Limitation Extension Request
Incontinent Supplies and Gloves

Attention: DME Program Manager
Durable Medical Equipment (DME) Program Management Unit
PO Box 45535  Olympia, WA 98504-5535
Fax:1-866-668-1214

This is confidential information intended only for the person to whom it is faxed. In addition to this form, you must send a completed HCA Rx form (HCA 13-794).

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<th>To be completed by vendor or clinician</th>
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<tr>
<td>CONTACT NAME</td>
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<td>PHONE NUMBER</td>
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<td>CLINICAL CONTACT</td>
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<td>CLIENT ID</td>
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**FOR INCONTINENT SUPPLIES**
1. What is the medical diagnoses(s) requiring additional incontinent supplies?
2. What is the frequency of use of incontinent supplies per day?
3. Has the frequency changed recently?  Yes  No  If yes, why?
4. What type of medications does the client currently use that may affect the amount of incontinent products required per month?
5. Has a bowel/bladder program been tried?  Yes  No
6. If yes, what was the outcome?
7. Is client dual incontinent?  Yes  No

**FOR GLOVES**
1. What is the medical diagnoses(s) requiring additional gloves?
2. What is the frequency of use of gloves per day?
3. Has the frequency changed recently? If yes, why?
4. Does the client have multiple non-family caregivers?  Yes  No
   If yes, how many?  ___  How many hours per day?  ___
5. Where does the client reside?
   Private home  Adult family home or boarding home (e.g. ALF)  Other state-funded living

**FOR SIZING THAT DOES NOT FIT INTO THE ALLOWABLES**
1. Waist measurement_______________________ Hip Measurement__________________________________

Please note: All supplies are authorized for 1 year. New documentation must be submitted yearly.

PHYSICIAN (OR PRESCRIBING PROVIDER) SIGNATURE  DATE