

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: _____ To: _____	4. Medical Record No.	5. Provider No.
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6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number
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8. Date of Birth	9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged
11. ICD-9-CM Principal Diagnosis	Date	
12. ICD-9-CM Surgical Procedure	Date	
13. ICD-9-CM Other Pertinent Diagnoses	Date	

14. DME and Supplies	15. Safety Measures:
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16. Nutritional Req.	17. Allergies:
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18.A. Functional Limitations 1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind 2 <input type="checkbox"/> Bowel/Bladder (Incontinence) 6 <input type="checkbox"/> Endurance A <input type="checkbox"/> Dyspnea With Minimal Exertion 3 <input type="checkbox"/> Contracture 7 <input type="checkbox"/> Ambulation B <input type="checkbox"/> Other (Specify) 4 <input type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech	18.B. Activities Permitted 1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Weight Bearing A <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Independent At Home B <input type="checkbox"/> Walker 3 <input type="checkbox"/> Up As Tolerated 8 <input type="checkbox"/> Crutches C <input type="checkbox"/> No Restrictions 4 <input type="checkbox"/> Transfer Bed/Chair 9 <input type="checkbox"/> Cane D <input type="checkbox"/> Other (Specify) 5 <input type="checkbox"/> Exercises Prescribed
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19. Mental Status:	1 <input type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful	5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated
	2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed	6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other

20. Prognosis:	1 <input type="checkbox"/> Poor	2 <input type="checkbox"/> Guarded	3 <input type="checkbox"/> Fair	4 <input type="checkbox"/> Good	5 <input type="checkbox"/> Excellent
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21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:	25. Date HHA Received Signed POT
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24. Physician's Name and Address	26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.
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27. Attending Physician's Signature and Date Signed	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.
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ADDENDUM TO:		<input type="checkbox"/> PLAN OF TREATMENT	<input type="checkbox"/> MEDICAL UPDATE	
1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: To:		4. Medical Record No.
6. Patient's Name			5. Provider No.	
8. Item. No.			7. Provider Name	

9. Signature of Physician	10. Date
11. Optional Name/Signature of Nurse/Therapist	12. Date