

**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 #: \_\_\_\_\_

**Agency Information**

Agency Name: \_\_\_\_\_  
 Provider Number: \_\_\_\_\_  
 Contact: \_\_\_\_\_  
 Telephone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

**DME/Supplies/IV/Lab**

Vendor Name: \_\_\_\_\_

**Community Resources**

\_\_\_\_\_

**Caregiver Information**

Name: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Type of Assistance: \_\_\_\_\_  
 Teachable/Not Teachable: \_\_\_\_\_  
 Primary Phone#: \_\_\_\_\_

**Maternity Care** N/A

Delivery Date \_\_\_/\_\_\_/\_\_\_ Time Of Delivery \_\_: \_\_  
 Discharge Date \_\_\_/\_\_\_/\_\_\_ Time of Discharge \_\_: \_\_

**Current Functional Status**

Cognitive	Dress Lower Extremities	Bathing	Toileting	Ambulation
<input type="checkbox"/> Alert/Oriented	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent
<input type="checkbox"/> Impaired	<input type="checkbox"/> Requires assist	<input type="checkbox"/> Requires assist	<input type="checkbox"/> Requires assist	<input type="checkbox"/> Requires assist
<input type="checkbox"/> Disoriented	<input type="checkbox"/> Unable	<input type="checkbox"/> Unable	<input type="checkbox"/> Unable	<input type="checkbox"/> Unable

Service Request	From	To	# Of Visits	Frequency	Auth # Visits	Health Plan Auth #
<b>RN</b>						
<b>HHA/Hrs&amp;Visits</b>						
<b>PT</b>						
<b>OT</b>						
<b>ST</b>						
<b>MSW</b>						
<b>Other</b>						

*Communication*

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**SKILLED NURSING** D/C Date: \_\_\_/\_\_\_/\_\_\_ Anticipated  Actual

**Clinical summary:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Reason for Home Health Aide Services:** \_\_\_\_\_

\_\_\_\_\_

Wound Care N/A <input type="checkbox"/>	Wound 1	Wound 2	Wound 3
Location			
Appearance			
Measurement			
Drainage			
TX and Frequency			

**Medications: Compliant: Y/N Teachable Patient: Y/N Med List Attached: NA/Y**

**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: \_\_\_/\_\_\_/\_\_\_**