Bureau of Long Term Care
Children Private Duty Nursing
Significant Change/Modification Request Form

Participant Name MID #

Justification for Changes [ ] Decrease in unmet needs [ ] Increase in unmet needs

Please document what has caused the participant's change in functioning, when the change began, and the anticipated length of time the change in function is expected to continue. Describe the change in the participant's specific ability in the appropriate box. **Only fill out the area in which a change in function has occurred.** If medical documentation exists supporting this change, please attach. Review the Child PDN Acuity Assessment and Plan of Care to determine any changes. (Attach additional sheet if more room is needed)

Medication/IV Delivery Need	Nutrition Needs
Comments	Comments
Respiratory Needs	**Assessment Needs**
Comments	Comments
Seizures	**Wound Care (PDN)**
Comments	Comments
Other Nursing Care Elements	
Comments	

Requesting Provider: Date of Request:

Agency RN Signature: Date:

Participant/Guardian Signature: Date:

[ ] Approval [ ] Denial Reason for Denial

BLTC Reviewer Signature: Date:

The Plan of Care must be updated to reflect the approved changes and the approved Significant Change Form attached to the Plan of Care.

Participant Zip Code__________________________ Participant DOB_______________________________

Instructions for completing Significant Change /Modification Request Form

Purpose

These instructions are intended to assist our agencies providing PDN to children to identify significant changes in participant functioning that result in an increase or decrease in the unmet needs. IDAPA 16.03.23.010.06**.** Significant Change in Client's Condition. A major change in the client's status that affects more than one area of the client's functional or health status, and requires review or revision of the care plan. The Medicaid nurse reviewer will use this information to approve or deny significant change requests.

Instructions

1. Verify the participant has had a change in functioning that is significant enough to warrant a change in the participant's amount of help they need in any areas found in the Private Duty Nursing Acuity Assessment.

2. Provider Supervising RN should visit the participant to assess what functioning areas have been impacted. Only in emergency situations will the Medicaid Nurse Reviewer consider a modification request without a provider visit to the participant's home.

3. If a change has occurred in any of the functioning areas, describe the participant's specific ability in the appropriate box. **Only fill out those areas in which a change has occurred.**

4. Under "Justification for Change" at the top of the form, please note what has caused the participant's change in functioning, when the change began, and the anticipated length of time the change in functioning will continue. Include in this area any changes to Available Supports when applicable.

5. Attach additional documentation that supports your observations if applicable and available. This may include attendant progress notes, supervising visit notes, the physician's history and physical, or office visit notes.

6. The Provider Supervising RN and the participant or the participant's guardian must sign and date the request.

7. If the change is approved by the Medicaid Nurse Reviewer. The Plan of Care must be updated to reflect the change and the Significant Change form must be attached to the updated Plan of Care