

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

Effective Date: \_\_\_\_\_

The purpose of this service plan addendum is to document a change in payment responsibility, based on client Long-Term Care insurance coverage and establish agreement between the client, or client's representative, and Recover Care. Based on the client's Long-Term Care Insurance (LTCI), the following outlines details of the client's LTCI policy and indicates what will be covered by the LTCI company and what is the financial responsibility of the client.

<b>Client Long-Term Care Insurance Details</b>
<ul style="list-style-type: none"> <li>- The client's Long-Term Care Insurance claim will start on:</li> <li>- The client policy outlines an elimination period of _____ days, indicating client will be responsible for all services provided for _____ days following claim submission.</li> <li>- After the elimination period is complete, LTCI policy will cover</li> <li>- The client's LTCI policy <b>does/does not</b> (circle one) have a cap amount.               <ul style="list-style-type: none"> <li>o If yes, the cap is</li> </ul> </li> </ul>

**Understanding of Client Financial Responsibility:** I allow Recover Care to bill my LTCI on my behalf. I understand I am responsible for all charges for services provided, not covered by my long-term care insurance benefit outlined above.

Based on the updated RN comprehensive assessment and my LTCI benefit, I understand that my estimated monthly cost is: \_\_\_\_\_ per month, after the elimination period, until the LTCI cap is met.

Accept     Decline    Initials: \_\_\_\_\_

**Certification:**

I acknowledge I have had the opportunity to participate in the development of this service plan addendum and agree with the conditions stated herein and certify that I am the client or the client's legal representative and am capable of executing the aforementioned conditions and accepting the terms. Further, I understand that this agreement can be revoked at any time by either party.

\_\_\_\_\_

Print Client Name

\_\_\_\_\_

**Recover Care** Witness

\_\_\_\_\_

Signature of Client or Legal Representative

\_\_\_\_\_

Date

**Contact a Recover Care Representative 24 hours / day, 7 days / week at:**

**Recover Care** Phone Number: (952) 230-6332

**Recover Care** Website: [www.recovercare.org](http://www.recovercare.org)