DDA AFTER HOURS EMERGENCY SERVICE REQUEST

TN Department of Disability & Aging

PLEASE NOTE: THE USE OF THIS FORM IS FOR NEEDS WHICH ARISE AFTER 4:30PM ON WEEKDAYS, WEEKENDS, AND OFFICIAL STATE HOLIDAYS.

YOUR NAME: _____ YOUR CONTACT INFO: _____

REGION: _____ PROVIDER AGENCY: _____

PERSON'S NAME: _____ PERSON'S SSN: _____ PERSON'S DOB: _____

ISC AGENCY / DDA CM: _____

FOR HOSPITAL ATTENDANT REQUEST

Justification for Requesting a Hospital Attendant: _____

1. Is the person under 18 years old? ☐ **YES** ☐ **NO**

   If **YES**, a hospital attendant cannot be approved; If **NO**, proceed to question #2

2. Does the person have immediate family members or friends who can provide the needed hospital attendant service without charge? ☐ **YES** ☐ **NO**

   If **YES**, a hospital attendant cannot be approved; If **NO**, proceed to question #3

3. Is the hospital attendant service being requested for a person in an Intensive Care Unit/Nursing Home/Rehab? ☐ **YES** ☐ **NO**

   If **YES**, a hospital attendant cannot be approved; If **NO**, proceed to question #4

4. Is the hospital attendant service being requested for a person in a psychiatric hospital or in a psychiatric unit of an acute care hospital? ☐ **YES** ☐ **NO**

   If **YES**, a hospital attendant cannot be approved; If **NO**, proceed to question #5

5. Is there documentation the person has a recent history of behavioral issues which place the person or others at imminent risk of harm or have resulted in a significant damage to property? ☐ **YES** ☐ **NO**

   If **YES**, proceed to question #6; If **NO**, proceed to question #7

6. Considering the circumstances of the person's illness and pattern of behavioral issues, is it likely the person would experience significant behavioral issues if a hospital attendant was not present? ☐ **YES** ☐ **NO**

   If **YES**, Stop and provisionally approve hospital attendant; If **NO**, proceed to question #7

7. Is the person capable of alerting hospital staff when assistance is needed, either by activating the "call button" or by calling for assistance (if located near the nurses station)? ☐ **YES** ☐ **NO**

   If **YES**, hospital attendant cannot be approved; If **NO**, proceed to question #8

8. Will the hospital attendant's primary role be to provide support which the hospital should be providing (e.g. assistance with meals, repositioning, assistance to the bathroom)? ☐ **YES** ☐ **NO**

   If **YES**, hospital attendant cannot be approved; If **NO**, stop and provisionally approve hospital attendant.

HOW MANY HOURS PER DAY OF HOSPITAL ATTENDANT ARE BEING REQUESTED?
(service will be effective from the date/time stamp of the electronically submitted request) _____

DATE OF REQUEST *(approval cannot be backdated before today at 12:00am)* _____

HOSPITAL ATTENDANT (*may be **provisionally approved** for up to seven days until Plans Review can conduct the full review process.*)

FOR ALL OTHER SERVICE REQUESTS: (*service will be effective from the date/time stamp of the electronically submitted request*)

Justification for request: _____

SERVICE NAME: _____ SITE CODE: _____

START DATE/TIME: _____ END DATE*: _____ NUMBER OF UNITS REQUESTED: _____

Will be **provisionally approved through 11:59 pm of the next business day*

All services are **provisionally approved** until Plans Review can conduct the full review process.
Plans Review will ensure financial and service caps are not exceeded, and protocols, service definitions, etc. are met.

SUBMIT FORM ELECTRONICALLY TO THE APPROPRIATE REGIONAL PLANS REVIEW EMAIL ADDRESS:

EAST: dd_etro.plans@tn.gov **MIDDLE**: mtro.plansreview@tn.gov **WEST**: plans.service@tn.gov