**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. Medications  Click 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)  No  Click 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. | | | | | | | | | | |