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. CLIENT'S DATE OF BIRTH
6. CASE MANAGER'S NAME	7. CASE MANAGER'S TELEPHONE NUMBER	8. CASE MANAGER'S E-MAIL

9. I will need more units in addition to the 36 units already authorized for the month of .
   This will allow me to bill for a total of units for the month.

10. 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:

11. DATE REQUESTED	12. REQUESTING ND SIGNATURE	
13. UNITS APPROVED	14. ND PROGRAM MANAGER SIGNATURE	15. DATE APPROVED

Scan and email additional unit request form:

Erika Parada
Nurse Delegation Program Manager
ParadE@dshs.wa.gov