WEA trust
PO Box 259537 | Madison, Wisconsin 53725-9537
800.279.4000 WEAtrust.org

Independent Caregiver Application Packet

Thank you for being a WEA Trust member. You are considering an independent caregiver (ICG) as your service provider under your long term care policy. This letter and the completion of any of the attached forms is not a guarantee of benefits, nor does it guarantee the approval, of any care provider. All policy terms, provisions, conditions, and exclusions apply.

Enclosed are the following documents:

☐ **INDEPENDENT CAREGIVER PERSONAL AND PROFESSIONAL HISTORY AND ACKNOWLEDGEMENT FORM -** This form should be used by you or your legal representative during the process of interviewing service providers. The form must be completed by each independent caregiver that you would like us to consider and returned to WEA Trust at your earliest convenience for our review. Proof of identification (driver's license or other government issued photo identification) of the caregiver should be submitted with this form.

☐ **INDEPENDENT CAREGIVER WEEKLY TIMESHEET** - To be completed after services are provided each day. The timesheet should be signed and dated by each independent caregiver and by you or your legal representative, and submitted to WEA Trust along with proof of payment on a weekly basis or as soon as possible to ensure prompt reimbursement.

☐ **INDEPENDENT CAREGIVER LIABILITY DISCLOSURE STATEMENT –** This form should be signed by you or your authorized representative acknowledging you have read and understand the Disclosure Statement.

Independent Caregiver Management

Once you or your legal representative have hired an independent caregiver, we request a copy of their driver's license or other government issued photo identification. Also, you will be responsible for the management of the caregiver's services. The following are guidelines for that management:

- You and your caregiver must complete the weekly timesheets as services are provided. Information entered on the timesheets must be contemporaneous and not copied information from prior weeks' timesheets.

- Proof of Payment must match the information set forth on the timesheet. If there is a difference between the check amount and the amount charged, you must provide a separate explanation outlining the reason(s) for the discrepancy. In the absence of this explanation, we may not be able to reimburse for services until we have clarified the discrepancy, or you may only be reimbursed based on the proof of payment amount. You or your legal representative (not your ICG) must write all checks for payments made for your care.

- An ICG cannot be a member of your immediate family. Immediate Family means the spouse or domestic partner, a daughter, son, daughter-in-law, son-in-law, father, mother, sister, brother, grandparent, or grandchild of the covered individual or the covered individual's spouse.

- If your claim is approved due to a cognitive impairment, we require that a legally authorized representative, typically a Power of Attorney, manage your care and represent your interests regarding this claim, including the oversight of any ICG's caring for you. This individual will be responsible to review and sign all timesheets. We recommend submitting proof of payment to us at least once per month to allow for efficient processing. However, this information is required to be submitted to us no later than 90 days from the date the expense was incurred.

Independent Caregiver Weekly Timesheets

You or your legal representative is responsible for submitting completed timesheets for the services provided to you by an ICG. Timesheets should be completed weekly and submitted either weekly, bi-weekly, or monthly, unless circumstances do not allow for this, however, they must be submitted no later than 90 days after services are received. Timesheets must be completed accurately and contemporaneously, and reflect all services provided to you. A new timesheet must be completed for each week of care. While you may make photocopies of blank timesheets for future submissions, all information you and your caregiver enter should be manually entered each day services are provided. Instructions for completing the ICG timesheets are enclosed for your reference.

No benefits will be provided for expenses claimed on timesheets which are incomplete, or which contain copied information from prior weeks. It is the ICG's responsibility to sign only completed timesheets. By signing and dating each timesheet, the ICG agrees the information you are submitting is accurate.

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Proof of Payment

You must submit proof of payment for ICG services with each request for reimbursement. Proof of payment must match information found on the timesheet. If there is a difference between what you pay your caregiver and the amount shown on the timesheet, you must explain the basis for the difference.

In the event proof of payment is not received as stated in the Independent Caregiver Liability Disclosure Statement, our ability to provide benefits timely may be impacted and additional information may be needed.

Submitting a Claim for Reimbursement

When submitting a claim for reimbursement, **you must send us the completed Independent Provider Weekly Timesheets and valid proof of payment.**

Changes in Care or ICG

Any changes regarding your ICG or your care needs during your coverage under the WEA Trust Long Term Care Plan must be promptly reported to us. Such changes include an increase or decrease in hours, services or wage, or a change in provider.

