**Multnomah County Aging, Disability & Veterans Services Division**

**Family Caregiver Support Program**

**In-Home Service Authorization**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ACTION** | | | | | | | | | **DISTRICT CENTER** | | | | | | | |
| New  Change | Add Service  Close | | | | | Reauthorize | | | EC  NH | | | ME  NE | | | PT | |
|  |  | | | | |  | | |  | | |  | | |  | |
| **FAMILY CAREGIVER INFORMATION** | | | | | | | | | | | | | | | | |
| First Name: | | | | Last Name: | | | | | | | | | Prime # | | | |
| Address: | | | | | | | | | | City: | | | | State: OR | | Zip: |
| Date of Birth: | | Phone #: | | | | | | Other Info.: | | | | | | | | |
|  | |  | | | | | |  | | | | | | | | |
| **CARE RECIPIENT INFORMATION** | | | | | | | | | | | | | | | | |
| First Name: | | | Last Name: | | | | | | | | | | Prime # | | | |
| Address: | | | | | | | | | | City: | | | | State: OR | | Zip: |
| Date of Birth: | | | | | Phone #: | | | | | | Other Info.: | | | | | |
| Emergency Contact: | | | | | | | Phone #: | | | |
|  | | | | | | |  | | | |
| **INTERMITTENT IN-HOME SERVICES** | | | | | | | | | | | | | | | | |
| Agency Provider Name: | | | | | | | | | | | | | | | | |
| Award Start Date: | | | | | | | | | Award End Date: | | | | | | | |
| **Client will schedule services as needed with Provider.** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Notes (service detail):** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| ***Client is authorized for a total of***$ ***for services provided during award period.*** | | | | | | | | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Case Manager Name: | | CM email: | CM phone: |
| Supervisor: | Date: | | |