Jefferson Health Plans | Health Partners Plans

Shift Care Form

This form must be completed in its entirety and included with your prior authorization request. All requests for prior authorization must be submitted via the MHK portal. **This form is not a replacement for the Letter of Medical Necessity.**

Form completed by:	**Date completed:**

Physician and Patient Information		
Ordering physician:	**Physician phone:**	**Physician fax:**
Physician address:		**Date of last office visit:**
Date(s) of last pediatric facility placement:	**Pediatric facility new auth number:**	
Date of last hospitalization:	**Dx:**	**Facility:**
Date of last ED visit:	**Reason:**	**Facility:**

Member Information and Services Requested		
Member Name:	**Member ID:**	**Member DOB:**
Member diagnosis:		
ICD-10 codes (include all codes):		

Services requested (e.g., SN or HHA shift care 8 hrs/night X 5 nights/week for caregiver's sleep; SN or HHA 6 hrs/day X 5 days/week for school accompaniment days):

Skill level requested: ☐RN T1002 ☐LPN T1003 ☐Home health aide G0156					
Monthly total hours					
Jan:	Feb:	Mar:	Apr:	May:	June:
July:	Aug:	Sept:	Oct:	Nov:	Dec:

Home Health Care Provider (HHCP)	
HHCP name:	HHCP contact phone:
HHCP contact name:	HHCP contact E-mail:
HHCP NPI:	HHCP contact fax:

Member's Social History
Caregivers available in the home and relationship (parent, guardian, foster parent): *If care cannot be provided due to caregiver disability, attach letter from the caregiver's physician stating level of disability and restrictions related to inability to perform care of the member.*
Other individuals living in home: *Indicate relationship to member, age, and if they receive shift care services; include foster siblings.*

Are hours being requested to cover caregiver, parent, or guardian work schedules? ☐ **Yes** ☐ **No** If yes, how many?	**Work letter(s) attached:** ☐ **Yes** ☐ **No** *If self-employed, include EIN number, validation of working hours (trips sheets, timecards, time schedule). (this section is optional)*

Work letter(s) verified		
Name:	**Phone:**	**Date:**
Name:	**Phone:**	**Date:**
Has a family member or caregiver been trained, competent, and willing to care for the member: ☐ **Yes** ☐ **No** *If "No," the parent/LRR is not eligible for HHA unless they complete state-mandated training. Please upload proof of training (e.g., HHA certificate).*		
School district:	**Method of transportation:**	**Total hours of school attendance daily, including travel time:**
Attach current school district calendar and letter from school. Letter must come from principal or director of special education on official letterhead stating why the school district is unable to accommodate the child's needs during school hours.		

Supporting Clinical Information	
Ventilator: ☐ **Yes** ☐ **No**	**Hours on ventilator/ ventilator type (BiPap, CPAP, traditional):**
Tracheostomy: ☐ **Yes** ☐ **No**	**Trach type:**

Additional trach information (date inserted, trach size, frequency of trach care, frequency changed, etc.):		
Oxygen: ☐Yes ☐No	☐Continuous ☐Intermittent	
If intermittent, frequency:	Liter/minute:	Route:

Pulse Ox:	☐Yes	☐No	☐Continuous	☐Intermittent
If Intermittent, frequency:				
Nebulizer:	☐Yes	☐No	Frequency:	
Cough assist device:	☐Yes	☐No	Frequency:	
Chest percussion:	☐Yes	☐No	Frequency:	
Chest vest therapy	☐Yes	☐No	Frequency:	
IPBV machine:	☐Yes	☐No	Frequency:	
Enteral feeding:	☐Yes	☐No	Formula and route:	
Bolus feeds:	☐Yes	☐No	Amount:	
Frequency:			Duration:	
Continuous feeds: ☐Yes ☐No If yes, indicate total hours for continuous feedings with times and rate of administration:				

Complications with the feedings when infusing: ☐Yes ☐No If yes, explain (venting, etc.):		
PO feeds: ☐Yes ☐No		
Ostomy: ☐Yes ☐No	Type:	
Incontinent of urine: ☐Yes ☐No	GI/GU descriptions (frequency of catheter care, frequency of incontinence, frequency of stoma care, etc.):	
Incontinent of bowel: ☐Yes ☐No		
Urinary catheter: ☐Yes ☐No		
Wounds: ☐Yes ☐No	Number of wounds:	Locations and measurements:
Frequency of wound care:	Type of wound care:	
IV Catheter: ☐Yes ☐No	Observation only: ☐Yes ☐No	
Type (Broviac, PICC, peripheral) and description:		
Interventions: ☐Yes ☐No	If yes, explain:	
TPN: ☐Yes ☐No	Frequency:	Duration:
Seizures: ☐Yes ☐No	Seizure log attached: ☐Yes ☐No	
Avg. number per day:	Avg. duration:	
Seizure interventions (VNS, Diastat, ketogenic diet, oxygen):		

Diabetes: ☐Yes ☐No	Insulin: ☐Yes ☐No	Insulin pump: ☐Yes ☐No
Finger sticks/ Dexcom: ☐Yes ☐No	Frequency:	
Ketone checks: ☐Yes ☐No	Frequency:	
Interventions/education:		
Additional diagnosis:		
Treatments:		

Environmental care assessment	Yes	No	Date	Initials
Adaptive equipment available/used: List:	☐	☐		

Ambulation/ADLs	Ambulatory: ☐Yes ☐No		Requires assistance: ☐Yes ☐No
	Independent	Supervision/ verbal cues	Assist	Dependent
Bathing				
Grooming				
Dressing				
Toileting				
Repositioning				
Transfers				
Eating				
Oral care				

Weight check: ☐Yes ☐No	Frequency:

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Therapies:

Describe therapies that are performed (e.g., range of motion)

Comments

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