AUTHORIZATION FOR PRIVATE DUTY NURSING PROVIDED BY A PARENT OR LEGAL GUARDIAN

Applies to Medicaid, Child Welfare, and LTC

Home Health Agency Name ______________________ Date of Request __________

Medicaid Provider Number ____________ Phone Number ____________ County ____________

Street Address ____

City ______________________ State __________ Zip Code ____________

This is to certify that

Child's Name ______________________ Date of Birth ______________

Child's Medicaid Number ______________________________________

Street Address ____

City ______________________ State __________ Zip Code ____________

has been evaluated and approved to receive private duty nursing services in the child's place of residence as outlined in the Florida Medicaid Home Health Services Coverage and Limitations Handbook. The private duty nursing services will be provided by a parent or legal guardian who meets the following criteria:

1. Has a valid and unencumbered license as a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the State of Florida; and
2. Employed by a Medicaid enrolled home health agency

Parent or Legal Guardian Name ______________________________________

Florida License Number (RN or LPN) ______________________ Expiration Date ______________

Phone Number ______________________

I certify that an initial assessment, all subsequent plan of care assessments and the nursing supervisory oversight of care for this child will be completed by a Registered Nurse that is a non-relative registered nurse while the parent or legal guardian is authorized to provide private duty nursing services. I understand that Medicaid will only reimburse a home health agency up to 40 hours per week of private duty nursing services provided by a parent or legal guardian. A non-relative RN or LPN employed by the home health agency must provide all other authorized private duty nursing hours above the 40 hour a week limit.

______________________________________ ______________

Home Health Agency Authorized Representative Date

______________________________________ ______________

Parent or Legal Guardian Date

______________________________________ ______________

Approval by Sunshine Health Representative Date

Submit the form for approval with the request for authorization of services via the secure online portal located at www.sunshinehealth.com or FAX to Sunshine Health Utilization Management Department **Medical Prior Authorization at 866-534-5978.**

This signed form will be faxed back to the serving provider and will also be attached to the prior authorization request for services in the member record.