Sincerely,

WEA Trust

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Independent Caregiver Personal/Professional History and Acknowledgement

Member Name: _____ Subscriber No.: _____

Please have the independent caregiver complete the following:

Full Legal Name: _____ Phone: _____

Address: _____

City: _____ State and Zip Code: _____

Driver License No.: _____ Social Security No.: _____

Are you related to the Member: Yes ☐ No ☐

If yes, what is the relationship? _____

Do you hold Power of Attorney or any other legal authorization to act on the member's behalf: Yes ☐ No ☐

If yes, please describe: _____

Do you live in the home with the member? Yes ☐ No ☐

If yes, how long have you lived with the member? _____

Are you receiving Social Security Disability Income or any other disability benefits or income? Yes ☐ No ☐

If yes, please describe: _____

Are you employed by anyone other than the member? Yes ☐ No ☐

If yes, please provide the name and phone number of the other employer(s): _____

Do you provide assistance or other services to anyone else in the member's household? Yes ☐ No ☐

If yes, please explain: _____

When did you start providing services to the member? Date: _____

Please list any training/education (include the institution and dates of any formal training or education that you have received:

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Independent Caregiver Personal/Professional History and Acknowledgement - continued -

Are you currently licensed or certified? Yes ☐ (if yes, please include a copy) No ☐

Please list any applicable skills or experience: _____

_____

_____

_____

Please list your past two employers where you have worked as a direct paid caregiver:

Name: _____ Phone: _____
Dates of Service: _____

Name: _____ Phone: _____
Dates of Service: _____

What days per week will you work for this client and what are your specific hours you intend to work?

_____

_____

What is the rate per hour you will be charging? (Daily and Weekly rates are not accepted): $ _____

I certify that to my knowledge the above information is true and correct.

Signature of Independent Caregiver: _____

Print name of Independent Caregiver: _____

Date: _____

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Member Name and Subscriber Number:

Independent Caregiver Weekly Timesheet

Activities of Daily Living / Supervision Services
(check all that apply)

Date (mm/dd/yyyy)	**Time In** (A.M./P.M.)	**Time Out** (A.M./P.M.)	**Total Hours**	**Hourly Charge**	**Total Daily Charge**	**Bathing**	**Continence**	**Dressing**	**Eating**	**Toileting**	**Transferring**	**Cognitive Supervision**	**Other** (detail below)
				$	$	☐	☐	☐	☐	☐	☐	☐	☐
				$	$	☐	☐	☐	☐	☐	☐	☐	☐
				$	$	☐	☐	☐	☐	☐	☐	☐	☐
				$	$	☐	☐	☐	☐	☐	☐	☐	☐
				$	$	☐	☐	☐	☐	☐	☐	☐	☐
				$	$	☐	☐	☐	☐	☐	☐	☐	☐
				$	$	☐	☐	☐	☐	☐	☐	☐	☐

TOTAL CHARGES $ ____________

Was the client hospitalized or in a facility this week? ________

If you selected **other** above, please provide additional details: ______________________________

Before we can process your reimbursement, you need to certify by signing below that the information you have provided on this form is accurate and complete to the best of your knowledge and ability. Any person who, with an intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to criminal and civil penalties. Please refer to the enclosed State fraud warnings for state-specific wording regarding the above fraud statement

Print Caregiver Name: ____________________ Caregiver Signature: ____________________ Date: ____________

Member/Legal Representative Name: ____________________ Member/Legal Representative Signature: ____________________ Date: ____________

Activities of Daily Living (ADLs) are Bathing, Continence, Dressing, Eating, Toileting, and Transferring as defined herein.

- Bathing means washing oneself by sponge bath or in either a tub or shower, including the task for getting into or out of the tub or shower, without Substantial Assistance from another person.

- Continence means the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag, without Substantial Assistance from another person.

- Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs without Substantial Assistance from another person. An individual will be considered able to dress himself or herself even if these tasks can only be performed by using modified clothing or adaptive devices such as tape fasteners or zipper pulls.

- Eating means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously without Substantial Assistance from another person. An individual will be considered able to eat even if he or she requires assistance preparing or serving the food, such as cutting food or opening cartons.

- Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene without Substantial Assistance from another person.

- Transferring means the ability to move into or out of a bed, chair, or wheelchair without Substantial Assistance from another person. An individual will be considered able to transfer even if he or she uses or requires equipment such as canes, quad canes, walkers, crutches, grab bars, or other support devices, including mechanical or motorized devices, in order to transfer or ambulate.

Substantial Assistance means Hands-on Assistance or Standby Assistance.

- Hands-on Assistance means the physical assistance of another person without which the Chronically Ill individual would be unable to perform the Activities of Daily Living.

- Standby Assistance means the presence of another person within arm's reach of the Chronically Ill individual that is necessary to prevent, by physical intervention, injury to the Chronically Ill individual while he or she is performing an Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Severely Cognitively Impaired individual from threats to his or her health or safety (such as may result from wandering).

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INDEPENDENT CAREGIVER LIABILITY DISCLOSURE STATEMENT

Member Name: _____

Subscriber No.: _____

The hiring of an independent caregiver is an important decision. The purpose of this disclosure statement is to provide you with information that you should carefully consider when hiring an independent caregiver and to clarify the relationships between WEA Trust, you and the independent caregiver. However, this should not be construed as legal advice or a legal opinion on any specific topic. Should you have questions concerning your legal rights or obligations, please consult your tax accountant or attorney.

If your benefit includes coverage for an independent caregiver benefit, and if you have been approved for such a benefit, you acknowledge the following in connection with your decision to hire an independent caregiver:

- Employer relationship – It is possible that you could be considered the employer for the independent caregiver and that the caregiver could be considered your employee. WEA Trust's decision to approve your choice of an independent caregiver and to pay covered benefits under the policy to you ***does not*** render WEA Trust the employer of the caregiver.

- Tax, Insurance and other Employment Implications – If the caregiver is deemed to be your employee, it is possible you could be responsible for various employment related taxes, for providing required employment-related insurance (e.g., workers compensation), and for complying with other employer requirements. WEA Trust is not responsible for, nor does the policy provide coverage for, the payment of any taxes, fees or insurance premiums owed by you as a result of your being deemed the employer of the caregiver.

- Liability for caregiver's actions – Please be aware that WEA Trust is not responsible for any injury or damage, including attorney's fees and costs, caused to property (real, personal or intangible) by or attributable to your independent caregiver or your hiring of an independent caregiver. WEA Trust is also not responsible for any loss, including attorney's fees and costs, injury to or death of you or any other person caused by or attributable to your independent caregiver or your hiring of an independent caregiver.

PLEASE KEEP THIS COPY FOR YOUR RECORDS

Signature and date of member/legal representative:

Signature	Printed Name	Date

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PLEASE RETURN THIS COPY TO WEA TRUST

Signature and date of member/legal representative:

Signature	Printed Name	Date

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Submitting Forms and Correspondence to WEA Trust

To make filling out forms easier, some of our forms are fillable PDFs which allow you to complete and then save the form on your computer or device. Depending on the browser you are using you may or may not not be able to use this feature.

Fillable PDFs require Adobe Acrobat or Acrobat Reader/Acrobat DC to fill them out online or on your computer. Many browsers use a different PDF viewer by default that doesn't support fillable form fields.

If you are unable to complete the forms on your computer or device, you may be able to download and save them to your computer and then fill them out. If you are unable to complete the forms on your computer or device or are unable to download the forms, please feel free to call us at **800.279.4000** and we will be happy to mail you paper copies.

Don't forget to save your work to your computer or device often.

You can submit forms and correspondence to us in whatever way works best for you …

Postal Service

Address your envelope to:
WEA Trust
PO Box 259537
Madison, WI 53725-9537

Fax

Include your name and Subscriber Number on the cover page of your fax and send to:
608.276.9119

Secure File Upload

Send scanned or electronically completed forms to us via our www.weatrust.org website at:
https://weatrust.org/secure-file-upload-1

Email

Attach your scanned or electronically completed forms to an email and send to us at:
customerservice@weatrust.org

Refer to your Benefit Summary and Plan Document for specific benefit information. If you have any questions, we encourage you to call us at **800.279.4000**.