APPENDIX B

Appendix B includes the following forms that are used in the Elderly and Disabled Adult Waiver Program:

- Log of Weekly Services/Supports and Daily Progress Notes for EDA Waiver – PAS – Single Employee
- Environmental Accessibility Adaptations Job Completion Form
- Request for Payment/Override Form
- Physician Delegation for Medication Administration and Medical Treatments

Providers are required to follow the procedures that are outlined in the *Quality Enhancement Plan Handbook.* This handbook can be obtained at the following website:

http://www.dhh.louisiana.gov/offices/publications.asp?ID=105&Detail=514

Providers are required to follow the procedures that are outlined in the *OAAS Critial Incident Reporting Policies and Procedures* manual and complete all forms as directed by this policy. The manual and forms can be obtained at the following website:

http://www.dhh.louisiana.gov/offices/page.asp?ID=105&Detail=8982

LOG of WEEKLY SERVICES/SUPPORTS and DAILY PROGRESS NOTES for EDA WAIVER – PAS – SINGLE EMPLOYEE

PROVIDER AGENCY NAME: DIRECT SERVICE WORKER'S NAME:

RECIPIENT NAME: RECIPIENT DOB:

Week Of: Through:

Day Of Week:	Sunday			Monday			Tuesday			Wednesday			Thursday			Friday			Saturday		
Date→																					
1st Arrival Time W/ Initials→																					
1st Departure Time W/ Initials→																					
2nd Arrival Time W/ Initials→																					
2nd Departure Time W/ Initials→																					

↓ Indicate Task Completed Each Day W/Initials ↓

↓ Tasks ↓	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3
Eating																					
Bathing																					
Dressing																					
Grooming																					
Transferring																					
Ambulation																					
Toileting																					
Light Housekeeping																					
Food Preparation & Storage																					
Shopping																					
Laundry																					
Medication Reminders																					
Assist To Sched Med Appts																					
Assist To Arrange Med Trans																					
Accompany To Med Appts																					
Protective Supervision																					
Supv/Assit W/Health Tasks																					
Escort for Assist W/Comm Tasks																					
Extension of Therapy Services																					
Daily Total # Of Hours →																					

WEEKLY TOTAL # of Hours→ WEEKLY PAS for 1:_____HOURS WEEKLY PAS for 2:_____HOURS WEEKLY PAS for 3:_____HOURS

RECIPIENT/DESIGNATED PERSONAL REPRESENTATIVE/LEGAL REPRESENTATIVE SIGNATURE & DATE: _____

DIRECT SERVICE WORKER'S PRINTED NAME, SIGNATURE, & DATE: _____

DSW SUPERVISOR'S REVIEW SIGNATURE & DATE (Use of this line is optional): _____

NOTE: DAILY SERVICES/SUPPORTS DESCRIPTIONS, COMMENTS AND PROGRESS NOTES ARE TO BE RECORDED ON PAGE 2 OF THIS FORM. ADDITIONAL PAGES MAY BE USED.

Effective July 4, 2010 OAAS-PF-10-009 Page ____ of ____

PROVIDER AGENCY NAME: DIRECT SERVICE WORKER's NAME:

RECIPIENT NAME: RECIPIENT DOB:

WEEK OF: THROUGH:

DAILY SERVICES/SUPPORTS DESCRIPTIONS, COMMENTS AND PROGRESS NOTES:

DAY OF WEEK AND DATE ↓	DESCRIPTIONS, COMMENTS, AND PROGRESS NOTES ↓

RECIPIENT/DESIGNATED PERSONAL REPRESENTATIVE/LEGAL REPRESENTATIVE SIGNATURE & DATE: _____

DIRECT SERVICE WORKER'S PRINTED NAME, SIGNATURE, & DATE: _____

DSW SUPERVISOR'S REVIEW SIGNATURE & DATE (Use of this line is optional): _____

Page___of___

OAAS-PF-10-009

Effective July 4, 2010

Instructions for Completion of Log of Weekly Services/Supports

for Elderly & Disabled Adult (EDA) Waiver –

Person Assistance Services (PAS) – Single Employee

Effective7/05/10, the provision of all Elderly and Disabled Adult (EDA) waiver Personal Assistance Services (PAS) must be documented on the Log of Weekly Services/Supports & Daily Progress Notes for EDA Waiver – PAS, hereinafter referred to as the "Service Log." The Service Log must be used to document services provided to:

- A person who receives EDA-PAS

NOTE: Services provided by only one worker to one recipient may be documented on a single Service Log.

