

Member's Name:		Member's UMI #:			
Current Medical Status/Treatment Plan (Include medications, diet, vital signs, weight, wounds and sizes, nursing assessment, etc.):					
Estimated Length of Stay:			Next MD Appointment:		
Living Arrangements:					
Caregiver Availability: Willing and Able Caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Lives with patient: <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship: Community Resources: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Explain/List:					
Please check referrals for any additional services: <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Medical Social Worker <input type="checkbox"/> Home Health Aide <input type="checkbox"/> RN					
Requested Visits and Date Ranges for Each Discipline:					
RN:	PT:	OT:	ST:	AIDE:	MSW:
Dates:	Dates:	Dates:	Dates:	Dates:	Dates:
Discharge Date:		Signature of Home Health Agency Nurse:			
<i>If request for extension of services:</i> Specific reasons for continued service, progress, or any other pertinent info related to extension of services:					
Additional Comments:					
Completed by:			Date:		
Title:		Phone #:		Fax #:	
For Internal Use Only:					
Decision: <input type="checkbox"/> Approved <input type="checkbox"/> Denied			Initial of Reviewer:		
Nurse Reviewer:		# Visits Approved:		Total # of Visits to Date:	
Review Date:		Call Back Date:			