

WEST VIRGINIA I/DD WAIVER PROGRAM
REQUEST FOR NURSING SERVICES

TO BE COMPLETED BY SERVICE COORDINATOR			
Member Name		APSID#	
Medicaid #		Date of Birth	
SC Provider		SC Name	
Living Arrangement (✓)	<input type="checkbox"/> NF/SFCH	<input type="checkbox"/> ISS (unlicensed home)	<input type="checkbox"/> Group Home (licensed home)
Principal Diagnosis			
Describe any change in the member's condition during the last year			

WV I/DD Waiver program cannot reimburse for greater than 11,680 units/2,920 hours annually LPN services (in combination with all other direct care services). This equates to about 8 hours per day. I/DD Waiver cannot reimburse for greater than 480 units/120 hours annually RN services (about 10 hours per month).

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REQUEST FOR NURSING SERVICES

Member Name		APSID#	
TO BE COMPLETED BY THE ATTENDING PHYSICIAN			
Briefly describe the member's medical status			
Has the family/caregiver been trained to adequately care for the member?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
List/Describe exactly what procedures this member requires that must be performed by a licensed nurse (use additional pages as necessary)			
List all medications and treatment orders			
<p>RX:</p> <p>I certify that this patient is in need of skilled nursing services @ _____ hours per day/ _____ days per week. The patient is under my care and requires the skilled procedures as listed above. Unless otherwise indicated this authorization covers a one year period, unless there is a change in the patient's condition.</p>			
Physician Signature		Date	