|  |  |
| --- | --- |
| Transforming Lives |  AGING AND LONG-TERM SUPPORT ADMINISTRATION **Nurse Delegation: Request For Additional Units** **To be completed by Delegating Nurse** |
| 1. RND NAME | 2. RND TELEPHONE NUMBER | 3. RND E-MAIL ADDRESS |
| 4. CLIENT’S NAME | 5. ACES ID NUMBER | 6. CLIENT’S DATE OF BIRTH |
| 7. CASE MANAGER’S NAME | 8. CASE MANAGER’S TELEPHONE NUMBER | 9. CASE MANAGER’S E-MAIL |
| 10. I will need  more units in addition to the 100 units already authorized for the month of . This will allow me to bill for a total of  units for the month of .11. Reason Additional Units Needed: A. **For insulin,** complete the section below (no additional narrative required).[ ]  Initial visit;  units needed. [ ]  Supervisory visit;  units needed. [ ]  New support providers / caregivers;  units needed. Total number of caregivers delegated insulin:  B. **Other than insulin** please list reasons units needed: |
| 12. DATE REQUESTED | 13. REQUESTING ND SIGNATURE |
| 14. UNITS APPROVED | 15. ND PROGRAM MANAGER SIGNATURE | 16. DATE APPROVED |
| **Scan and email additional unit request form to** nursedelegation@dshs.wa.gov**.** |