UNIVERSAL HEALTH PLAN/ HOME HEALTH AUTHORIZATION FORM

S.O.C. Date: ___/___/___ Initial: □ Reauthorization: ___/___/___
Agency D/C Date: ___/___/___: Anticipated □ Actual □ MD Agrees: Y/N Patient Agrees: Y/N

Patient Information
Name: ________________________________
S.O.C. Address: ________________________________
Telephone #: ________________________________
DOB: ___/___/___
Homebound: Y/N Why? ________________________________
Diagnosis: ________________________________
Surgery: N/A
Patient Prognosis
Poor / Guarded / Fair / Good / Very Good / Excellent / <6 months to live / Terminal.

MD Information
Ordering MD: ________________________________
MD Phone#: ________________________________
PCP: ________________________________
Date of Next MD Visit: ___/___/___

Health Plan Information
Health Plan Name: ________________________________
Insurance #: ________________________________
Health Plan CM: ________________________________
Initial Auth#: ________________________________
Telephone #: ________________________________ Fax #: ________________________________

Agency Information
Agency Name: ________________________________
Provider Number: ________________________________
Contact: ________________________________
Telephone #: ________________________________ Fax #: ________________________________

DME/Supplies/IV/Lab
Vendor Name: ________________________________

Community Resources

Caregiver Information
Name: ________________________________
Relationship: ________________________________
Type of Assistance: ________________________________
Teachable/Not Teachable: ________________________________
Primary Phone#: ________________________________

Maternity Care
N/A □
Delivery Date ___/___/___ Time Of Delivery: __:
Discharge Date ___/___/___ Time Of Discharge: __:

Current Functional Status

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Dress Lower Extremities</th>
<th>Bathing</th>
<th>Toileting</th>
<th>Ambulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Alert/Oriented</td>
<td>□ Independent</td>
<td>□ Independent</td>
<td>□ Independent</td>
<td>□ Independent</td>
</tr>
<tr>
<td>□ Impaired</td>
<td>□ Requires assist</td>
<td>□ Requires assist</td>
<td>□ Requires assist</td>
<td>□ Requires assist</td>
</tr>
<tr>
<td>□ Disoriented</td>
<td>□ Unable</td>
<td>□ Unable</td>
<td>□ Unable</td>
<td>□ Unable</td>
</tr>
</tbody>
</table>

Service Request

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
<th># Of Visits</th>
<th>Frequency</th>
<th>Auth # Visits</th>
<th>Health Plan Auth #</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
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<tr>
<td>HHA/Hrs&amp;Visits</td>
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<tr>
<td>PT</td>
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<td>ST</td>
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<tr>
<td>MSW</td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

Communication

Comments: ____________________________________________

Name: ________________________________ Title: ________________________________ Date: ___/___/___

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SKILLED NURSING  D/C Date: ___/___/___ Anticipated □ Actual □

Clinical summary:

Reason for Home Health Aide Services:

<table>
<thead>
<tr>
<th>Wound Care</th>
<th>N/A □</th>
<th>Wound 1</th>
<th>Wound 2</th>
<th>Wound 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td></td>
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</tr>
<tr>
<td>Appearance</td>
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<tr>
<td>Measurement</td>
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<tr>
<td>Drainage</td>
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<tr>
<td>TX and Frequency</td>
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</tr>
</tbody>
</table>

Goals/Plan for this Authorization Period:

Barriers to Achieve Goals/Plan:

Interventions:

Signature: __________________________ Title:______ Department:_____________ Date:___/___/___

OTHER SKILLED DISCIPLINES  D/C Date: ___/___/___ Anticipated □ Actual □
Please complete a separate pg. 2 when more than one skilled discipline providing care
PT OT ST MSW Other
Reason for Home Health Aide Services:

Clinical summary?

Goals/Plan for this authorization period:

Barriers to achieve goals/plan:

Interventions:

Signature: __________________________ Title:______ Department:_____________ Date:___/___/___

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