Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
	9/10/15	From: 11/10/15 To: 1/9/16	ABC12345678	1174852867

6. Patient's Name and Address

Jane Doe
1234 Sample Rd #567
City, State 12345

7. Provider's Name, Address and Telephone Number

Achieve Beyond
11240 Waples Mill Rd. Suite 101
Fairfax VA 22090
703-237-2729

8. Date of Birth 00/00/0000

9. Sex ☐ M ■ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

N/A

11. ICD-9-CM	Principal Diagnosis	Date
F82.0	Specific developmental disorder of motor function	00/00/2015
12. ICD-9-CM	Surgical Procedure	Date
13. ICD-9-CM	Other Pertinent Diagnoses	Date
Q90.9	Down Syndrome, unspecified	0/00/2015

14. DME and Supplies
N/A or Wheelchair, etc

15. Safety Measures:
N/A

16. Nutritional Req. N/A

17. Allergies: N/A

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinence)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ■ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea With Minimal Exertion
B ■ Other (Specify) Mobility, coordination, weakness

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☐ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ■ No Restrictions
D ☐ Other (Specify)

19. Mental Status: 1 ■ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☐ Fair 4 ■ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

Physical/Occupation therapy one time weekly, for 45 minute sessions each.
Speech Language therapy two times weekly, for 30 minute sessions each.

First Name Last Name, Credentials
Provider's Name

Provider's Signature, Credentials, and Date

22. Goals/Rehabilitation Potential/Discharge Plans Long-term goals: Squat to pick up a half full basket of laundry and carry it 20 feet from one room to the next without loss of balance or assistance; Hop in place 15 times on each foot without loss of balance or extreme compensatory patterns; Walk with her feet flat, demonstrating a heel strike 50% of the time during daily activities; Jane will demonstrate normal lower extremity range of motion.

Short-term goals: Balance on each leg for 10 seconds each without loss of balance or compensatory sway and limb movement; Stand up from the ground from a half kneel position without the use of her hands, 5 times with each leg within a PT session; Jump up and down on a trampoline 20 times in a row clearing her feet from the surface without loss of balance; walk with her feet flat, demonstrating a heel strike 50% of the time during daily activites; demonstrate normal lower extremity range of motion. Discharge will occur when Jane has achieved all of her goals and/or when she is appropriate for discharge with an ongoing home exercise program. Discharge may also occur at any time per the parent(s) decision and/or if no progress is made.

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/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.

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.

Privacy Act Statement

Sections 1812, 1814, 1815, 1816, 1861, and 1862 of the Social Security Act authorize collection of this information. The primary use of this information is to process and pay Medicare benefits to or on behalf of eligible individuals. Disclosure of this information may be made to : Peer Review Organizations and Quality Review Organizations in connection with their review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Social Security Act; State Licensing Boards for review of unethical practices or nonprofessional conduct; A congressional office from the record of an individual in response to an inquiry from the congressional office at the request of that individual.

Where the individual's identification number is his/her Social Security Number (SSN), collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including the SSN, is voluntary, but failure to do so may result in disapproval of the request for payment of Medicare benefits.

Paper Work Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0357. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.