APPS
PARA MEDICAL SERVICES

LONG TERM CARE ASSESSMENT

Insurance Company: _____

_____

Instructions to Medical Examiner:

- **Form to be completed in ink and in interviewer's own handwriting.**
- **Each question to be read, and answered by, the proposed Insured.**
- **Record full details to every answer.**

Last Name	First	Middle	Date of Birth

Residential Address	City	State	Zip

Type of Residence	Home Phone Number

Date	Signature

Are you currently employed? ____ **What is your occupation?** _____

Number of hours worked on a weekly basis? _____

INSTRUCTIONS FOR DWR PORTION OF LTC EXAM

Questions 1a, 1b and 15 are part of a short memory test called the Delayed Word recall (DWR). This is a standard test used to measure short-term memory and is used in evaluating applicants for this type of insurance. In order for the DWR test to be reliable as a screening tool, its administration must be consistent. Before administering the DWR test, please read these instructions carefully, as well as the specific instructions on pages 2 and 4. **THE ATTACHED CHART OF 10 WORDS SHOULD BE PRECUT INTO FLASH CARDS PRIOR TO THE APPOINTMENT.** THESE WORDS MATCH THE WORDS LISTED ON PAGE 2. If 2 persons are being interviewed, i.e., husband and wife, use 2 different forms (containing different words).

PLEASE RECORD THE TIME AFTER 1b IS COMPLETED AND BEFORE 15 IS STARTED.

Continue with the examination, allowing a delay interval of 5 to 15 minutes between completion of question 1b and the start of 15. **It is imperative to have a delay of at least 5 but no more than 15 minutes. If 15 minutes goes by following question 1b and you have not reached question 15, please go to it immediately. After completion of question 15, complete all remaining sections of the exam.**

For question 15, record the time before starting this question, then read the question as stated. **Do not repeat the words to the applicant.** Write down each word as it is recalled by the applicant, even if the same word is repeated or the word is not included in the original list. Please do this without questioning or prompting.

The DWR test may annoy the applicant. Unfortunately, this is often the only way we can effectively screen an applicant for cognitive impairment. You should convey to the applicant that this test is important to the insurance company. **If at any time during the DWR test the applicant becomes overly anxious or annoyed, please note on exam and proceed with the next question. The evaluation of the entire exam will be done by the underwriting department at the home office. They will notify the applicant of their decision.**

VITALS: **Measured Height** _____ **Scale Weight** _____	**Blood Pressure** **(If 1st reading is greater than 150/90 take two additional readings)**
Any recent weight loss? ____ **If so, how much?** _____ **lbs.** **Why?** _____	**Systolic** _____ **Diastolic** _____

	1	2	3
Systolic			
Diastolic			

1.a. **EXAMINER INSTRUCTIONS**: Show each word to the applicant while you read each word aloud. Ask the person to form a sentence using that word. Wait for his/her reply. Then proceed to the next word. Repeat this process with all of the words. Use the flash cards for the following 10 words:

HOUSE - FRUIT - SUGAR - DOG - HORN - CHAIR - SHIRT - BALL - LAKE - DOOR

NO RECORDING OF HIS/HER REPLY IS REQUIRED.

If 2 persons are being interviewed, i.e., husband and wife, use 2 different exam forms containing different word lists.

b. **EXAMINER INSTRUCTIONS**: Inform the applicant as follows: "Now I am going to repeat the same words as before, and ask you to again use them in a sentence. You may either make up a new sentence or use the same sentence you used before." Read each word aloud. Ask the person to form a sentence using that word. Wait for his/her reply. Then proceed to the next word. Repeat this process with all of the words.
NO RECORDING OF HIS/HER REPLY IS REQUIRED.

HOUSE - FRUIT - SUGAR - DOG - HORN - CHAIR - SHIRT - BALL - LAKE - DOOR

Time _____ **(RECORD THE TIME WHEN EXERCISE 1b IS COMPLETED)**

2. Name, address and phone number of your primary care physician who has your complete medical records:

_____

Date last seen and reason for consultation: _____

_____

3. Have you consulted with or been referred to any other physicians by your primary care physician within the last three years? _____
Date and reason for consultations: _____
Name, address & phone number of doctors: _____

_____

_____

4. Have you been hospitalized within the past three years? Y ☐ N ☐ If yes, details i.e. when, how long, where, reason, procedures, surgery, etc._____

_____

_____

5. In the past five years, have you experienced or have you been treated for the following (answer "yes" or "no" and record the answer next to each disorder listed below):

Y	N		Y	N		Y	N	
☐	☐	Headaches	☐	☐	Chest Pain/Angina	☐	☐	Periods of Memory Problems
☐	☐	Weakness	☐	☐	Irregular Heartbeat	☐	☐	Periods of Confusion
☐	☐	Numbness	☐	☐	Paralysis or Stroke	☐	☐	Recent Onset Visual Problems or Blindness
☐	☐	Dizziness	☐	☐	Parkinson's	☐	☐	Swelling or Pain in Legs or Arms
☐	☐	Fainting	☐	☐	Emphysema			
☐	☐	Falls	☐	☐	Shortness of Breath			

Please provide details to any "yes" answer: _____

_____

_____

6. Please list all medications currently being taken, the dosage and date prescribed, and the reason for taking. Include any recent changes or adjustments.

_____

_____

_____

7. Is any assistance needed for walking, such as a wheelchair, walker, cane, crutches, electric cart or support from another person? Y ☐ N ☐ If yes, give details: _____

_____

8.a. Are you able to do your own laundry, cooking, cleaning and grocery shopping? Y ☐ N ☐

If no to any, give details: _____

b. Do you drive? Y ☐ N ☐ If "yes", how many miles per week or per month? i.e. 50 mi/wk. _____

If "no", do you use public transportation? Y ☐ N ☐ If "No", what form of transportation are you using?

_____

9. Please describe your current activities on a typical day. Any outside activities, volunteer work (# of hours) or hobbies? Regular exercise Y ☐ N ☐ If "yes", what kind, how often? _____

_____

_____

10. Do you experience any loss of control of your bowel or bladder? Y ☐ N ☐
If yes, how often does this happen? _____

11. Functional abilities (please check the appropriate box):

Any assistance needed with the following?	No Help	Assistive Device	Physical Assist or Supervision Needed
Bath/Shower	☐	☐	☐
Indoor mobility	☐	☐	☐
Outdoor mobility	☐	☐	☐
Getting in or out of a bed or chair	☐	☐	☐
Climbing stairs	☐	☐	☐
Eating	☐	☐	☐
Toileting/dressing	☐	☐	☐

Please record details if assistance is needed, including what kind of assistance and how often needed.

_____

_____

_____

12. Do you manage your own financial matters such as paying bills, banking, balancing your checkbook?

Y ☐ N ☐ If "yes", How (i.e., in person, mail, phone)? _____

13.a. Who would take care of you in the event of a prolonged illness? _____

b. Do you have family in this area? ____ Relationship? _____

14. **EXAMINER INSTRUCTIONS**: Please **ask the applicant to stand up**, then **remain standing in place for 10 to 15 seconds with eyes open** and also **with eyes closed**. Please **observe for any loss of balance**. The **applicant** should then **walk 10-15 feet, turn around and walk back to the chair and sit down. Please describe your observations**.

Did the applicant need the aid of the chair armrest to stand? _____

Any unsteadiness, imbalance or other difficulties? _____

Any devices? _____

_____

Time: _____ **(RECORD THE TIME AND BEGIN THE FOLLOWING)**

15. **EXAMINER INSTRUCTIONS**: Read the following aloud to the applicant: "A few minutes ago, I read you some words and asked you to make a sentence with each of them. I would like you to tell me as many of the words as you can remember. Take your time." **(EXAMINER NOTE: Do not repeat the list of words.)** Record his/her reply below, even if the same word is repeated or the word is not included on the original list. Please do this without questioning or prompting. This is not a pass or fail exercise

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____

Signature of Applicant Date Signature of Interviewer and Title/Accreditation

EXAMINER:

Please provide an explanation for any questions that are unanswered or examiner's observation, i.e., mental slowness or physical problems/limitations.

_____

_____

_____

_____

_____

_____

_____

HOUSE	FRUIT
SUGAR	DOG
HORN	CHAIR
SHIRT	BALL
LAKE	DOOR