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CAREGIVER QUESTIONNAIRE
The Benefits Center
P.O. Box 100196, Columbia, SC 29202-9975
Phone: 1-800-693-4988, Fax: 1-800-268-1377

02875012133162001

GENERAL INFORMATION

Claimant's Name: Esther Cho Claim Number: 20433514

CURRENT DIAGNOSIS, SYMPTOMS, OR COMPLICATIONS

Primary Diagnosis: ADULT CARE

Are there any additional/new diagnosis, symptoms or complications that impact daily functioning: _____

FUNCTIONAL STATUS

Please check off the applicable letter (I, SBA or HA) based on your knowledge of the claimant's ability to perform Activities of Daily Living (ADLs):
I = INDEPENDENT, **SBA** = STANDBY ASSISTANCE, **HA** = HANDS ON ASSISTANCE

LEVEL OF ASSISTANCE NEEDED	I	SBA	HA	PROVIDE DETAILS
Bathing		✓		
Dressing/Undressing Upper Body		✓		
Dressing/Undressing Lower Body		✓		
Toileting				
Transferring (in/out of bed or chair)				
Continence Care			✓	
Ambulation/Mobility				
Eating (to bring food to mouth)			✓	

COGNITIVE STATUS

Does the claimant show signs of any cognitive concerns/issues? Yes: ☐ No: ☐

Please check off any of the below items that apply:

☐ Not alert
☑ Confused
☑ Forgetful
☐ Not oriented to self (such as who they are).
☐ Not oriented to family and friends (such as names and relationship)
☐ Not oriented to place (such as location)
☑ Not oriented to time (such as day, date and time)
☑ Short Term Memory Loss
☐ Long Term Memory Loss

Please provide examples and details. List any safety concerns you may have witnessed.
physically weak & needs daily care to prevent falls

HOME CARE INFORMATION

Who is the primary caregiver and what is the care schedule?

Caregiver Name (s)	Relationship to claimant	Phone Number(s)	Start of Care Date
1. Shaun Cho	Son	215-837-3356	NOV. 2021
2. Grace Lee	caregiver	215-935-2500	NOV. 2021
3. Cha. Yun	Caregiver		OCT 2021
4. Maila	Caregiver	267-644-9[illegible]	OCT 2021

CURRENT SCHEDULE:

Caregiver	Hours Sun.	Hours Mon.	Hours Tues.	Hours Wed.	Hours Thurs.	Hours Fri.	Hours Sat.
Shaun Cho	10	2	2	2	2	2	10

Is claimant ever left alone? If yes, for how long and how does the claimant manage when no one is there? Yes, a 3 hours or so. I have arrange an emergency Phone if so needed

Are there any plans to increase or decrease the hours of care provided (If yes, explain)? yes to increase She is getting very weak, + unable to do daily Chores

Is the claimant receiving any physical, occupational, or speech therapy? If yes, please provide the following information:

Reason for Therapy: _____
Therapy Provider Name: _____
Therapy Provider Address: _____
Phone: _____ Fax: _____

Are there plans to move to an Assisted Living/Nursing Home or to change professional home care providers? If yes, please provide the following information so that we may verify if the provider is approved based on the Long Term Care policy:

Name of Provider: NOT AS OF NOW
Address: _____
Phone #: _____ Fax#: _____

HOSPITALIZATIONS

Have there been any overnight hospital stays in the last 6 months? Yes:___ No: ✓

If yes, please provide the following:

Name of Hospital:_____
Address: _____
Phone #:_____ Fax#:_____

Admission Date/Discharge date: _____
Reason for hospitalization: _____
_____

If the claimant was admitted to a skilled facility for rehabilitation after the hospital stay, please provide the full name, address and telephone number of this facility.

Name of facility:_____
Address: _____
Phone #:_____ Fax#:_____

Rehab Admission Date/Discharge date: _____

PHYSICIAN/PROVIDER INFORMATION

When we need to request an updated Medical Eligibility Form or medical records, which health care professional (ex.: Primary Care Physician, Physicians Assistant, Nurse Practitioner, Licensed Social Worker, Registered Nurse) is the most familiar with his/her care needs?

Physician/Provider specialty name: Gwynedd family Medicine
Address: 1600 Horizon Dre Chalfont, PA 18914
Phone #: 215-997-9737 Fax#:_____

The above statements are true and complete to the best of my knowledge and belief.

Signature of Individual Completing this form: _____

Print Name of Individual Completing this form: Shaun Dito

Date: 6/4/24