A BRIDGE OVER TROUBLED WATERS
Long-Term Care Consultants
9100 Arboretum Parkway, Suite 180, North Chesterfield, VA 23236
Linda@LTCCINC.COM www.LTCCINC.COM 804-272-5827 Office Phone =804-272-5825 Office 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? AIC Level _____/_____**	**____yes ____no**

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	
_____yes _____no	**community or retirement community, adult day care?**	**_____yes _____no**
	4. Do you currently use any medical equipment (e.g. cane, brace,	
_____yes _____no	**crutches, hospital bed or stair lift?**	**_____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

_____

_____

_____

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

_____

_____

_____

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:

_____

_____

_____

_____

_____

Date last seen: _____

Primary Care Physician Name, Address, Phone:

_____

_____

_____

_____

_____

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., 804-272-5825 or email to Linda@LTCCINC.COM.

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