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| 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](mailto:nursedelegation@dshs.wa.gov)**.** | | | | | |