General Assistance Medical Program
Home Care Authorization

Date:_____ Home care service Provider _____ Tax ID #

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

Patient Name:_____ DOB:_____ SS# :_____

Diagnosis: _____

GAMP Eligibility Dates: Anticipated Date of Hospital

Why is / What makes patient homebound?

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

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

General information must include your return fax number and the phone number of contact person.

The patient must be homebound to be eligible for these services. Your request will not be considered if this section is not completed.

Identify the type of service being requested (PT vs. RN) and whether this is a new request or a request for additional visits. Identify what tasks will be performed.

What services are to be provided by you, how frequently, and to whom?

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

Form updated 9/2007