REQUEST FOR SUPERVISION HOURS IN PERSONAL ASSISTANCE

Individual Name: ______________________________ Medicaid ID: ______________________________

Personal Assistance Provider/Services Facilitation Provider: ____________________________________

INDIVIDUAL COGNITIVE AND PHYSICAL NEEDS WHICH JUSTIFY NEED FOR SUPERVISION (for children under 18 years of age)

A. **Cognitive Status**: Describe the individual's cognitive status and the impact it has on his/her behavior, which may necessitate supervision by a Personal Assistant (for example, may include but not be limited to, self-injury, elopement, impulsivity).

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Can the individual be left alone without risking their health or safety? ☐ Yes ☐ No (If no, why (Please explain below.)

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What is the maximum amount of time, if any, that the individual can be left alone without risking their health or safety?

Hrs.	Min.

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Does the individual have sufficient judgement/decision making abilities to enable him/her to be safe if left alone? ☐ Yes ☐ No

B. **Physical Status**: Please check all that apply.

Physical Issue	**Presence/Absence**	**Further Detail**	
Incontinence	☐ Yes ☐ No	☐ Bowel	☐ Bladder
Ability to Transfer	☐ Yes ☐ No	☐ Cannot Transfer	☐ Requires Assistance
Potential for skin breakdown	☐ Yes ☐ No	☐ Temporary	☐ Ongoing
Fall Risk	☐ Yes ☐ No	☐ Frequent	☐ Infrequent
Seizures	☐ Yes ☐ No	☐ Frequent	☐ Infrequent
		☐ Type___________________________________	
Mobility		☐ Ambulatory	☐ Non-ambulatory

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C. Can the individual call (via telephone) for assistance: ☐ Yes ☐ No

D. CURRENT SUPPORT SYSTEM

1. Primary Caregiver Information

Name: ______________________________ Home/Cell Phone: ______________________________

Does the primary caregiver live with the individual? ☐ Yes ☐ No

If no, primary caregiver's address is:

____

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Does the primary caregiver work outside of home? ☐ Yes ☐ No
Does the primary caregiver work from the home? ☐ Yes ☐ No
If yes, to either of the above, what are the days/hours worked:____________________________
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Are there other children (under 18) in the home? ☐ Yes ☐ No

2. Backup Plan/System for the primary care giver when the Personal Assistant is absent from home.

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E. Provide any additional information/justification not addressed above to further demonstrate the need for supervision.

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Agency Representative Date

____ ________________________

RN Supervisor/Service Facilitator Date

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Instructions

If a participant is requesting supervision, the provider must fill this form out completely and submit it to DBHDS SA for authorization. The DBHDS SA must approve the request before DMAS will reimburse for this service.

This form contains patient-identifiable information and is intended for review and use of no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form by mistake, please send it to: DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219