

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient HI Claim No.	2. Start Of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.
6. Patient's Name and Address			7. Providers' Name, Address and Telephone Number	
8. Date of Birth		9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	10. Medications : Dose/Frequency/Route [N]ew [C]hange	
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:	
16. Nutritional Req.			17. Allergies:	
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	
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	
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	
24. Physician's Name and Address			26. I certify <input type="checkbox"/> recertify <input type="checkbox"/> 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.	
27. Attending Physician's Signature and Date Signed			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.	