# VERMONT DAY HEALTH REHABILITATION SERVICES
# PRIOR AUTHORIZATION FORM

**I. BASIC PARTICIPANT INFORMATION:**

| PARTICIPANT NAME (LAST, FIRST, MIDDLE INITIAL) | ☐ NEW<br>☐ RENEWAL | DATE |
|---|---|---|
| MAILING ADDRESS | TELEPHONE | |
| CITY/TOWN | STATE | ZIP |
| DAIL CLIENT IDENTIFICATION NUMBER | DATE OF ILA | PHYSICIAN |
| NAME OF DAY HEALTH REHABILITATION CENTER | NAME OF CONTACT PERSON | TELEPHONE |

| VT STATE RESIDENT | MEDICAID ID NUMBER | EDS VERIFIED | NO. DAYS/WK | NO. HRS./WK | PROPOSED DHRS START DATE |
|---|---|---|---|---|---|
| ☐ YES ☐ NO | | ☐ YES ☐ NO | | | |

DOES THE PARTICIPANT LIVE IN A RESIDENTIAL CARE HOME? ☐ YES ☐ NO NAME OF HOME:

IT IS THE RESPONSIBILITY OF THE DHR CENTER TO VERIFY THAT THE APPLICANT IS NOT ELIGIBLE FOR AND/OR PARTICIPATING IN OTHER PUBLIC FUNDING SOURCES. A CHECKMARK INDICATES THAT THE DHR CENTER HAS VERIFIED THAT THE FUNDING SOURCE FOR THE APPLICANT HAS BEEN CHECKED AND NO DUPLICATION OF FUNDING WAS FOUND:

- ❑ DAIL Choices for Care Waiver
- ❑ Medicaid State Plan Assistive Community Care Services (ACCS)
- ❑ Traumatic Brain Injury (TBI) Medicaid Waiver
- ❑ DAIL Developmental Services Medicaid Waiver
- ❑ Department of Mental Health (DMH) Community Rehabilitation and Treatment Medicaid services (CRT)
- ❑ DMH Children's Mental Health Medicaid Waiver
- ❑ Veteran's Administration reimbursement
- ❑ Hospital swing bed resident
- ❑ Hospital in-patient
- ❑ Intermediate Care Facility for the Mentally Retarded (ICF/MR)

**II. DIAGNOSES/ACTIVE PROBLEMS:**

PRIMARY: _____

SECONDARY: _____

OTHER PROBLEMS: _____

DIAGNOSIS OF ALZHEIMER'S DISEASE OR RELATED DEMENTIA **BY A PHYSICIAN**? YES ☐ NO ☐

**III. DAY HEALTH REHABILITATION SERVICES NEEDED:**

**A. PERSONAL CARE (PER CLIENT INDEPENDENT LIVING ASSESSMENT - ILA)**

| ILA # | ACTIVITY OF DAILY LIVING | SCORE | | | |
|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 |
| 1 | DRESSING & UNDRESSING UPPER BODY | | | | |
| 2 | DRESSING & UNDRESSING LOWER BODY | | | | |
| 6 | TOILET USE | | | | |
| 10 | TRANSFERRING | | | | |
| 11 | MOBILITY | | | | |
| 12 | EATING/FEEDING | | | | |

**PARTICIPANT NAME (LAST, FIRST):**_____**DATE:**_____

**B. NURSING SERVICES**

| SERVICE/TREATMENT | FREQUENCY | DURATION |
|---|---|---|
| ASSESSMENT, MONITORING & INTERVENTION FOR ON-GOING MEDICAL CONDITIONS.<br>SPECIFY : | | |
| EVALUATE AND MONITOR FOR DRUG INTERACTIONS , EFFECTIVENESS AND SIDE EFFECTS<br>NUMBER OF MEDICATIONS: | | |
| INTRAVENOUS, INTRAMUSCULAR OR SUBCUTANEOUS INJECTIONS | | |
| PAIN MANAGEMENT | | |
| DRESSING CHANGES/WOUND CARE | | |
| SUCTIONING/TRACH CARE/RESPIRATOR | | |
| FEEDING TUBE | | |
| OTHER (SPECIFY): | | |

