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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: |       |
|    |
|    |
|    |
| 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) |
|    |
|    |
| 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 TermSafe Care Pending Placement Special Approval (beyond policy)  |
| Rationale (explanation) For Special Request: (including urgency) |
|    |
|    |
|    |
| 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) |
|    |
|    |
|    |
|  |
| 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 OtherService Provided by Other Condition Deteriorated Resources Unavailable  |
| Case Coordinator Signature: |   | Date: | Click here to enter a date. |