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

Use of this template is voluntary / optional

Home Health Plan of Care / Certification

Patient information

Last name: _____ First name: _____ MI: ___

DOB (MM/DD/YYYY): _____ Gender: ___M ___F ___Other Medicare ID:_____

F2F evaluation information

Physician / NPP who performed the F2F visit:*

*Check if same as the certifying physician or enter name below:*_____

*Last name:*_____ *First name:*_____ *MI:*___ *Suffix:*___

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

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: _____

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*)

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

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

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): _____