

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patients HI Claim No.	2. Start of Care Date	3. Certification Period From: To:	4. Medical Record #	5. Provider #
6. Patient's Name and Address		7. Provider's Name, Address and Telephone Number		
8. Date of Birth:		9. M <input type="checkbox"/> F <input type="checkbox"/>		
11. ICD-9-CM	Principal Diagnosis	Date	10. Medications: Dose, frequency/Route (N)ew (C)hanged	
12. ICD-9-CM	Surgical Procedures	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		18.B Activities Permitted		
1. <input type="checkbox"/> Amputation 5. <input type="checkbox"/> Paralysis 9. <input type="checkbox"/> Legally Blind 2. <input type="checkbox"/> B/B Incont. 6. <input type="checkbox"/> Endurance A <input type="checkbox"/> Dyspnea w/ min. Ex. 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		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 Restriction 4. <input type="checkbox"/> Transfer bed/chair 9. <input type="checkbox"/> Cane D <input type="checkbox"/> Other 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			25. Date HHA Received Signed POT	
24. Physician's Name and Address		26. I certify 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		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.		