The Service Log is not a substitute for a Time Sheet. A separate Time Sheet is required for each worker. The design of the Time Sheet is the responsibility of the provider agency.

When an error is made, **only the individual who made the entry is allowed to correct the error**. Corrections must be made by drawing a single line through the incorrect entry, writing "error" above the entry, initialing the correction, and placing the correct information on the form.

The use of carbon is permissible. It is also permissible for this form to be two-sided.

The following instructions should be used to complete the Service Log:

PAGE 1 OF THE SERVICE LOG

PROVIDER AGENCY NAME: (1)	**DIRECT SERVICE WORKER'S NAME:** (2)
RECIPIENT NAME: (3)	**RECIPIENT DOB:** (4)

Items 1-7 are to be completed by the provider agency. It is permissible for this information to be typed onto the form.

(1) Enter the provider agency's name.

(2) Enter the name of the direct service worker.

(3) Enter the recipient's name.

(4) Enter the recipient's date of birth.

	WEEK OF: (5) THROUGH: (6)						
DAY OF WEEK:	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
DATE→	(7)						
1ST ARRIVAL TIME W/ SIGNED INITIALS→							
1ST DEPARTURE TIME W/ SIGNED INITIALS→							
2ND ARRIVAL TIME W/ SIGNED INITIALS→							
2ND DEPARTURE TIME W/ SIGNED INITIALS→							

(5) Enter the beginning date of the prior authorization week (example: 7/04/10).

(6) Enter the ending date of the prior authorization week (example: 7/10/10).

NOTE: The prior authorization week begins on Sunday at 12:00 a.m. and ends on the following Sunday at 12:00 a.m. Unused portions of the prior authorized weekly allocation may not be saved or borrowed from one week for use in another week.

(7) Enter the date of each day in which services are scheduled to be performed. Start the date on the day of the week that services are to begin in accordance with the recipient's plan of care. For example, if services are to begin on Monday, 7/05, place 7/05 in Monday's block and continue through the week.

Item 8 <u>MUST</u> be completed by the Direct Service Worker (DSW) and must be handwritten.

	WEEK OF: _____ THROUGH: _____						
DAY OF WEEK:	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
DATE→							
1ST ARRIVAL TIME W/ SIGNED INITIALS→	(8)						
1ST DEPARTURE TIME W/ SIGNED INITIALS→							
2ND ARRIVAL TIME W/ SIGNED INITIALS→	(8)						
2ND DEPARTURE TIME W/ SIGNED INITIALS→							

(8) The DSW must write-in the time the services began each day with his/her signed initials **<u>and</u>** the time services ended each day with his/her <u>signed</u> initials. <u>This form allows the DSW to document up to two periods of time for each day services were performed.</u>

Items 9 MUST be completed by hand by the Direct Service Worker (DSW).

↓Tasks ↓	↓ Indicate Task Completed Each Day W/Initials ↓																				
	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3	PAS1	PAS2	PAS3
Eating																					
Bathing	9																				
Dressing																					
Grooming																					
Transferring																					
Ambulation																					
Toileting																					
Light Housekeeping																					
Food Preparation & Storage		9																			
Shopping																					
Laundry																					
Medication Reminders																					
Assist To Sched Med Appts																					
Assist To Arrange Med Trans																					
Accompany To Med Appts																					
Protective Supervision																					
Supv/Assit W/Health Tasks																					
Escort for Assist W/Comm Tasks																					
Extension of Therapy Services																					

9 The DSW must enter his/her signed initials next to each task under the appropriate service type (PAS1 for one recipient [unshared], PAS2 for two recipients [shared by 2] or PAS3 for three recipients [shared by 3]) column. A signed initial in the appropriate block will indicate that the task was completed on that day. Only those tasks that were performed that day should be indicated with signed initials. If the task was not performed for that particular day, the box should be left blank. All entries must be completed on the Service Log by the DSW on the day he/she performs the task(s).

Items 10 must be completed by the DSW.

Daily Total # Of Hours →	10																			

10 The total PAS1 hours for one recipient (unshared), the total PAS2 hours for two recipients (shared by 2) and/or the total PAS3 hours for three recipients (shared by 3) that were worked each day must be written-in on this row.

Item 11 is to be completed by either the DSW or the Provider Agency.

