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|  | 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 Requested.  Comments: | | | | | |
| 12. Supporting Document include:  14-484 Nurse Delegation: Nursing Visit  13-678, Nurse Delegation: Instructions for Nursing Task (page 2)  10-217 Nurse Delegation: Credentials and Training Verification for new delegated caregivers  Billing Tracker for the month of request  All other supporting documents to support time.  \*\* All attachments must have Client Name, date, and which form it is attached to. | | | | | |
| 13. DATE REQUESTED | | 14. REQUESTING ND SIGNATURE | | | |
| 15. UNITS APPROVED | | 16. ND PROGRAM MANAGER SIGNATURE | | | 17. DATE APPROVED |
| **Scan and email additional unit request form to** [nursedelegation@dshs.wa.gov](mailto:nursedelegation@dshs.wa.gov)**.** | | | | | |