Hawaii Life & Disability Insurance Guaranty Association
1003 Bishop Street
Suite 2030
Honolulu, HI 96813

tel. (808)749-4919
penntreatyaloha@hilifega.org

Monthly Care Certification

This form must be completed by facility staff only; incomplete forms will delay adjudication of the claim.

Resident and Facility Information

1. Resident name: _____Policy: _____
2. Facility Name: _____
3. Contact person: _____ Title: _____
   Tel: _____ Fax: _____

Confinement Information

All of the following questions must be completed for each month being claimed for benefits. Please attach and submit the billing statement from the facility **for the dates covered in this certification** with this form to one the preferred methods above. Do not submit until after month's end.

4. This form is submitted for service dates: _____**through**_____
   Discharge date: _____
5. **Was the resident out of the facility overnight?** ☐ Yes ☐ No *if yes, complete the following:*
   Bed hold charge? ☐ Yes ☐ No
   Left on:_____Returned on:_____Due to: ☐ Hospital ☐ Other _____
   Left on:_____Returned on:_____Due to: ☐ Hospital ☐ Other _____
6. **Care level:** ☐ Skilled ☐ Intermediate ☐ Assisted Living ☐ Other _____
7. **Current Diagnosis:** _____

Please indicate with a check mark the level of assistance provided by the facility staff with the following activities:

Activities of Daily Living (ADLs)	Bathing/ Showering	Indoor mobility/walking	Getting in/out of bed/chair	Continence care bladder/bowel	Eating	Toileting	Dressing	Medication
Independent	☐	☐	☐	☐	☐	☐	☐	☐
Supervision	☐	☐	☐	☐	☐	☐	☐	☐
Standby Assistance	☐	☐	☐	☐	☐	☐	☐	☐
Hands-On Assistance	☐	☐	☐	☐	☐	☐	☐	☐

8. **Was prompting, cueing or supervision provided?** ☐ Yes ☐ No
9. **Does the resident use any of the following?**
   ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other _____
10. **Are any of the dates above covered by Medicare** ☐ Yes ☐ No
    If yes, list Paid-In Full and Coinsurance dates: _____

If the facility statement does not reflect payments made by Medicare, Medicaid or other sources for the same period that reduces the resident's liability for charges, please attach payment information for the dates in this submission.

For your protection, state insurance laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signed_____Title:_____Date: _____