WEEKLY TOTAL # of Hours→ **WEEKLY PAS for 1:** (11) HOURS **WEEKLY PAS for 2:** (11) HOURS **WEEKLY PAS for 3:** (11) HOURS

(11) At the end of the week, total the number of PAS1 hours for one recipient (unshared), the number of PAS2 hours for two recipients (shared by 2), and/or the number of PAS3 hours for three recipients (shared by 3) worked for this recipient for the week and write-in the amount on this row.

Items 12 and 13 are to be completed only after the form has been fully completed for the given week.

RECIPIENT/DESIGNATED PERSONAL REPRESENTATIVE/LEGAL REPRESENTATIVE SIGNATURE & DATE: (12) _____

DIRECT SERVICE WORKER'S PRINTED NAME, SIGNATURE, & DATE: (13) _____

(12) The signature of the recipient or the recipient's designated personal representative or the recipient's legal representative and the date of that signature must appear on this line. This signature should be obtained at the end of the prior authorized week.

(13) The printed (legible) name of the DSW must appear on this line, followed by the signature of the worker and the date the DSW signed the form. **The DSW should not complete this section until the work for that prior authorized week has been completed.**

Item 14 is for optional use at the discretion of the provider agency.

DSW SUPERVISOR'S REVIEW SIGNATURE & DATE (Use of this line is optional): (14) _____

NOTE: **DAILY SERVICES/SUPPORTS DESCRIPTIONS, COMMENTS, AND PROGRESS NOTES are to be recorded on page 2 of this form. Additional pages may be used.**

(14) Use of this line is optional at the discretion of the provider agency. It can be used to document supervisory review of the completed service log.

SECOND PAGE OF THE SERVICE LOG

NOTE: **The second page of this form is to be duplicated as needed.**

Items 1-6 are to be completed the same way as described in the Instructions for items 1-6 for Page 1 of this form

PROVIDER AGENCY NAME: (1)	**DIRECT SERVICE WORKER'S NAME:** (2)
RECIPIENT NAME: (3)	**RECIPIENT DOB:** (4)
	WEEK OF: (5) **THROUGH:** (6)

4

Effective July 4, 2010 **OAAS-PF-10-009**

Items 15 and 16 MUST be completed by the DSW for each day worked, as applicable, and must be handwritten.

DAILY SERVICES/SUPPORTS DESCRIPTIONS, COMMENTS, AND PROGRESS NOTES:

Day of Week & Date ↓	DESCRIPTIONS, COMMENTS, AND PROGRESS NOTES ↓
15	
	16

15 Anytime the DSW makes either a description, comment or progress note entry, the day of the week should be noted with the particular date.

16 Use this area to document progress notes for PAS and/or to indicate why assistance with a particular activity was not provided, or why assistance with an activity differed from the Plan of Care.

Example:

Tuesday, September 8	*Ms. Jones refused assistance with dressing today since she chose to remain in her*
	pajamas all day.

NOTE: **In this case there would be no signed initials indicating the performance of assistance with the task of "dressing" in Tuesday's column on Page 1 of the Service Log.**

Items 17, 18 & 19 are to be completed the same way as described in Instructions for items 12, 13 & 14 on Page 1 of this form.

RECIPIENT/DESIGNATED PERSONAL REPRESENTATIVE/LEGAL REPRESENTATIVE SIGNATURE & DATE: 17 _____

DIRECT SERVICE WORKER'S PRINTED NAME, SIGNATURE, & DATE: 18 _____

DSW SUPERVISOR'S REVIEW SIGNATURE & DATE (Use of this line is optional): 19 _____

NOTE: If the second page is duplicated, the recipient/designated personal representative/legal representative, employee and supervisory (if used) signatures must be obtained on each page.

NOTE: **Number each page of the service log. This is located on the bottom right of each page as Page____of____**

Example: There are three pages. Write Page 1 of 3 on the bottom of the first page, Page 2 of 3 on the bottom of the second page, and Page 3 of 3 on the bottom of the third page.

