WEST VIRGINIA I/DD WAIVER
REQUEST FOR NURSING SERVICES

This assessment must be completed by the RN and submitted with all initial requests and/or increases in LPN services. This form serves as justification for LPN/RN services, and information provided unrelated to LPN/RN care will not be considered and may result in a delay of authorization. The form must be uploaded to UMC's web portal before review of requests will take place.

General Information (fill out each line item)			
Date Submitted:		Record ID:	
Name of Person Who Receives Services:			
Age of Person Who Receives Services: (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:			
Current Living Arrangement	☐ Unlicensed Residential/GH ☐ NF/SFCH		
Case Management Provider Agency:			
Residential Services Provider Agency:			
Name of person submitting request:			
Phone #/Extension:		Email Address:	

LPN Units Requested (Specify number of LPN units requested under-budget and over-budget (when applicable). Put N/A for areas not applicable to the member. Members residing in NF settings and NOT attending FBDH are not eligible for the 240 additional indirect LPN over service caps, therefore the amount of LPN requested must be considered within the 11,680 cap. You may still split the services between direct and indirect and explain the justification for the total amount of units.)	
Direct LPN Units Under-Budget:	**Direct** LPN Units Over-Budget:
Indirect LPN Units Under-Budget:	**Indirect** LPN Units Over-Budget:

RN Units Requested (Specify number of RN units requested under-budget and over-budget (when applicable). Put N/A for areas not applicable to the member.)	
RN Units Under-Budget:	RN Units Over-Budget:

Medications (put N/A if not applicable)
MAR Attached to UMC's web portal? (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

Hospitalizations/Surgeries (List all hospitalizations/surgeries occurring within the **past calendar year only**. This includes ER visits and outpatient procedures relevant to a continuing issue. Put N/A if not applicable.)

Reason for Hospital Admission/Surgery	Date(s)	Hospital Course/ Significant Findings	Discharge Instructions

Medical Conditions (list diagnosed medical conditions — add rows as needed. Put N/A for any section not applicable.)

Medical Condition/Diagnosis	Approx. Date of Diagnosis	Duration of Condition	Changes in Condition (describe how the members care will need to be different from the previous year, if applicable)

LPN Medically Necessary Direct-Care Tasks (list **ONLY** those tasks requiring administration from a licensed medical professional. Tasks could include treatments, evaluation of member, administration of medications requiring a nurse, etc. – any situation requiring a nurse to be physically present with the member to provide care. Tasks able to be administered by an AMAP should **not** be included. Put N/A if not applicable.)

Task	Reason Why Task is Required	Frequency of Task (approximate number of times per week or month the task will be completed)	Duration of Task (approximate amount of time per each administration and/or how long a treatment is ordered)	Severity of Incident (list any common member-specific information related to Reason which may serve to justify frequency and duration)

LPN Indirect-Care Tasks (list tasks completed by the medical professional related to management of care, not requiring direct, physical presence with the member to complete. This could include scheduling appointments, monitoring logs, checking equipment, etc. – add rows if necessary. Put N/A if not applicable)

RN Tasks (list tasks completed by a Registered Nurse **ONLY** for each request – add rows if necessary. RNs may complete LPN billable tasks if they bill the LPN code. However, any LPN billable tasks – regardless of whether an LPN/RN completes the task – should be listed in the Direct Care and/or Indirect Care boxes accordingly.)

Supporting Documentation (for this request to be considered, the following documentation must be attached to UMC's web portal prior to purchase request/modification.)
☐ IPP detailing member's level of LPN need including team recommendations and agreement ☐ 15-minute schedule detailing LPN services to be provided (**only** required when two or more hours of direct-care LPN (2,920 units) is requested) ☐ Minimum of 1 week of LPN Notes (**only** required when two or more hours of direct-care LPN (2,920 units) is requested) ☐ Hospital Records/Treatment Administration Records (TARs), other (**only** required if further justification of need is necessary): _____

Additional Information
Usual response to medical treatment ☐Cooperative ☐Partially cooperative ☐Resistant ☐Fearful ☐Requires sedation (explain) _____ ☐Requires special positioning for treatment (explain) _____ ☐Requires special staffing for treatment (explain) _____

RN Acknowledgement	
Printed Name of RN Completing Form:	
Signature of RN Completing Form:	
Date:	

*Provider should include this form with the clinical record for verification of any approvals.
For consideration, all supporting documentation described above must be included.