

**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. 1174852867	
6. Patient's Name and Address			7. Provider's 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)hanged		
11. ICD-10-CM	Principal Diagnosis	Date			
12. ICD-10-CM	Surgical Procedure	Date			
13. ICD-10-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	1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	A <input type="checkbox"/> Wheelchair
2 <input type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea With Minimal Exertion	2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent At Home	B <input type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input type="checkbox"/> Ambulation	B <input type="checkbox"/> Other (Specify)	3 <input type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	C <input type="checkbox"/> No Restrictions
4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		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:			5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated	
	1 <input type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful	6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other	
	2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed			
20. Prognosis:			3 <input type="checkbox"/> Fair	4 <input type="checkbox"/> Good	5 <input type="checkbox"/> Excellent
	1 <input type="checkbox"/> Poor	2 <input type="checkbox"/> Guarded			
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)					

\_\_\_\_\_  
 Provider's Name

\_\_\_\_\_  
 Provider's Signature, Credentials, and Date

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/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.