



Veteran Name: _____ Last 4 digits of SSN or DOB (required): _____
Agency Name: _____ Agency Fax: _____

Request: Add New Service Reauthorization

This form must be received **30 days** prior to the end of a current authorization period.

Return completed form via fax# _____ with supporting medical justification
for VA review and processing.

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): _____

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: _____

Description of education and home exercise program provided: _____

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

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

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

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:** _____

Treating Therapist Signature

Date