

Survey Date:

HOME HEALTH FUNCTIONAL ASSESSMENT INSTRUMENT: MODULE A

Provider Medicare ID:
Patient HI Claim No:

PATIENT INFORMATION	CONDITION/PROBLEM	A.20 Anticipated patient care outcomes related to medical, nursing, and rehabilitative services. Patient and condition specific outcomes should be measureable and quantifiable. Include date outcome was defined and/or revised. Review the plan of care; other parts of the clinical records.																																																																																																		
<p>A1. Patient Name</p>	<p>A12. ICD-9-CM Principal Diagnosis Date</p>	<p>Level of Achievement for Patient Care Outcome</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:10%;"></th> <th style="width:15%;">Completely</th> <th style="width:15%;">Partially</th> <th style="width:15%;">Not At All</th> <th style="width:45%;">Surveyor Comments</th> </tr> </thead> <tbody> <tr><td>1. _____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> <tr><td>2. _____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> <tr><td>3. _____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> <tr><td>4. _____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> <tr><td>5. _____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> <tr><td>6. _____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td><td></td><td></td></tr> </tbody> </table>					Completely	Partially	Not At All	Surveyor Comments	1. _____					_____					_____					2. _____					_____					_____					3. _____					_____					_____					4. _____					_____					_____					5. _____					_____					_____					6. _____					_____					_____				
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<p>A2. Date of Birth/Age: A3. Sex <input type="checkbox"/> M <input type="checkbox"/> F</p>	<p>A13. ICD-9-CM Surgical Procedure Date</p>																																																																																																			
<p>A4. Referral Date</p>	<p>A14. ICD-9-CM Other Pertinent Diagnoses Date</p>																																																																																																			
<p>A5. Start of Care (SOC) Date</p>	<p>A15. Impairments <input type="checkbox"/> Speech <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> None</p>																																																																																																			
<p>A6. Admitted From <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Home <input type="checkbox"/> Other _____</p>	<p>A16. Review medication orders. Check for notations in the record of the following situations: (Do Not list out medications)</p> <p>_____ No. of medications ordered <input type="checkbox"/> HHA awareness of drug sensitivity/allergies with specific and visible warnings on patient record.</p> <p><input type="checkbox"/> Contraindications</p> <p><input type="checkbox"/> Psychotropic mood altering drugs</p> <p><input type="checkbox"/> Other (Specify) _____</p>																																																																																																			
<p>A7. Patient Risk Factors related to medical diagnoses <input type="checkbox"/> Alcoholism <input type="checkbox"/> Obesity <input type="checkbox"/> Heavy Smoking <input type="checkbox"/> Drug Dependency <input type="checkbox"/> Chronic Conditions _____ <input type="checkbox"/> None Known</p>	<p>A17. Prognosis (at start of care) <input type="checkbox"/> Poor <input type="checkbox"/> Guarded <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent</p>																																																																																																			
<p>A8. Family Situation/Living Arrangement <input type="checkbox"/> Alone <input type="checkbox"/> With Spouse <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____</p>	<p>A18. Medical Condition at Review (as compared to time of admission) <input type="checkbox"/> Improved <input type="checkbox"/> Deteriorated <input type="checkbox"/> Unchanged <input type="checkbox"/> Unknown</p>																																																																																																			
<p>A9. Primary Informal Caregiver(s) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other Relative <input type="checkbox"/> Friend <input type="checkbox"/> None <input type="checkbox"/> Paid Attendant <input type="checkbox"/> Child <input type="checkbox"/> Other Volunteer</p>	<p>A19. Review plan of care and interim orders for type, duration, and frequency of services ordered. Use the calendar worksheet to ensure that services were delivered as required in the plan of care. Were services delivered as ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																																																																																																			
<p>A10. Informal caregiver(s) is (are) able to receive instructions and provide care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Not Known</p>	<p>A11. Is there information that the patient's living environment might detract from HHA's ability to implement or complete the plan of care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																																																																																																			
		<p>More than 6 outcomes? <input type="checkbox"/> Yes <input type="checkbox"/> No (Continue on back of module)</p> <p>Is there evidence of planning toward discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Appropriate</p> <p>Does record contain progress notes that describe the level of achievement for anticipated outcomes? <input type="checkbox"/> Yes <input type="checkbox"/> Some <input type="checkbox"/> No</p>																																																																																																		
		<p>SURVEYOR NOTES:</p> <p>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 0938-0355. The time required to complete this information collection is estimated to average 1 hour 10 minutes per response, including the time to review instructions, searching 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, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.</p>																																																																																																		