**HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS**

REQUEST FOR PRIOR AUTHORIZATION OF SKILLED NURSING SERVICES

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| 1. Requested Service Start Date:Click here to enter a date.Request Type: [ ] New [ ]  Renewal [ ]  Modification | 2. Waiver Care Plan Dates:From: Click here to enter a date.To: Click here to enter a date. | 3. Waiver Program:Choose an item. |
| 4. Participant Information:WY Medicaid ID: Click here to enter text.Name: Click here to enter text.Address: Click here to enter text.Date of Birth: Click here to enter a date.Sex: [ ]  Male [ ]  Female | 5. Service Provider Information:WY Medicaid Provider ID: Click here to enter text.Name: Click here to enter text.Address: Click here to enter text.Telephone Number: Click here to enter text.Registered Nurse Completing Form: Click here to enter text. |
| 6. MedicationsClick here to enter text. | Dose/Frequency/Route/(N)ew (C)hanged:Click here to enter text. |
| 7. Principal Diagnosis:Click here to enter text. | ICD-10:Click here to enter text. | Date:Click here to enter a date. |
| 8. Other Pertinent Diagnoses: Click here to enter text. | ICD-10:Click here to enter text. | Date:Click here to enter a date. |
| 9. DME and Supplies:Click here to enter text. | 10. Safety Measures:Click here to enter text. |
| 11. Nutritional Requirements:Click here to enter text. | 12. Allergies:Click here to enter text. |
| 13A. Functional Limitations: | 13B. Activities Permitted: |
| [ ]  Amputation[ ]  Bowel/Bladder[ ]  Contracture[ ]  Hearing | [ ]  Paralysis[ ]  Endurance[ ]  Ambulation[ ]  Speech | [ ]  Legally Blind[ ]  Dyspnea With Minimal Exertion[ ]  Other (Specify): Click here to enter text. | [ ]  Complete Bedrest[ ]  Bedrest BRP[ ]  Up As Tolerated[ ]  Transfer Bed/Chair[ ]  Exercises Prescribed | [ ]  Partial Weight Bearing[ ]  Independent At Home[ ]  Crutches[ ]  Cane | [ ]  Wheelchair [ ]  Walker[ ]  No Restrictions[ ]  Other (Specify): Click here to enter text. |
| 14. Mental Status: | 15. Prognosis: |
| [ ]  Oriented[ ]  Comatose[ ]  Forgetful | [ ]  Depressed[ ]  Disoriented[ ]  Lethargic | [ ]  Agitated[ ]  Other (Specify): Click here to enter text. | [ ]  Poor[ ]  Guarded | [ ]  Fair[ ]  Good | [ ]  Excellent |
| 16. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration):Click here to enter text. |
| 17. Goals/Rehabilitation/Potential Discharge Plans:Click here to enter text. |
| 18. Residential Service Coordination: [ ]  Yes (Specify) [ ]  NoClick here to enter text. |
| 19. Registered Nurse Signature and Date: | 20. I have assessed this participant and attest to the information provided in this request as a true and accurate representation of the participant’s current condition and need for skilled nursing services.  |
| 21. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal/State funds may be subject to fine, imprisonment, or civil penalty under applicable Federal/State laws.  |