



DIVON DESTINY

VA Service Facilitator Company

Service Authorization – Justification for Hours Form

Member Information

- **Member Name:** _____
 - **Medicaid ID #:** _____
 - **Date of Birth:** _____
 - **Managed Care Organization (MCO):** _____
 - **Primary Diagnosis:** _____
 - **Secondary Diagnosis (if applicable):** _____
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Assessment Information

- **Date of Functional Assessment (UAI):** _____
 - **Assessor Name/Agency:** _____
 - **Level of Care Determination:** Nursing Facility Other: _____
 - **Current Authorized Hours:** _____
 - **Requested Hours:** _____
-

Clinical & Functional Justification

1. ADL Dependency (Check all that apply)

- Bathing – Level of Assistance: _____
- Dressing – Level of Assistance: _____
- Toileting – Level of Assistance: _____
- Transferring – Level of Assistance: _____
- Eating/Feeding – Level of Assistance: _____
- Mobility – Level of Assistance: _____

Explanation of ADL Limitations:

2. IADL Limitations (Check all that apply)

- Meal Preparation
- Medication Management
- Housekeeping
- Laundry
- Shopping
- Transportation
- Money Management

Explanation of IADL Support Needs:

3. Cognitive / Behavioral / Supervision Needs

- Memory Impairment
- Disorientation
- Poor Safety Awareness
- Wandering Risk
- Behavioral Concerns
- Requires Cueing/Redirection

Supervision Requirements & Risk Factors:

4. Skilled Medical or Health-Related Needs

- Fall Risk
- Seizure Disorder
- Diabetes Management

Oxygen Use

Other: _____

Explanation of Medical Necessity:

Environmental & Social Considerations

- Lives Alone? Yes No
- Availability of Informal Supports: _____
- Caregiver Limitations (if applicable): _____
- Risk of Institutionalization Without Services:

Justification Summary

Based on the completed assessment, the member requires _____ **hours per week** of personal care services due to documented functional limitations in ADLs and/or IADLs, medical necessity, and identified safety risks.

Without the requested hours, the member is at risk for:

- Falls
- Hospitalization
- Medication Mismanagement
- Malnutrition
- Institutional Placement
- Other: _____

The requested hours are **medically necessary** to ensure the member's health, safety, and ability to remain safely in the community in accordance with Virginia Department of Medical Assistance Services guidelines.

Service Facilitator Certification

I certify that the above information is accurate and reflects the member's current needs based on assessment and documentation.

Service Facilitator Name: _____

Signature: _____

Date: _____

Company: Divon Destiny VA Service Facilitator Company

Phone: _____

Email: _____