CCWU care

BUILDING HEALTHY FUTURES

CCWU™

Canadian Construction Workers Union Benefit Trust Fund

NURSING CARE

CANADIAN CONSTRUCTION WORKERS UNION BENEFIT TRUST FUND

NURSING CARE

SUBMISSION INSTRUCTIONS:

- Section 1 & 4 to be completed and signed by Member (or Power of Attorney).
- Section 2 to be completed and signed by your Physician.
- Section 3 to be completed and signed by your Case Manager.
- Policy No. 177869. Please keep a copy of completed application package for your records to substantiate your claim.
- Send all original completed applications to:

CCWUcare
2100 - 200 Labourers Way
Vaughan, ON L4H 5H9

Tel: 416-240-0047
Fax: 416-240-7488
Email: info@ccwucare.com

Nursing Care Health Assessment Form

Once complete, return this form to:

Mail to: CCWUcare
200 Labourers Way
Suite 2100
Vaughan, ON L4H 5H9

Instructions for completion

This form ***must be completed in full*** to avoid a delay in assessing the claim. Once we have all the required information and have assessed the claim, we will notify the claimant in writing regarding plan coverage and the number of eligible hours.

Fees for providing medical information are not payable by your plan.

If you have questions, please refer to your Canada Life employee benefits booklet or call 416.240.0047.

Part 1 – Patient information - to be completed IN FULL by plan member

Plan Number: 177869 Plan Member I.D. Number: _____

Patient Name: _____ Phone Number: _____

Patient Address _____
Number and street Apt. number City or town Province Postal code

Date of Birth _____
Month Day Year

Language preference: ☐ English ☐ French

Correspondence preference: ☐ Letter mail ☐ Email

Email address: _____ (illegible writing will default communication to letter mail)

Has a previous application for nursing benefits or health assessment form been submitted? ☐ Yes ☐ No

Other Insurance? ☐ Yes ☐ No

If "Yes", name of insurance company _____ Plan number _____

If you have been approved for nursing under another plan/government program aside from provincial home care; please provide us with a copy of this approval.

Part 2 – Current medical information - to be completed by physician (please print clearly).

If additional space is required, please attach a separate sheet. Ensure writing is legible.

Current Diagnosis _____

_____

Past Medical History _____

_____

Prognosis _____

_____

Surgical procedures and dates _____

Condition classified as ☐ Acute (< 3 months) ☐ Convalescent (3-6 months) ☐ Chronic (>12 months)
☐ Palliative (end of life) ☐ PPS Score: _____

Condition classified as ☐ Unstable/unpredictable ☐ Stable/predictable

Level of Care recommended (Coverage will be based on plan design)

☐ RN (Physician must specify details in nursing treatments section)
☐ RPN / LPN (Physician must specify details in nursing treatments section)
☐ HCA / PSW

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Part 2 – Current medical information - to be completed physician (please print clearly) (Con't)

Details of Health Care Aid / Personal Support Worker requirements (non-nursing duties)

_____

_____

Details of nursing (RN/RPN/LPN) treatments: dressings, injections, etc. (must be specific to nursing care requested)

***Reminder: These duties cannot be those which can be completed by (HCA/PSW). Frequency and length of treatment required.**

1. _____
2. _____
3. _____
4. _____

Current medications: route, dose, frequency

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

CHECK OR COMMENT ON ALL THAT APPLY:

Vital signs: BP _____ Pulse _____ Resp. _____ Temp _____ O2 sats _____

Pain/discomfort Location 1: _____ **Pain/discomfort Location 2:** _____

Frequency _____ Frequency _____

Duration _____ Duration _____

Alleviated by _____ Alleviated by _____

Precipitating factors _____ Precipitating factors _____

Integument

☐ No skin problems ☐ Lesion ☐ Rash ☐ Callous ☐ Bruise ☐ Ulcer ☐ Discharge ☐ Varicosity ☐ Skin breakdown

If yes, explain _____

Oral cavity Special diet ☐ Yes ☐ No Type: _____

☐ No reported concerns ☐ Difficulty chewing ☐ Difficulty swallowing ☐ Dentures: ☐ Upper ☐ Lower

☐ Other _____

Neurological/cognitive levels Level of consciousness ☐ Alert ☐ Altered

☐ Seizures ☐ Fainting ☐ MMSE Score: _____ Date: _____ ☐ Tremors ☐ Spastic

☐ Cognition/Orientation: Difficulty ☐ Yes ☐ No If yes, please explain: _____

☐ Other _____

Respiratory/cardiovascular

☐ S.O.B. ☐ Rest or activity ☐ Orthopnea Cough: ☐ Non-productive ☐ Productive

☐ Cyanosis ☐ Wheezes ☐ Crackles Oxygen use: ☐ Continuous ☐ Intermittent ☐ Rate _____

