Department of Veterans Affairs
Home and Community Based Services

V23 Community Adult Day Health Care Reauthorization

Veteran Name: ______________________ Last 4 digits of SSN or DOB (required):__________
Agency Name: __________________________ Agency Fax: ____________________

This form must be received 10 days prior to the end of a current authorization period.

Return completed form via fax# ____________________for VA review and processing with *care plan* and charting records for the most recent *2 weeks of attendance*.

Nursing

☐Medication Management ☐Medication Set Up/Pill Box Fill

☐Nursing Assessment/Health Monitoring ☐Lab Draws:______________________

☐Education:______________ ☐Wound Care: specify: ____________________

☐Treatments: specify__________ ☐Other: ________________________

Frequency (# of skilled nursing visits per week):______________________

Occupational Therapy/Physical Therapy/Speech-Language Pathology:

Add New: ☐ OT ☐PT ☐ Speech-Language Pathology

Diagnosis and justification for therapy:______________________________

Therapy Reauthorization/Extension: *please complete page 2*

Other Services: Request: ______________________________

Personal Care Services: Assisting Veterans unable to perform tasks independently

☐ Bathing assistance ☐ Grooming assistance ☐ Dressing assistance ☐ Other______________

Frequency (hours per week):______________________________

Homemaker: Veteran/caregiver unable to perform tasks to maintain safe/sanitary home setting

☐ Dishes ☐ Meal prep ☐ Laundry assistance ☐ Light housekeeping: i.e. sweep/mop/dust/vacuum Veteran's living areas/sleeping area/bathroom

Frequency (hours per week):______________________________

- **NO deep cleaning or heavy-duty house cleaning is permitted**
- **NO yard work is to be performed**
- **NO pet care is allowed**

****Not following these guidelines may result in loss of services****

☐ **Respite:** Provide caregiver break from duties to alleviate caregiver burnout

Frequency:______________________________

Requested By (must be clinical staff (RN/OT/PT):______________________________

Clinician's Signature & Title/Credentials *Date*

Request for Home Therapy Reauthorization/Extension Supplement

This information MUST be provided when requesting extension of therapy services (either on this form or in supplemental documentation). Please also send associated evaluation/re-evaluation and daily notes that demonstrate progress toward therapy plan of care.

Today's date: ____________________ Authorization Expiration Date ________________________________

Date of Evaluation: ____________________________________Diagnosis: ________________________________

Number of treatments to date: ____________________________Number of cancel/no-show: __________________

Description of interventions provided and Veteran's response: ____

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Description of education and home exercise program provided: ______________________________________

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____

Outcome Measures at Evaluation and Reassessment (scores and interpretation):______________________

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____

Statement/Review of specific, measurable and functional progress to date including most recent goals:

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____

If goals not met, give reason(s) why: ____

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Future treatments requested: Frequency _______________________Duration ____________________________

Future treatment goals and plan of care (please include plan to transition to self-management): _________

____

Treating Therapist: (please print): _______________________ **Phone Number:** ________________________

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Treating Therapist Signature *Date*