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| **HOME CARE SPECIAL APPROVAL REQUEST FORM**  **OVER SERVICE/OVER PROTOCOL** | | | | | | | | | | | |
|  | | | | Client Name: | |  | | | | | |
| Address: | |  | | | | | |
| Phone: | |  | | | | | |
| P.H.I.N.: | |  | | | | M.H.S.C.: |  |
| D.O.B.: | |  | | | | | |
| Home Care  Case Coordinator: | |  | | | | Phone: |  |
| Initial Request Reassessment | | | | | |  | | | | | |
| Diagnosis: |  | | | | | | | | | | |
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|  | | | | | | | | | | | |
| Medically Stable: | | Yes No | | | | | | | | | |
| Level of Care: | | Level 1 Level 2 Level 3 Level 4  Acute Hosp/Extended Care Other Facility No Facility | | | | | | | | | |
| Current Home Care Services: - include family & other community supports (attach service plan if appropriate) | | | | | | | | | | | |
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| SPECIAL REQUEST INFORMATION | | | | | | | | | | | |
| Reason For Special Request: | | | Over Protocol Over Cost Off Site  Safety Risk Eligibility Other | | | | | | | | |
| Start Date of Special Request: | | | Click here to enter a date. | | | | | | | | |
| End Date of  Special Request:(if known) | | | Click here to enter a date. | | | | | | | | |
| Expected Duration Of Special Request: | | | End of Life/Palliative Care (max. 3 mths) Short Term (max. 3 mths) Long Term  Safe Care Pending Placement Special Approval (beyond policy) | | | | | | | | |
| Rationale (explanation) For Special Request: (including urgency) | | | | | | | | | | | |
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| SPECIAL REQUEST INFORMATION cont…. | | | | | | | | | | | |
| Other Options Considered:( e.g. other resources and why not appropriate) | | | | | | | | | | | |
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| Case Coordinator Signature: | | |  | | | | | Date: | Click here to enter a date. | | |
| AUTHORIZATION  REGIONAL DIRECTOR OR DESIGNATE | | | | | | | | | | | |
| Conditions of Authorization and Reassessment Intervals:(special considerations &/or directions if any) | | | | | | | | | | | |
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| Approved Declined | | | | | | | | | | | |
| Regional Director or Designate Signature: | | | | |  | | Date: | | Click here to enter a date. | | |
| REASSESSMENT | | | | | | | | | | | |
| Rational to Support Continuation of Request: | | | | | | | | | | | |
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| Date of Reassessment: | | | | | Click here to enter a date. | | | | | | |
| Case Coordinator Signature: | | | | |  | | Date: | | Click here to enter a date. | | |
| Approved Declined | | | | | | | | | | | |
| Regional Director or Designate Signature: | | | | |  | | Date: | | Click here to enter a date. | | |
| TERMINATION | | | | | | | | | | | |
| Reason of Termination: | | | | | Hospital/ECU P.C.U. Deceased Improved/Recovered Other  Service Provided by Other Condition Deteriorated Resources Unavailable | | | | | | |
| Case Coordinator Signature: | | | | |  | | | Date: | Click here to enter a date. | | |