**UNIVERSAL HEALTH PLAN/ HOME HEALTH AUTHORIZATION FORM**

**S.O.C. Date:** / /  
**Initial:** □  
**Reauthorization:** / /  
**Agency D/C Date:** / / : Anticipated □ Actual □  
**MD Agrees:** Y/N  
**Patient Agrees:** Y/N

### Patient Information
- **Name:**
- **S.O.C. Address:**
- **Telephone #:**
- **DOB:** / /  
- **Homebound:** Y/N Why? 
- **Diagnosis:**
- **Surgery:** N/A
- **Patient Prognosis:** Poor / Guarded / Fair / Good / Very Good / Excellent / <6 months to live / Terminal.

### MD Information
- **Ordering MD:**
- **MD Phone #:**
- **PCP:**
- **Date of Next MD Visit:** / / 

### Health Plan Information
- **Health Plan Name:**
- **Insurance #:**
- **Health Plan CM:**
- **Initial Auth #:**
- **Telephone #:**
- **Fax #:**

### Current Functional Status

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Dress Lower Extremities</th>
<th>Bathing</th>
<th>Toileting</th>
<th>Ambulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□Alert/Oriented</td>
<td>□ Independent</td>
<td>□ Independent</td>
<td>□ Independent</td>
<td>□ Independent</td>
</tr>
<tr>
<td>□ Impaired</td>
<td>□ Requires assist</td>
<td>□ Requires assist</td>
<td>□ Requires assist</td>
<td>□ Requires assist</td>
</tr>
<tr>
<td>□ Disoriented</td>
<td>□ Unable</td>
<td>□ Unable</td>
<td>□ Unable</td>
<td>□ Unable</td>
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</table>

### Service Request

<table>
<thead>
<tr>
<th>Service Request</th>
<th>From</th>
<th>To</th>
<th># Of Visits</th>
<th>Frequency</th>
<th>Auth # Visits</th>
<th>Health Plan Auth #</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td></td>
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<tr>
<td>HHA/Hrs&amp;Visits</td>
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<tr>
<td>PT</td>
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<td>OT</td>
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<td>ST</td>
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<tr>
<td>MSW</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

### Communication

**Comments:**

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**Name:**

**Title:**

**Date:** / / 

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SKILLED NURSING  D/C Date: ___/___/___ Anticipated □ Actual □

Clinical summary:

____________________________________________________________________________________

Reason for Home Health Aide Services:

____________________________________________________________________________________

<table>
<thead>
<tr>
<th>Wound Care</th>
<th>N/A □</th>
<th>Wound 1</th>
<th>Wound 2</th>
<th>Wound 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
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</tr>
<tr>
<td>Appearance</td>
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<td>Measurement</td>
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<tr>
<td>Drainage</td>
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<tr>
<td>TX and Frequency</td>
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</tbody>
</table>


Goals/Plan for this Authorization Period:

____________________________________________________________________________________

Barriers to Achieve Goals/Plan:

____________________________________________________________________________________

Interventions:

____________________________________________________________________________________

Signature: __________________________ Title: ______ Department: ____________ Date: ___/___/___

OTHER SKILLED DISCIPLINES  D/C Date: ___/___/___ Anticipated □ Actual □

Please complete a separate pg. 2 when more than one skilled discipline providing care

PT _______ OT _______ ST _______ MSW _______ Other _______________

Reason for Home Health Aide Services:

____________________________________________________________________________________

Clinical summary?

____________________________________________________________________________________

Goals/Plan for this authorization period:

____________________________________________________________________________________

Barriers to achieve goals/plan:

____________________________________________________________________________________

Interventions:

____________________________________________________________________________________

Signature: __________________________ Title: ______ Department: ____________ Date: ___/___/___

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