Department of Veterans Affairs
Home and Community Based Services

General Information:

Veteran Name: _____ DOB (required): _____
Agency Name: _____ Agency Fax: _____
Request: ☐ Add New Service Requested start date: _____
☐ Reauthorization End of current authorization: _____
Veteran lives with: ☐ alone ☐ with caregiver ☐ Other:_____

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: for reauthorization, last 2 skilled nurse visit notes required

☐Medication Management ☐Medication Set Up/Pill Box Fill
☐Nursing Assessment/Health Monitoring ☐Lab Draws:_____
☐Education:_____ ☐Wound Care: specify: _____
☐Treatments: specify_____ ☐Other: _____

Frequency Requested (# of skilled nursing visits per week):_____
Clinical Indication for Requested Service: _____

Occupational Therapy/Physical Therapy/Speech-Language Pathology: for reauthorization, refer to page 2

☐ OT ☐PT ☐ Speech-Language Pathology

Diagnosis and justification for therapy:_____

Other Services: Request: _____

Home Health Aide: for reauthorization, 2 weeks of documentation required

☐ Bathing assistance ☐ Toileting assistance ☐ Dressing assistance ☐ Other_____

Frequency (hours per week):_____

Homemaker: for reauthorization, 2 weeks of documentation required

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

Frequency (hours per week):_____

- **SERVICES NOT COVERED: deep cleaning, yard work, pet care or transportation**

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

☐ **Respite:** for reauthorization, 2 weeks of documentation required

Frequency:_____

Requested By (must be clinical staff):_____

_____

Clinician's Signature *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 all 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-shows: _____

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*