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Use of this template is voluntary / optional

Home Health Services Plan of Care / Certification Template

A Medicare allowed NPP is defined as a nurse practitioner, clinical nurse specialist or physician assistant [as those terms are defined in section 1861 (aa) (5) of the Social Security Act] who is working in accordance with State law.

Note: If the Home Health Services Plan of Care / Certification Template is used:

- 1) CDEs in black Calibri are required
- 2) CDEs in *burnt orange Italics Calibri* are required if the condition is met
- 3) CDEs in blue Times New Roman are recommended but not required
- 4) CDEs in purple Tahoma are required for certification and, where noted, for recertification

Version R1.0b

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Home Health Plan of Care / Certification			
Patient information			
Last name: _____ First name: _____ MI: _____			
DOB (MM/DD/YYYY): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other Medicare ID: _____			
F2F evaluation information			
<i>Physician / NPP* who performed the F2F visit:</i>			
<i>Check if same as the certifying physician or enter name below: _____</i>			
<i>Last name: _____ First name: _____ MI: _____ Suffix: _____</i>			
NPI: _____			
Date of F2F visit (MM/DD/YYYY): _____			
Patient HI Claim No: _____ Medical Record Number: _____			
Initial start of care date (MM/DD/YYYY): _____			
For recertification: start/end of this episode of care (MM/DD/YYYY): _____/_____			
Diagnoses (status: acute, chronic, acute-chronic, resolved, resolving, managed)			
ICD-10-CM	Description	Start date	Status
Principal (related to the need for ordered services)			
_____	_____	_____	_____
_____	_____	_____	_____
Other pertinent diagnoses			
_____	_____	_____	_____

Relevant procedures (e.g. surgical)			
ICD-10-CM	Description	Date	
_____	_____	_____	
_____	_____	_____	

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Medications (Status: N=New, C=Current, M=Modified, D=Discontinued)					
RxNorm	Description	Dose	Frequency	Route	Status
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Other medications					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies (Include RxNorm if known)			
RxNorm	Description	RxNorm	Description
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Functional assessment:

Functional limitations (check all that apply): Amputation, Bowel/bladder (Incontinence), Contracture, Hearing, Paralysis, Endurance, Speech, Legally blind, Dyspnea with minimal exertion, Angina with minimal exertion or at rest, CVA/hemiparalysis/paralysis/dysphonia, Confined to wheelchair, Fall risk

Other functional limitations: _____

Activities permitted (check all that apply): Complete bedrest, Bedrest BRP, Up as tolerated, Transfer bed/chair, Partial weight bearing, Independent at home, Crutches, Cane, Wheelchair, Walker, No restrictions

Other activities permitted: _____

Mental status (check all that apply) Oriented, Comatose, Forgetful, Depressed, Disoriented, Lethargic, Agitated

Other mental status: _____

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DME and supplies: _____

Safety measures: _____

Nutritional requirements: _____

Prognosis: ___ Poor, ___ Guarded, ___ Fair, ___ Good, ___ Excellent
Additional clarification: _____

Orders (may be satisfied with an attached, signed order template)

Intermittent skilled nursing services (LOS = Length of Session) (*complete all that are required*)

<i>Administration of medications</i>	LOS: _____	Frequency: _____	Duration: _____
<i>Tube feeding</i>	LOS: _____	Frequency: _____	Duration: _____
<i>Wound care</i>	LOS: _____	Frequency: _____	Duration: _____
<i>Catheters</i>	LOS: _____	Frequency: _____	Duration: _____
<i>Ostomy care</i>	LOS: _____	Frequency: _____	Duration: _____
<i>NG and tracheostomy aspiration/care</i>	LOS: _____	Frequency: _____	Duration: _____
<i>Psychiatric evaluation and therapy</i>	LOS: _____	Frequency: _____	Duration: _____
<i>Teaching/training</i>	LOS: _____	Frequency: _____	Duration: _____
<i>Observe/assess</i>	LOS: _____	Frequency: _____	Duration: _____
<i>Complex care plan management</i>	LOS: _____	Frequency: _____	Duration: _____
<i>Rehabilitation nursing</i>	LOS: _____	Frequency: _____	Duration: _____
<i>Other: _____</i>	LOS: _____	Frequency: _____	Duration: _____
<i>Other: _____</i>	LOS: _____	Frequency: _____	Duration: _____

Justification and signature if the patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan or complex care plan management):

_____ Signature: _____

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Therapy services (*complete all that are required*)

Physical therapy

Restore patient function LOS: _____ Frequency: _____ Duration: _____
Perform maintenance therapy LOS: _____ Frequency: _____ Duration: _____
Therapeutic exercises LOS: _____ Frequency: _____ Duration: _____
Gait and balance training LOS: _____ Frequency: _____ Duration: _____
ADL training LOS: _____ Frequency: _____ Duration: _____
Other: _____ LOS: _____ Frequency: _____ Duration: _____

Occupational therapy

Restore patient function LOS: _____ Frequency: _____ Duration: _____
Perform maintenance therapy LOS: _____ Frequency: _____ Duration: _____
Therapeutic exercises LOS: _____ Frequency: _____ Duration: _____
ADL training LOS: _____ Frequency: _____ Duration: _____
Other: _____ LOS: _____ Frequency: _____ Duration: _____

Are OT services above provided because physical therapy services ceased? Yes: ____ No: ____

Speech-language pathology

Swallowing LOS: _____ Frequency: _____ Duration: _____
Restore language function LOS: _____ Frequency: _____ Duration: _____
Restore cognitive function LOS: _____ Frequency: _____ Duration: _____
Perform maintenance therapy LOS: _____ Frequency: _____ Duration: _____
Other: _____ LOS: _____ Frequency: _____ Duration: _____

Other Services

Home health aide services LOS: _____ Frequency: _____ Duration: _____
Medical social services LOS: _____ Frequency: _____ Duration: _____

Goals/rehabilitation potential/discharge plans

Service	Goals	Rehabilitation potential
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Discharge plans _____

If this is a subsequent episode:

How much longer will skilled services be needed? _____

I certify that this patient is confined to his/her home (as outlined in section 30.1.1 in Chapter 7 of the Medicare Benefit Policy Manual (Pub. 100-02)) 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 services on this plan of care and will periodically review the plan. The patient had a face-to-face encounter with an allowed provider type and the encounter was related to the primary reason for home health care.

Signature: _____

Name (Printed): _____

Date (MM/DD/YYYY): _____ NPI: _____

Date signed POC was received by the HHA (MM/DD/YYYY): _____