

## Concise Statement

**Acuity Level Header** (A clear explanation that sets forth the presenting problem that requires the 1:1 supervision and the number of requested hours for the 1:1 service and supporting documentation). Must include justification for overnight hours (if requested):

(**Example:** Acuity level 6 1:1 skilled nursing, 24 hours a day, 7 days/week, for continuous G-tube feeding for 14 hours a day, water flushes every 2 hours for a period of 1 year.)

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**Dates of Service Requested:** (Date must correlate with the Acuity Packet Cover Sheet and ISP date).

**Brief Background/Pertinent History:** (1 paragraph):

(Example- Mr. Doe is a 50-year-old African American male residing in an ICF-ID residential home. Mr. Doe diagnosis requiring ongoing medical and nursing monitoring includes the following: Gastrostomy tube feedings, severe oral dysphagia, Acute Esophagitis/Inflammation of the Esophagus, Seizure disorder, Re-current Aspiration Pneumonia, Recurrent failure of G-tube function.)

**Reason/Purpose of Requested Service:** (For Behaviors, must be in accordance with the BSP). (1 paragraph).

(Example- Mr. Doe requires continuous G-tube feeding for 14 hours a day, and water flushes every 2 hours for a period of 1 year.)

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Name & Title of Person Completing Statement/Date

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Signature