**WEST VIRGINIA I/DD WAIVER**
**REQUEST FOR NURSING SERVICES**

Submit by fax to (866) 521-6882 or email to wviddwaiver@kepro.com

**This assessment must be completed by the RN and submitted with all requests for LPN and/or RN services.**

| General Information | | | |
|---|---|---|---|
| Date Submitted: | **Click here to enter a date.** | Record ID: | Click here to enter text. |
| Name of Person Who Receives Services: | **Click here to enter text.** | | |
| Age of Person Who Receives Services: **Click here to enter text.**<br>(Unless the individual aged 18-20 attends day service or lives in an Unlicensed Residential Home/GH, LPN services are available to those aged 21 and over ONLY) | | | |
| Anchor Date: | **Click here to enter a date.** | | |
| Current Living Arrangement | ☐ Unlicensed Residential/GH<br>☐ NF/SFCH | | |
| Service Coordination Provider Agency: | **Click here to enter text.** | Agency Location (if applicable): | **Click here to enter text.** |
| Residential Services Provider Agency: | **Click here to enter text.** | | |
| Name of person submitting request: | **Click here to enter text.** | | |
| Phone #/Extension: | **Click here to enter text.** | Email Address: | **Click here to enter text.** |

| Units Requested (specify units of LPN and/or RN the team has or will request.) | | | |
|---|---|---|---|
| **LPN:** | | **RN:** | |

**Medications**

**MAR Attached to CareConnection©? (not required if medications are listed below)**

☐Yes

☐No—below, list all medications as indicated on the current MAR—add rows as needed

| Name of Medication | Dose/ Frequency | Route | Special Instructions | Purpose/Diagnosis for Which Medication is Prescribed |
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Hospitalizations/Surgeries (list all hospitalizations/surgeries in the past year. Include any issues/complications that may have occurred that could impact services needed—add rows as needed.)

| Type of Hospital Stay/Surgery | Date(s) | Hospital Course/Significant Findings | Discharge Instructions |
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| Medical Conditions (list diagnosed medical conditions that require the individual to receive LPN services—add rows as needed.) | | |
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| **Medical Condition/Diagnosis and Brief Description** | **Approx. Date of Diagnosis** | **Duration of Condition** |
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| Medically Necessary Specialized Treatments (list frequent and time-consuming treatments that are required—add rows as needed.) | | | |
|---|---|---|---|
| **Name/Description of Required Treatments** | **Reason Treatment is Required** | **Frequency/Duration of Required Treatment** **(include approximate time per treatment and how long it is anticipated treatment will be needed)** | **Identify Available Natural Supports Who Can Administer Treatment** |
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| Describe reasons the team has identified that skilled nursing services are required and Approved Medication Assisted Personnel (AMAP) cannot be used to meet identified needs. |
|---|
| **Click here to enter text.** |

| Supporting Documentation (for this request to be considered, the following documentation must be attached to CareConnection©.) |
|---|
| ☐ IPP detailing member's level of LPN need and team recommendations and approval |
| ☐ 15 minute schedule detailing LPN services to be provided |
| ☐ Minimum of 1 week of LPN Notes |
| ☐ Hospital Records/Treatment Administration Records (TARs), other (list): |
| **Click here to enter text.** |

| Additional Information |
|---|
| Usual response to medical treatment |
| ☐Cooperative ☐Partially cooperative ☐Resistant ☐Fearful |
| ☐Requires sedation (explain) **Click here to enter text.** |
| ☐Requires special positioning for treatment (explain) **Click here to enter text.** |
| ☐Requires special staffing for treatment (explain) **Click here to enter text.** |

| RN Acknowledgement | |
|---|---|
| Printed Name of RN Completing Form: | |
| Signature of RN Completing Form: | |

*Provider should include this form with the clinical record for verification of any approvals.

**For consideration, all supporting documentation described above must be included.**

BMS/UMC use only below this line.

| |
|---|
| ☐Approved |
| ☐Not Approved (Describe)<br><br>**Click here to enter text.** |
| ☐Requested Additional Documentation (see notes section for more information) |

**Notes:**

| |
|---|
| Click here to enter text. |

Name of BMS staff reviewing request: **Click here to enter text.**
Email Address: **Click here to enter text.**