# UNIVERSAL HEALTH PLAN/ HOME HEALTH AUTHORIZATION FORM

**S.OC. 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 |
|---|---|---|---|---|
| □Alert/Oriented | □ Independent | □ Independent | □ Independent | □ Independent |
| □ Impaired | □ Requires assist | □ Requires assist | □ Requires assist | □ Requires assist |
| □ Disoriented | □ Unable | □ Unable | □ Unable | □ Unable |

| Service Request | From | To | # Of Visits | Frequency | Auth # Visits | Health Plan Auth # |
|---|---|---|---|---|---|---|
| **RN** | | | | | | |
| **HHA/Hrs&Visits** | | | | | | |
| **PT** | | | | | | |
| **OT** | | | | | | |
| **ST** | | | | | | |
| **MSW** | | | | | | |
| **Other** | | | | | | |

***Communication***

**Comments:**_____
_____
_____
_____
_____
**Name:**_____**Title:**_____**Date:** ___/___/___

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**SKILLED NURSING** D/C Date:___/___/___ Anticipated □ Actual □
***Clinical summary:*** _____

**Reason for Home Health Aide Services:** _____

| **Wound Care N/A□** | **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:** ___/___/___

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