



Long-Term Care Consultants

9100 Arboretum Parkway, Suite 180, North Chesterfield, VA 23236

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www.LTCCINC.COM

804-306-0016 Phone

=888-877-6625 Facsimile=

Date: _____ Submitting Agent, if applicable: _____

Name: _____ Spouse/Partner: _____

Gender: _____ Gender: _____

Address: _____

City & State & Zip Code: _____

Email Address: _____

Daytime Phone Number: _____ Evening Phone Number: _____

Applicant A: _____ Applicant B: _____

Birth Date: _____ Height: _____ Birth Date: _____ Height: _____

How much did you weigh at your last doctor's appointment? _____/_____

Are you receiving Social Security Disability, have a handicap placard or receiving Workmen's Compensation? ___/___

Have you ever been declined for health insurance, life insurance or long term care insurance? ___/___

Are you or your spouse a wartime Veteran? _____

Have you had a steroid (cortisone) shot in the last 12 months? _____/_____

Have you used any form of tobacco in the last 2 years? _____/_____

Applicant A: _____ Applicant B: _____

1. Have you had, do you currently have, have you been medically diagnosed as having or have you been treated for:

____yes ____no a. Cancer (except basal cell cancer)? ____yes ____no

____yes ____no b. Heart disease, congestive heart failure, angina, heart attack, heart surgery, angioplasty or hypertension? ____yes ____no

____yes ____no c. Stroke or any other type of cerebral vascular accident (CVA); transient ischemic attack (TIA)? ____yes ____no

____yes ____no d. Asthma, chronic lung, liver or kidney disease? ____yes ____no

____yes ____no e. Diabetes – Type I or II – insulin or non-insulin dependent? ____yes ____no AIC Level _____/_____

Applicant A: _____ Applicant B: _____

- ____yes ____no f. Chronic neurological disease (e.g., brain disorder or seizure disorder, or conditions of the spine or peripheral nerves) or any psychiatric disorder (e.g., bipolar, depression, anxiety)? ____yes ____no
- ____yes ____no g. Osteoarthritis, rheumatoid arthritis, immune system disorders any connective tissue disorders? ____yes ____no
- ____yes ____no h. Amputation, osteoporosis, joint replacement? ____yes ____no
- ____yes ____no i. More than one fractured bone or any falls in the last 2 years? ____yes ____no
- ____yes ____no j. Paralysis, weakness or numbness of extremities, tremors, Imbalance, gait disturbance or dizziness? ____yes ____no
- ____yes ____no k. Memory loss? ____yes ____no

2. Have you ever:

- ____yes ____no a. Been treated for degenerative joint disease, scoliosis, or spinal stenosis? ____yes ____no
- ____yes ____no b. Been eligible to receive payment for long-term care services under any long-term care insurance plan? ____yes ____no

3. Have you ever resided in or been advised to enter a nursing home, assisted living community or retirement community, adult day care?

____yes ____no ____yes ____no

4. Do you currently use any medical equipment (e.g. cane, brace, crutches, hospital bed or stair lift)?

____yes ____no ____yes ____no

5. In the last 2 years, have you been hospitalized?

____yes ____no ____yes ____no

6. In the past 10 years, have you had any surgeries or do you plan to have surgery? Or have you been advised to seek medical attention for any symptoms, testing, surgery or treatment?

____yes ____no ____yes ____no

7. Have you taken any prescription medications during the past 12 months?

____yes ____no ____yes ____no

Applicant A: _____

Medication Name	Dosage	Reason for Taking	Date Began Taking

Do you use any disposable medical devices, i.e., catheter?

If you have answered "yes" to any of the questions above, please provide full details. Attach a separate sheet if you need additional space.

Is there anything else about your health that we have not asked that we should discuss? _____yes _____no

Applicant B: _____

Medication Name	Dosage	Reason for Taking	Date Began Taking

Do you use any disposable medical devices, i.e., catheter?

If you have answered "yes" to any of the questions above, please provide full details. Attach a separate sheet if you need additional space.

Is there anything else about your health that we have not asked that we should discuss? _____yes _____no

Applicant A: _____ Applicant B: _____

Primary Care Physician Name, Address, Phone:

Primary Care Physician Name, Address, Phone:

Date last seen: _____

Date last seen: _____

Have you seen a specialty physician(s) in the last three years? If so, please list below.

Specialty Physician(s) Name, Address, Phone, Reason for visit:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please attach a separate sheet if you need additional space.

Do you own a permanent life insurance policy with a cash value? _____yes _____no

If yes, have you reviewed it lately? _____yes _____no

Please forward via facsimile to: Long Term Care Consultants, Inc., 888-877-6625 or email to Linda@LTCCINC.COM.

Or mail to: Long-Term Care Consultants Inc., 9100 Arboretum Parkway, Suite 180, North Chesterfield, VA 23236