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## LTCI Pre-Qualification Questionnaire

Producer: \_\_\_\_\_ State: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Spouse: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Client      Spouse**

Y/N	Y/N	
Y/N	Y/N	1. Are you currently using oxygen, a wheelchair, crutches or cane, or receiving physical therapy?
Y/N	Y/N	2. Are you currently in a nursing home or receiving home health care?
Y/N	Y/N	3. Have you applied for or are you eligible for Medicaid?
Y/N	Y/N	4. Are you currently on disability? <b>Please describe the circumstance below.</b>
Y/N	Y/N	5. Have you been declined for LTCI? <b>If yes, please provide details below.</b>
Y/N	Y/N	6. Have you used tobacco in the last 36 months?
Y/N	Y/N	7. Do you have any surgery scheduled in the next 6 months or has surgery been recommended? <b>If yes, please provide details below.</b>
Y/N	Y/N	8. Have you been hospitalized in the past 10 years? <b>If yes, please list dates, treatments, and details below.</b>
Y/N	Y/N	9. Have you received treatment for any medical condition? (Including but not limited to; Anxiety, High Blood Pressure, Diabetes or Arthritis? <b>If yes, please list details below.</b>
Y/N	Y/N	10. Are you taking any prescription medications? <b>If yes, please list all medications below, along with the condition each was prescribed for, length of time taken and dosage amounts.</b>

Details to "Yes" answers above and ALL medications taken.

Client: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Spouse: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_