# General Assistance Medical Program
# Home Care Authorization

Date:_____ Home care service Provider _____ Tax ID #: _____

Contact Person:_____ Contact's Phone No:_____ Fax:_____

Patient Name:_____ DOB:_____ SS# :_____

Diagnosis: _____

GAMP Eligibility Dates: Anticipated Date of Hospital Discharge:

**Why is / What makes patient homebound?**

☐ bedridden ☐ BR with BRP ☐ ambulates w/assist _____feet ☐ ambulates independently _____feet

☐ Other: _____

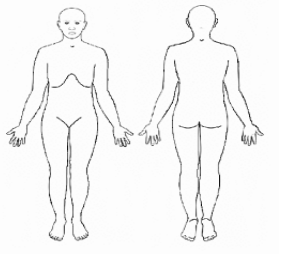
**(must be completed to be eligible for services)**

**Patient Needs**

**Request:** ____ RN Visits (Initial No.) _____Additional Visit(s) Reason?

____ PT Visits (Initial No.) _____Additional Visit(s) Reason?

**What tasks will they be performing?**

| **Teaching Needs:** | **Wound Care:** | **IV Therapy:** |
|---|---|---|
| ☐ DM education<br>☐ Safety assessment<br>☐ Drsg change/wound care<br>☐ IV administration and Site care<br>☐ Anticoagulation TX & teaching<br>☐ Other: (explain)<br><br>**Who is to receive Instruction?**<br><br>**Teaching Concerns(if any):** | Locate wound site on chart<br>  <br>**What is frequency of drsg change?**<br><br>**Anticipated duration of treatment?** | **Name of Drug:**<br><br>**Infusion Frequency:**<br><br>**Duration of Treatment:** |

***For GAMP UM Use Only***

| | |
|---|---|
| Todays Date: | Auth No.: |
| Primary Care Clinic: | Service Dates: |
| **Authorized:** **RN / PT Visits** | Provider: |
| Signature: | Provider Number: |

*Issuance of number indicates medical necessity, and does not necessarily guarantee payment of services.*

**Please FAX form to: (414) 289-8516 Telephone (414) 289-6731**