OFFICE OF AGING AND ADULT SERVICES
ENVIRONMENTAL ACCESSIBILITY ADAPTATION JOB COMPLETION FORM

SECTION 1 – IDENTIFYING & JOB SPECIFIC INFORMATION (To be completed by the support coordinator)	
Recipient's Name:	SSN:
Address:	
Personal Representative's Name (if applicable):	
Support Coordination Agency:	
Address:	
Phone #:	Provider #:
Adaptation Provider:	
Address:	
Phone #:	Provider #:
Description of Requested Service:	Requested Amount: $
Procedure Code:	Are funds available? □ Yes □ No
Anticipated Completion Date:	
Provider Agreement Signature & Date:	
Support Coordinator Agreement Signature & Date:	
Recipient/Personal Representative Agreement Signature & Date:	
SECTION 2 – OAAS AGREEMENT & PRIOR APPROVAL DETAILS (To be completed by OAAS Regional Office)	
Description of Approved Service:	
Procedure Code:	Approved Amount: $
OAAS Prior Approval Signature:	Date of Prior Approval:
SECTION 3 – PROVIDER'S VERIFICATION OF JOB COMPLETION (To be completed by the provider)	
Description of Completed Job:	
Does the job meet all state and/or local requirements? □ Yes □ No	
Provider's Signature:	Date Job Completed:
SECTION 4 – FINAL DETERMINATION ON JOB COMPLETION (To be completed by the support coordinator and OAAS Regional Office)	
Date Completed Job Verified:	Is the Job Acceptable?: □ Yes □ No
Comments:	
Recipient/Personal Representative Determination Signature:	
Support Coordinator's Determination Signature:	
Is the Job Given Final Approval by OAAS?: □ Yes □ No If "No" explain:	
OAAS Final Determination Signature:	Date of OAAS Final Determination:

Issued March 2, 2010 OAAS-PF-10-001

OFFICE OF AGING AND ADULT SERVICES
ENVIRONMENTAL ACCESSIBILITY ADAPTATION JOB COMPLETION FORM

INSTRUCTIONS

This form is to be used for all Environmental Accessibility Adaptation (EAA) to be included in the recipient's approved Plan of Care (POC). If more than one EAA is being requested, a separate Job Completion form is to be used for each EAA. The support coordinator (SC) will complete Section 1, obtain proper signatures, and send along with the OAAS POC revision form, the required bid and if applicable a doctor's statement attesting to medical necessity (if for air filtering device and/or heating/cooling adaptation) to the OAAS Regional Office (R.O.). Section 2 will be completed by the OAAS R.O. and sent back to the SC who will forward it to the provider. Section 3 will be completed by the provider and returned to the SC as soon as the job is completed. The applicable parts of Section 4 will be completed by the SC and returned to the OAAS R.O. After reviewing for completeness and accuracy, the OAAS R.O. will complete the remainder of Section 4 and submit the documents to the prior authorization contractor for processing. All signatures are mandatory.

Section 1 – Identifying & Job Specific Information:
After the POC is approved and the recipient and/or personal representative has selected a provider for the service, the information in this section shall be completed by the SC. The SC shall then obtain signatures of the provider and recipient and/or personal representative to indicate agreement of all parties involved. The SC will ensure that the provider is aware of building codes. The provider will bear the burden of liability with all applicable local and state building codes and licensing/certification requirements in effect.

Recipient's Identifying Information:	The recipient's full legal name, social security #, address, and, the personal representative's name (if applicable) are to be entered in the spaces provided.
SC Agency's Identifying Information:	The SC agency's name, address, telephone # and provider # are to be entered in the spaces provided.
Adaptation Provider's Identifying Information:	The adaptation provider agency's name, address, telephone # and provider # are to be entered in the spaces provided.
Description of Requested Service:	The applicable service description from the current Elderly and Disabled Adult Waiver Services Procedure Codes/Rates chart is to be entered in the space provided. If the request is for "Other Adaptations" please specify.
Requested Amount:	The dollar amount being requested for the job is to be entered in the space provided.
Procedure Code:	The applicable procedure code from the current Elderly and Disabled Adult Waiver Services Procedure Codes/Rates chart is to be entered in the space provided.
Funds Available:	Indicate whether or not funds are available by marking the box next to either "Yes" or "No". The SC shall verify this via the appropriate source in accordance with established procedure.
Anticipated Completion Date:	The anticipated completion date of the job as indicated by the provider is to be entered in the space provided.
Agreement Signatures and Dates:	Signatures of the provider, the SC and the recipient/personal representative in the spaces provided indicate agreement to the described service, cost and anticipated completion date. The date of signature is to be entered behind each signature.

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OFFICE OF AGING AND ADULT SERVICES
ENVIRONMENTAL ACCESSIBILITY ADAPTATION JOB COMPLETION FORM

After Section 1 has been completed, the SC will forward the form to the OAAS R.O. along with written bids and the POC revision form for completion of Section 2.

Section 2 – OAAS Agreement & Prior Approval Details:
OAAS R.O. staff will review the packet and if the request is approvable will enter the description, procedure code, and dollar amount of the prior approved service in the spaces provided. OAAS R.O. staff will also sign and date this section to indicate prior approval of the requested service and dollar amount payable to the provider once OAAS R.O. has given final approval subsequent to completion of the job.

