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FAX 608.276.9119
CUSTOMER CONTACT CENTER 800.279.4000

Plan of Care

Complete all sections of this form. Please complete electronically, or print (use either black or blue ink) and return the completed form to WEA Trust at the address listed above.

Claimant Name:	Subscriber No.:
	Date of Birth:

1. What type of long term care services are recommended? (Please check all that apply.)

   ☐ Nursing Facility
   ☐ Home Health Care
   ☐ Alternate Care Facility
   ☐ Adult Day Care
   ☐ Hospice
   ☐ Respite Care
   ☐ Other (Please explain) _____

2. Based on your clinical assessment, what specific care will the above-named individual require (e.g., standby or hands-on assistance with feeding, ambulation, medication administration, ensuring safety)?:

3. How long do you anticipate the above-named individual will require services?

I certify that the above information is a true and accurate representation of the above-named individual's current capacity.

Provider's Name (please type or print): _____

Degree: ☐ M.D. ☐ Other: _____ Specialty: _____

Name of Clinic: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone No.: _____

Provider's Signature: _____ Date: _____