**C. SPECIAL THERAPIES :**

TYPE(S) OF THERAPY TO BE PROVIDED (CHECK): ☐ PHYSICAL ☐ OCCUPATIONAL ☐ SPEECH ☐ OTHER _____

NAME OF THERAPIST(S): _____

| TYPE (SPECIFIC SERVICES TO BE PROVIDED) | FREQUENCY | DURATION |
|---|---|---|
| | | |
| | | |

**D. SOCIAL WORK: [PARTICIPANT AND/OR SERVICES TO FAMILY/CAREGIVER(S)]**

PARTICIPANT/FAMILY/CAREGIVER SHOWS SIGNS OF (CHECK ALL THAT APPLY): ☐ STRESS/ANXIETY ☐ SITUATIONAL DEPRESSION

☐ CAREGIVER BURN OUT ☐ GRIEF ☐ ISOLATION ☐ ABUSE/NEGLECT/EXPLOITATION ☐ OTHER (SPECIFY):_____

NAME AND TITLE OF PERSON TO BE PROVIDING SOCIAL WORK SERVICES _____

| TYPE | FREQUENCY | DURATION |
|---|---|---|
| COUNSELING TO FACILITATE ADJUSTMENT TO DHRS | | |
| ON-GOING COORDINATION OF SERVICES WITH OTHER PROVIDERS | | |
| ASSESSMENT & REFERRAL OF MENTAL ILLNESS/DEMENTIA | | |
| BEHAVIORAL INTERVENTION IN DHRS ENVIRONMENT | | |
| ASSESSMENT & COUNSELING OF SOCIAL & EMOTIONAL FACTORS RELATED TO PARTICIPANT'S HEALTH/FUNCTIONING | | |
| COUNSELING FOR LONG RANGE PLANNING & DECISION MAKING OF LONG TERM CARE NEEDS | | |

**PARTICIPANT NAME (LAST, FIRST):**_____**DATE:**_____

**E. NUTRITION COUNSELING AND SERVICES**

NAME OF REGISTERED DIETICIAN: _____

| PARTICIPANT INDICATOR | YES | SERVICES REQUIRED | FREQUENCY |
|---|---|---|---|
| NSI SCORE OF 6+ | | NUTRITION ASSESSMENT & SCREENING | |
| DIAGNOSIS OF MALNUTRITION | | | |
| SIGNIFICANTLY LOW/HIGH WEIGHT FOR HEIGHT | | NUTRITION CARE PLAN DEVELOPMENT AND MONITORING | |
| SIGNIFICANT REDUCTION IN SERUM ALBUMIN | | | |
| DYSPHAGIA | | NUTRITION COUNSELING | |
| DEHYDRATION | | | |
| POORLY CONTROLLED BLOOD GLUCOSE LEVELS | | OTHER (SPECIFY) | |
| POORLY HEALING WOUNDS/PRESSURE/ULCERS | | | |

**F. ADDITIONAL COMMENTS**

| |
|---|
| |

**IV. ELIGIBILITY SUMMARY:**

INDICATE AREAS WHERE CLIENT MEETS CRITERIA FOR DAY HEALTH REHABILITATION SERVICES:

| CHECK | SERVICE CATEGORY | COMMENTS |
|---|---|---|
| | A. PERSONAL CARE | |
| | B. NURSING SERVICES | |
| | C. SPECIAL THERAPIES | |
| | D. SOCIAL WORK | |
| | E. NUTRITION | |

**THE VT DHRS PRIOR AUTHORIZATION FORM MUST BE SIGNED AND DATED BY THE REGISTERED NURSE WHO WILL BE SUPERVISING THE CARE STATED ON THE FORM. SUPERVISION OF CARE INCLUDES BUT IS NOT LIMITED TO REVIEWING THE PARTICIPANT'S INDEPENDENT LIVING ASSESSMENT, PLAN OF CARE, AND PROGRESS NOTES AS WELL AS OVERSEEING THE DHRS SERVICES BEING PROVIDED TO THE PARTICIPANT.**

**RN SIGNATURE:** _____ **DATE:** _____