UNIVERSAL HEALTH PLAN/ HOME HEALTH AUTHORIZATION FORM

S.O.C. 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 __________________________

**Agency Information**
Agency Name: __________________________
Provider Number: __________________________
Contact: __________________________
Telephone #: __________________________ Fax#: __________________________
DME/Supplies/IV/Lab
Vendor Name: __________________________
Community Resources __________________________

**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#: __________________________

**Current Functional Status**

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Dress Lower Extremities</th>
<th>Bathing</th>
<th>Toileting</th>
<th>Ambulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alert/Oriented</td>
<td>Independent</td>
<td>Independent</td>
<td>Independent</td>
<td>Independent</td>
</tr>
<tr>
<td>Impaired</td>
<td>Requires assist</td>
<td>Requires assist</td>
<td>Requires assist</td>
<td>Requires assist</td>
</tr>
<tr>
<td>Disoriented</td>
<td>Unable</td>
<td>Unable</td>
<td>Unable</td>
<td>Unable</td>
</tr>
</tbody>
</table>

**Maternity Care** N/A □
Delivery Date __/__/____ Time Of Delivery: __________________________
Discharge Date __/__/____ Time Of Discharge: __________________________

**Cognitive**
Alert/Oriented
Impaired
Disoriented

**Dress Lower Extremities**
Independent
Requires assist
Unable

**Bathing**
Independent
Requires assist
Unable

**Toileting**
Independent
Requires assist
Unable

**Ambulation**
Independent
Requires assist
Unable

**Service Request**
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:

<table>
<thead>
<tr>
<th>Wound Care</th>
<th>N/A</th>
<th>Wound 1</th>
<th>Wound 2</th>
<th>Wound 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td></td>
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</tr>
<tr>
<td>Measurement</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Drainage</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>TX and Frequency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


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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