Health Insurance Department
Personal Home Care Services
Request for Benefits Form

(All sections must be completed)

FOR OFFICIAL USE
Policy Number: _____
Received Date (d/m/y): _____
Meets Policy Requirements? : **Yes** **No**
Circle Policy Plan : **HIP** **FC** **FA** **WV**
Processed by CSR and Date (d/m/y):
_____

Please indicate if this is a ☐ New Request or ☐ Request for Re-Assessment

I. POLICYHOLDER INFORMATION:

☐ **I, the policyholder, have had an active policy with HIP or FutureCare for at least one year.** Tick the box if true. If unsure, contact a HID Customer Service Representative before completing the application. This is a requirement to be eligible for the benefit.

Name: **(Mr./Mrs./Miss/Ms.)** **(First Name)**
(Middle Name) **(Last Name)**

Home Address:

Parish: Postal Code:

Date of Birth (dd/mm/yy): / / Group Number (if applicable):

Policy Number: Social Insurance Number:

Primary Telephone Number: - Alt Telephone #: -

Email Address (if available): _____
(Hotmail accounts not accepted) (Please Print)

Tick the appropriate box**:**

☐ **I, the policyholder, am able to manage my own care.** (go to section II)

☐ **The policyholder is unable to manage their own care.** Provide the following information for the responsible person who will manage the policyholder's care:

Name: **(Mr./Mrs./Miss/Ms.)** **(First Name)**
(Last Name)

Relationship to Policyholder: _____ Best Times to be reached? _____

Preferred Telephone #: - (Home) - (Work) - (Other)

Email Address (if available): _____
(Hotmail accounts not accepted) (Please Print)

II. MEDICAL INFORMATION:

With this request form please submit:

- A doctor's letter (issued in the last 90 days) which must include: medical diagnosis, care needs, cognition level and list of current medications;

In addition, if the policyholder is in the hospital, please submit:

- A Multi-Disciplinary Transfer form and / or OT / PT / Speech Evalution reports (issued in the last 30 days).
- What ward is the policyholder currently on? _____
- Name of Physician / Hospitalist if Policyholder is in Hospital:_____
- Date of admission _____Predicted Date of Discharge_____

Name of General Practitioner (GP) of Policyholder: _____

GP Practice Name:

GP's Address:

Parish:

Contact #: -

GP's Email Address (if available): _____
(Hotmail accounts not accepted) (Please Print)

III. CASE MANAGEMENT

If approved for this benefit, participation in on-going case management is required.

Has the policyholder had any previous history with any agencies? If so, please specify in the table below:

Agency	Name and Title	Contact #	Email
Dept of Financial Assistance			
Office for Ageing and Disability Services			
Community Nursing			
Other _____ (Please describe)			

I, or the responsible person, agree to ongoing case management if approved for the benefit. I declare that the information I have given above is accurate to the best of my knowledge. I understand that this form does not automatically grant me coverage under this Personal Home Care Services Benefit.

Signed: _____ Date (dd/mm/yy): / /

Submit the completed form with required documentation to:
Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Phone: 441-295-9210 **Fax:** 441-295-9213 **Website:** www.gov.bm **Email:** hip@gov.bm

Health Insurance Department
Personal Home Care Services
Physician's Letter

FOR OFFICIAL USE ONLY:
Received Date (d/m/y)

*Received by:

(All Sections to be Completed)

POLICYHOLDER INFORMATION:

Name: **(Mr./Mrs./Miss/Ms.)** **(First Name)**

(Middle Name) **(Last Name)**

Mailing Address:

Policy ID: Contact #: --

Date of Birth (dd/mm/yy): / /

Please give name and contact of responsible person, if known, for those with dementia:

Name: _____ Contact #: --

PHYSICIAN INFORMATION:

Name of General Practitioner (GP) of Policyholder: _____

GP Practice Name: _____

GP's Address: _____

Parish: _____ Contact #: _____

GP's Email Address (if applicable): _____

(Hotmail account not accepted) **(Please print)**

MEDICAL INFORMATION:

Diagnosis	Date of Onset (d/m/y)	Comments

When completed, this form should be returned with supporting documentation to:
Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Phone: 441-295-9210 **Fax:** 441-295-9213 **Website:** www.gov.bm **Email:** hip@gov.bm

Medicine Name	Dose	Route	Frequency	Purpose
ALLERGIES if any				

Does person have cognitive ability to organize and plan own health care?
Please note date (dd/mm/yy) of any mini mental status exam and score:
Are there any concerns regarding the person's behaviors when interacting with others or potential care givers?
Are there any advanced directives in place? Y N. Comments:

Please note which activities of daily living person may need assistance with:
Bathing; Dressing; Toileting; Walking 10 steps or more; Transferring self from chair to bed, etc.
Eating
DIET or fluid restrictions
Wound care
Other education/supports needed:

Additional Comments

Signed _____ Date (dd/mm/yy): ☐☐/☐☐/☐☐