☐ Nebulization ☐ Ventilator ☐ Tracheotomy

☐ Other _____

Cardiovascular Chest pain? ☐ Yes ☐ No (If yes, please explain)_____

History of: ☐ Hypertension ☐ Hypotension ☐ Dizziness

If yes, explain aggravating factors / remarks: _____

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Part 2 – Current medical information - to be completed physician (please print clearly) (Con't)

Circulation Difficulty? ☐ Yes ☐ No (If yes, please explain) _____

☐ Edema: ☐ Pitting ☐ Dependent ☐ Right ☐ Left ☐ Bilateral

Gastrointestinal system

☐ Bleeding ☐ Ostomy ☐ GI upset ☐ Diarrhea Appetite: ☐ Good ☐ Poor

☐ Constipation ☐ Nausea/vomiting ☐ Gastrostomy/enteral tube

☐ Other _____

Vision

☐ No reported visual loss ☐ Blind ☐ Cataracts ☐ Partially impaired (details) _____

Hearing/ears

☐ No hearing loss ☐ Hearing device ☐ Deaf ☐ Partially impaired (details) _____

Musculoskeletal

☐ No reported concerns

☐ Coordination/Balance _____ ☐ Swollen joints _____

☐ Prosthesis R/L _____ ☐ Limited R.O.M. _____

☐ Amputation R/L _____ ☐ Other _____

Genital/Urinary

☐ Full control _____ ☐ Frequency _____

☐ Incontinence _____ ☐ Blood in urine _____

☐ Difficulty urinating _____ ☐ Nocturia _____

☐ Indwelling catheter _____ ☐ Other _____

Activities of daily living

Adaptive Equipment used at Home:

☐ Cane ☐ Wheelchair ☐ Hospital bed ☐ Eating aids ☐ Standard walker ☐ Wheeled walker ☐ Commode ☐ Toilet aids ☐ Lift

☐ Tub aids ☐ None ☐ Other _____

☐ Independent _____

☐ Requires assistance with: ☐ Mobility ☐ Feeding ☐ Hygiene ☐ Dressing ☐ Toileting ☐ Other _____

Assistance provided by: _____

Physician name (print): _____ Phone number _____

Address _____

Number and street City or town Province Postal code

Physician's signature: _____ Date: _____

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Nursing Care Health Assessment Form

Part 3 – Confirmation of provincial homecare entitlement - to be completed by provincial coordinator.

Please be advised that this document will enable the nursing specialist at Canada Life to expedite your claim in an efficient and accurate manner. Please have your homecare case co-ordinator / manager fill this out.

Patient name: _____

Canada Life policy number: _____ Canada Life ID Number: _____

Homecare Manager Name: _____ Phone number: _____

Case manager: Please provide the current level of care patient is receiving.

Home Support Workers (☐ HCA ☐ PSW ☐ HOMEMAKERS) - hourly

Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? ☐ Yes ☐ No

Nurse Practitioner Visits

Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? ☐ Yes ☐ No

Nursing (☐ RN ☐ LPN ☐ RPN)

☐ Home visits only - Frequency _____ Focus of intervention _____

☐ Shifts in home - Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? ☐ Yes ☐ No

Palliative Pain & Symptom Management

Frequency _____ Focus of intervention _____

Treatment end date _____ Max hours reached? ☐ Yes ☐ No

Case manager signature _____ Date _____

Part 4 – Privacy

Protecting your personal information. At Canada Life, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information. Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to provide you with advice, evaluate your eligibility for products, price our products, collect feedback on our customer service, process claims and other financial transactions, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. If you provided your social insurance number (SIN), we'll use it for tax reporting. Your SIN is also used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with. We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, our Canadian subsidiaries, and other organizations that provide us services such as paramedical examiners, medical laboratories, MIB, LLC., specialty coverage providers, independent medical examiners, and pharmacy benefits managers. As well, we may share your information with claims assessors, travel assistance providers, technology suppliers, other insurance or reinsurance companies, other financial institutions, and credit reporting agencies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies and may be communicated outside your province of residence or outside Canada. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information. We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by updating your privacy preferences through your online account or by submitting a request through our privacy centre at canadalife.com/privacy. This includes choosing whether you receive customer experience surveys, the use of your SIN for non-tax reporting purposes, and whether and how you want to receive information and offers from Canada Life using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights through our privacy centre such as access to or correction of your personal information.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

Want to learn more? Please visit canadalife.com/privacy.

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Part 5 – Privacy consent, authorization and signature

I understand that my personal information will be collected, used and shared as set out above.

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependants; and that my spouse and/or dependants are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offense. Canada Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

I agree that by submitting this form or authorizing it to be submitted, I am consenting to the terms set out in this section, even if I have not signed the form.

Plan member name: _____ Signature: _____

Patient name: _____ Signature: _____

Date: _____

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