retiree Welfare Fund or representatives, any information with respect to any illness including mental illness, drug/alcohol abuse, injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records that may be requested, I understand that any information obtained pursuant to this authorization will be used to evaluate my claim. This authorization is valid during the pendency of my claim. I understand I have the right to request a copy of this authorization and that a copy will be sent to me if requested. A photostatic copy of this form will be as valid as the original.

X \_\_\_\_\_  
Please print name here

X \_\_\_\_\_  
Signature of Claimant or Claimant's Designated Representative

IF SOMEONE OTHER THAN THE CLAIMANT SIGNS THIS FORM, PLEASE ENCLOSE A COPY OF ANY POWER OF ATTORNEY, GUARDIANSHIP, OR TRUST PAPERS.

**TO BE COMPLETED BY PRIMARY PHYSICIAN:**

WHAT IS PATIENT'S PRIMARY DIAGNOSIS? \_\_\_\_\_  
\_\_\_\_\_

ARE THERE OTHER CONDITIONS CONTRIBUTING TO PATIENT'S NEED FOR ASSISTANCE? \_\_\_\_\_  
\_\_\_\_\_

WHAT ASSISTANCE DOES PATIENT NEED AND WHY? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHEN DID PATIENT FIRST BEGIN TO NEED ASSISTANCE? \_\_\_\_\_

WHO PROVIDED THIS ASSISTANCE? \_\_\_\_\_

HOW LONG DO YOU ANTICIPATE PATIENT WILL NEED THIS ASSISTANCE? \_\_\_\_\_  
\_\_\_\_\_

SIGNATURE OF PHYSICIAN: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

PRINT NAME OF PHYSICIAN \_\_\_\_\_

- HOW TO FILE A CLAIM:**
1. PLEASE COMPLETE ALL PORTIONS OF THIS FORM. WE CANNOT PROCESS YOUR CLAIM WITHOUT A COMPLETED FORM.
  2. ATTACH COPIES OF ITEMIZED BILLS, INCLUDING DATES AND TIME OF HOME HEALTH AIDE SERVICE AND COPIES OF CANCELLED CHECKS (FRONT &N BACK) CORRESPONDING TO SERVICES.
  3. A COPY OF HOME HEALTH AIDE CERTIFICATION MUST BE ATTACHED FOR EACH HOME HEALTH AIDE PROVIDING CARE.

**BENEFIT LIMITATIONS:** THE PURPOSE OF THIS BENEFIT IS TO PROVIDE NECESSARY HOME CARE FOR MEMBERS AND/OR ELIGIBLE DEPENDENTS WHO CANNOT PERFORM AT LEAST TWO ACTIVITIES OF DAILY LIVING WITHOUT ASSISTANCE AS CERTIFIED BY THE PATIENT'S PRIMARY CARE PHYSICIAN. SUCH SERVICES MUST BE PROVIDED BY A CERTIFIED HOME HEALTH AIDE OR A LICENSED HOME CARE AGENCY.

ELIGIBILITY FOR THIS BENEFIT REQUIRES THAT THE PATIENT BE HOSPITALIZED FOR A LEAST THREE DAYS AND HOME CARE SERVICES COMMENCE WITHIN 30 DAYS AFTER DISCHARGE.

THE ACTIVITIES OF DAILY LIVING ARE EATING, BATHING, BLADDER CONTROL, TOILETING, DRESSING, AND TRANSFERRING. IN ADDITION, ELIGIBILITY MAY ALSO INCLUDE COGNITIVE IMPAIRMENT DUE TO SUDDEN INJURY OR STROKE.

BENEFITS WILL BE PAID AT 80% OF REASONABLE AND CUSTOMARY CHARGES TO A CALENDAR YEAR MAXIMUM OF \$4,000 AND LIFETIME MAXIMUM OF \$12,000. THE DETERMINATION OF ELIGIBILITY AND REASONABLE & CUSTOMARY CHARGES WILL BE AT THE SOLE DISCRETION OF TRUSTEES OF THE CSA RETIREE WELFARE FUND.