Section 3 – Provider's Verification of Job Completion:
Upon completion of the pre-approved job the selected provider will complete this section.

Description of Completed Job:	A description of the completed job is to be entered in the space provided.
Job meets state &/or local requirements:	Indicate whether or not the completed job meets applicable state and/or local requirements by marking the box next to either "Yes" or "No".
Provider's Signature:	The provider's signature in the space provided indicates the prior approved job has been completed by the provider, as previously agreed and in accordance with all applicable local and state building codes and licensing/certification requirements in effect.
Date Job Completed:	The actual Date that the job was completed is to be entered in the space provided.

Upon completion of this section, the provider will submit the form with his/her original signature to the SC. This form may be faxed to the SC and the original form mailed to expedite the process.

Section 4 – Final Determination on Job Completion:
Upon receipt of this form with section 3 completed, the SC shall view the completed job with the recipient and/or personal representative and complete the top part of this section of the form.

Date completed job verified:	Enter the date the SC viewed the completed job with the recipient/personal representative in the space provided.
Job Acceptable:	Indicate whether or not the completed job is acceptable by marking the box next to either "Yes" or "No". If not considered acceptable the SC shall negotiate with the provider in accordance with the established policy.
Comments:	If the job is not accepted by either the SC or the recipient the SC shall provide an explanation in the space provided.
Determination Signatures and Dates:	Signatures of the SC and the recipient/personal representative in the spaces provided indicate that an acceptance determination has been made. In the event that there isn't agreement between the SC and the recipient/personal representative, the SC shall note that the recipient is not in agreement and declined to sign.

Issued March 2, 2010

OAAS-PF-10-001

OFFICE OF AGING AND ADULT SERVICES
ENVIRONMENTAL ACCESSIBILITY ADAPTATION JOB COMPLETION FORM

The completed form must be mailed or faxed by the SC to the OAAS R.O. within ten (10) working days of the date of the actual job completion.

OAAS Final Determination:	OAAS R.O. staff shall indicate whether or not the job meets final approval criteria by marking the box next to either "Yes" or "No". If the review results in the job not being approved, the R.O. staff will explain why in the space provided.
OAAS Final Determination Signature and Date:	OAAS R.O. staff signature and date in the spaces provided indicate that a final determination has been made.

Once a final determination is made, the OAAS R.O. will submit the Job Completion form and all applicable documents to the SC and if applicable to the prior authorization contractor for processing.

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Reissued March 5, 2010
Replaces All Previous Issuances

REQUEST FOR PAYMENT/OVERRIDE FORM

OAAS-PF-08-014
Page 1 of 2

This form will be used for: *Request for Payment of Transition Intensive Support Coordination* _____ *Request for payment of Transition Services* _____ *Request for Payment of Denied Claims* _____

Participant Name: _____ Medicaid # (13 digits): _____ Date of Birth: _____

Agency Name: _____ Agency Contact Person: _____ Agency Phone: _____

Agency Fax Number _____ Agency E-mail Address: _____

Population: Check One _____ EDA _____ ADHC _____ Other

Reason for Request: _____

PA Request is for: Begin Date: ___/___/___ End Date: ___/___/___ Initials Only: Date Support Coordination Agency Received the 18-W: ___/___/___

ATTACH ONLY THOSE DOCUMENTS NECESSARY TO JUSTIFY REQUEST: (DHH may request additional information.) Check documents that are attached.

_____ Approved CPOC _____ Progress Notes/Typed Chronology _____ CMS 1500 (completed) _____ Other:

DHH WILL NOT OVERRIDE TIMELY FILING LIMITS. IT IS THE RESPONSIBILITY OF EACH AGENCY TO RECONCILE ALL BILLINGS IN A TIMELY MANNER. DHH WILL REQUIRE A MAXIMUM OF FORTY-FIVE (45) CALENDAR DAYS TO PROCESS ALL REQUESTS AFTER RECEIPT OF ALL REQUIRED DOCUMENTATION. ANY REQUEST NOT CONTAINING THE NECESSARY INFORMATION WILL BE RETURNED AS INCOMPLETE AND CONSIDERED NOT RECEIVED.

TO BE COMPLETED BY OAAS: _____ APPROVED _____ DENIED _____ RETURNED (See Reason Below)

Notes: _____ If Denied or returned, please provide reason below:

_____

_____

OAAS Authorized Reviewer _____ Date _____

TO BE COMPLETED BY DHH/WAIVER ASSISTANCE AND COMPLIANCE (WAC) **IF APPLICABLE:** _____ APPROVED _____ DENIED _____ RETURNED (See Reason Below)

Notes: _____ If Denied or returned, please provide reason below:

_____

_____

DHH/WAC Authorized Reviewer _____ Date _____

INSTRUCTIONS FOR COMPLETING REQUEST FOR PAYMENT/OVERRIDE FORM

Step One - Indicate Reason for Use of Form.

1.) **Request for Payment of Transition Intensive Support Coordination (TISC)** – Use form to request payment for TISC services for up to four months prior to the individual transitioning out of a nursing facility.

2.) **Request for Payment of Transition Services** – Use form to request payment of funds expended by a designated purchaser prior to learning a participant will be unable to transition back into the community with a waiver opportunity..

3.) **Request for Payment of Denied Claims** – Use form to request payment of claims denied by UNISYS.

Step Two - Complete Demographic and Support Coordination Agency Information

Do not leave any blanks. Indicate the waiver or targeted case management population the request is for.

Step Three - Reason for Request:

Be specific. For "Request for Payment of Denied Claims", indicate the reason for the request and include the 3 digit Medicaid claim denial code from the Remittance Advice, i.e., observation services could not be completed because services did not begin until after the quarter, indicate what services did not begin in that quarter and the date the services did begin (this is needed so the PA for the provider can be canceled for that period). Denial Code 191

Step Four - PA Request is for:

Indicate the start and end date for the period of reimbursement you are requesting.

Step Five - Date Support Coordination Agency Received the 18-W:

Indicate the date the support coordination agency received the 18-W

Step Six - Support Documents Required:

Based on documentation provided, DHH will review and either approve, deny, or return the request.
Attach only those documents necessary to justify your request; i.e.

Request for Payment Reason 1.) Approved POC, progress notes, CMS 1500 (completed), and any other pertinent documents necessary.

Request for Payment Reason 2.) Copy of Pre-approved Transition Services Expense Planning and Approval (TSEPA) form, copy of revised POC budget sheet, copies of all receipts for expenditures from designated purchaser, copies of canceled checks, and narrative explaining why transition did not take place.

Request for Payment Reason 3.) If observation of services could not be completed submit program notes or typed chronology that supports request for payment. If denial is for late CPOC due to issues with requesting additional information, attach any correspondence received relative to the delay. **PROGRESS NOTES MUST BE LEGIBLE.**

Step Seven - First Signature Block

To be completed by OAAS Regional Office (R.O.) - Support coordinator agency will submit completed form and supporting documentation to OAAS R.O. for approval and signature. If denied or returned, the OAAS R.O. will give a detailed explanation for rejection, using an extra sheet if necessary. If approved, OAAS R.O. will e-mail a copy to the support coordination agency, a copy to SRI ljarrett@statres.com for payment, and a copy to susan.robinson@la.gov at OAAS State Office (S.O.).

Step Eight - Second Signature Block

TO BE USED BY DHH/WAIVER ASSISTANCE AND COMPLIANCE (WAC) SECTION, WHEN APPLICABLE.

Reissued March 5, 2010
Replaces All Previous Issuance

OAAS-PF-08-014
Page 2 of 2

State of Louisiana
Department of Health and Hospitals
Office of Aging and Adult Services

PHYSICIAN DELEGATION FOR MEDICATION ADMINISTRATION AND MEDICAL TREATMENTS

Participant's Name:	SSN:	DOB:
Direct Service Provider's Name:	Telephone #:	
DSP Employee's Name: **(List only one name per page.)**		

MEDICATION/TREATMENT	DOSAGE/SITE	INSTRUCTIONS (Including frequency of medication)

I have provided the above named employee, of the above named Medicaid direct service provider, with specific training and instructions concerning the administration of the medication(s) and medical treatment(s) listed above. This employee is acting under my authority.

Delegation Physician's Signature _____ Date _____

Please PRINT the following information:

Physician's Name :		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	

I have been instructed concerning administration of the medication(s) and medical treatment(s) described above and agree to administer only these medications and treatments and to do so according to the instructions given.

Employee's Signature _____ Date _____

NOTE: This form is valid only until there is any change in the approval granted herein. Changes in authorized attendant, medication, dosage, treatment or instructions require the completion of a new form prior to the implementation of the change.

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