CSA RETIREE WELFARE FUND

HOME HEALTH AIDE CARE CLAIM FORM

TO BE COMPLETED BY PATIENT. (A DESIGNATED REPRESENTATIVE OF THE PATIENT MAY COMPLETE THIS PORTION OF THE FORM IF THE PATIENT IS UNABLE TO DO SO.)

MEMBER: _____ SOCIAL SEC #: _____
(Last, First, Middle Initial)

ADDRESS: _____ TELEPHONE #: _____

NAME OF PATIENT (If not member): _____ DATE OF BIRTH: __/__/__
(Last, First, Middle Initial)

RELATION TO MEMBER: _____

ADDRESS: _____ TELEPHONE # (___)_____
(If different from member) (Street, City, State, Zip)

WHERE IS PATIENT CURRENTLY RESIDING?*

☐ OWN RESIDENCE ☐ RESIDENTIAL/ASSISTED LIVING/PERSONAL CARE FACILITY

☐ OTHER (EXPLAIN)_____

*PATIENTS WHO ARE HOSPITALIZED, OR RESIDING IN A NURSING HOME OR REHABILATION CENTER ARE ELIGIBLE FOR THIS BENEFIT.

IF OTHER THAN YOUR RESIDENCE, WHAT IS THE NAME, ADDRESS, TELEPHONE NUMBER AND DATE YOU ENTERED THIS LOCATION?

LOCATION: _____ ADDRESS: _____

_____ TELEPHONE: # _____ DATE ENTERED: __/__/_____
(City, State, Zip)

IF PATIENT HAS BEEN HOSPITALIZED OR CONFINED TO ANY OTHER TYPE OF FACILITY WITHIN THE LAST YEAR, PLEASE COMPLETE THIS SECTION:

1.	NAME OF HOSPITAL/FACILITY:	ADDRESS: (City, State, Zip)	__/__/_____ DATE ADMITTED:	__/__/_____ DATE DISCHARGED
2.	NAME OF HOSPITAL/FACILITY:	ADDRESS: (City, State, Zip)	__/__/_____ DATE ADMITTED:	__/__/_____ DATE DISCHARGED

PLEASE LIST THE PHYSICIANS PATIENT SEES ON A REGULAR BASIS OR HAS CONSULTED IN REGARDS TO THIS CONDITION. ALSO INDICATE WHICH PHYSICIAN IS THE PRIMARY PHYSICIAN.

1. NAME:	SPECIALTY:	DATE 1ST SEEN: __/__/_____	DATE LAST SEEN: __/__/_____
ADDRESS: (Street, City, State, Zip)	TELEPHONE #: ( )		
NAME:	SPECIALTY:	DATE 1ST SEEN: __/__/_____	DATE LAST SEEN: __/__/_____
ADDRESS: (Street, City, State, Zip)	TELEPHONE # ( )		

IS PATIENT CURRENTLY, OR HAS PATIENT RECENTLY RECEIVED ANY OF THE FOLLOWING SERVICES?

☐ HOME HEALTH SERVICES ☐ PHYSICAL THERAPY ☐ OCCUPATIONAL THERAPY

☐ OTHER SERVICES _____

IF YES, PROVIDE THE NAME, ADDRESS, AND TELEPHONE NUMBER OF THE AGENCY OR INDIVIDUAL PROVIDING THE SERVICE(S)

PRIMARY CONTACT (IF DIFFERENT THAN CLAIMANT): ( )

NAME: TELEPHONE #:

ADDRESS: (STREET, CITY, STATE, ZIP) RELATIONSHIP TO CLAIMANT:

INDIVIDUAL COMPLETING THIS FORM IF DIFFERENT FROM ABOVE: ( )

NAME : TELEPHONE #:

ADDRESS: (STREET, CITY, STATE, ZIP) RELATIONSHIP TO CLAIMANT:

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_____

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NAME OF HOSPITAL/FACILITY: ADDRESS: (City, State, Zip) DATE ADMITTED: DATE DISCHARGED

_____

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ADDRESS: (Street, City, State, Zip) TELEPHONE #: ( )

NAME: SPECIALTY: DATE 1ST SEEN: __/__/__ __ __ __ DATE LAST SEEN: __/__/__ __/__ __ __ __

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NAME : TELEPHONE #:

ADDRESS: (STREET, CITY, STATE, ZIP) RELATIONSHIP TO CLAIMANT: