THIS FORM MUST BE RECEIVED 30 DAYS PRIOR TO THE END OF THE CURENT AUTHORIZAITON PERIOD.

VISN 23 REAUTHORIZATION REQUEST FOR HOME BASED COMMUNITY CARE

Authorization for services (initial, revised, or extension) must be pre-approved to be considered for reimbursement.

Date: _____

Veteran Name: _____ Veteran last four _____
Veteran Date of Birth: _____

Agency Name: _____
Phone: _____
Fax: _____

Agency Representative Signature/Title: _____

Services Requested and frequency: SN _____ HHA _____ HM _____
Respite _____ In home therapy (specify discipline): _____
Complete this form and fax it to FARGO (612-725-1319) with the necessary attachments:

A) Signed Physician Plan of Care (VA Physician) if not previously sent
B) 2 weeks of HMKR/HHA/HHA Respite assignment sheets
C) Last 2 skilled nurse visit notes

Veteran resides alone? YES_____ NO_____
Significant Cognitive Impairment: YES _____ NO_____
Utilizes Assistive Equipment (AE): YES _____ NO_____
List AE: _____

Identify All ADL Dependencies (assistance required) to safely complete ADL:

_____Dressing
_____Grooming
_____Bathing
_____Eating
_____Bed Mobility
_____Transferring
_____Walking
_____Toileting/Incontinent Bowel/Bladder

Identify All IADL Dependencies (assistance required) to safely complete IADL:

_____Medication Management
_____Meal Preparation
_____Housework (dust/dishes/laundry)
_____Telephone Use
_____Shopping
_____Money Management
_____Transportation

Special Treatments/Monitoring

_____IV Therapy
_____Drainage Tubes
_____Wound Care
_____Oxygen Therapy
_____Catheter Care
_____Symptom control for terminal illness
_____Ostomies
_____PICC/Central Line
_____Nebulizer Treatments

VA USE ONLY

Approved _____ (authorization will be extended)
Not Approved_____

- Missing information _____
- Lacks Clinical Requirements
- Other _____

THIS FORM MUST BE RECEIVED 30 DAYS PRIOR TO THE END OF THE CURENT AUTHORIZAITON PERIOD.