

Homecare Allocation Automation Guide

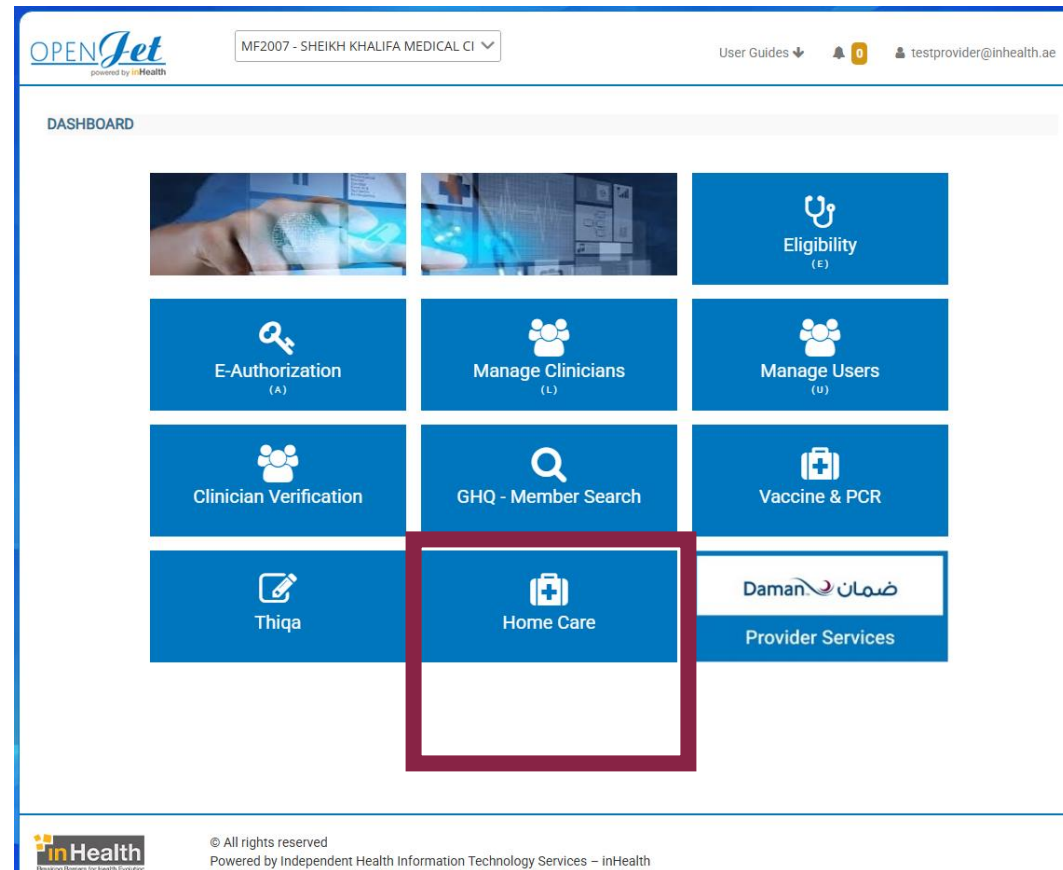
Jan 2025

Homecare Allocation Automation Guide

Step - 1

All providers will now, initiate request from Openjet for Homecare allocation. This guide explains how to raise a homecare allocation request from Openjet.

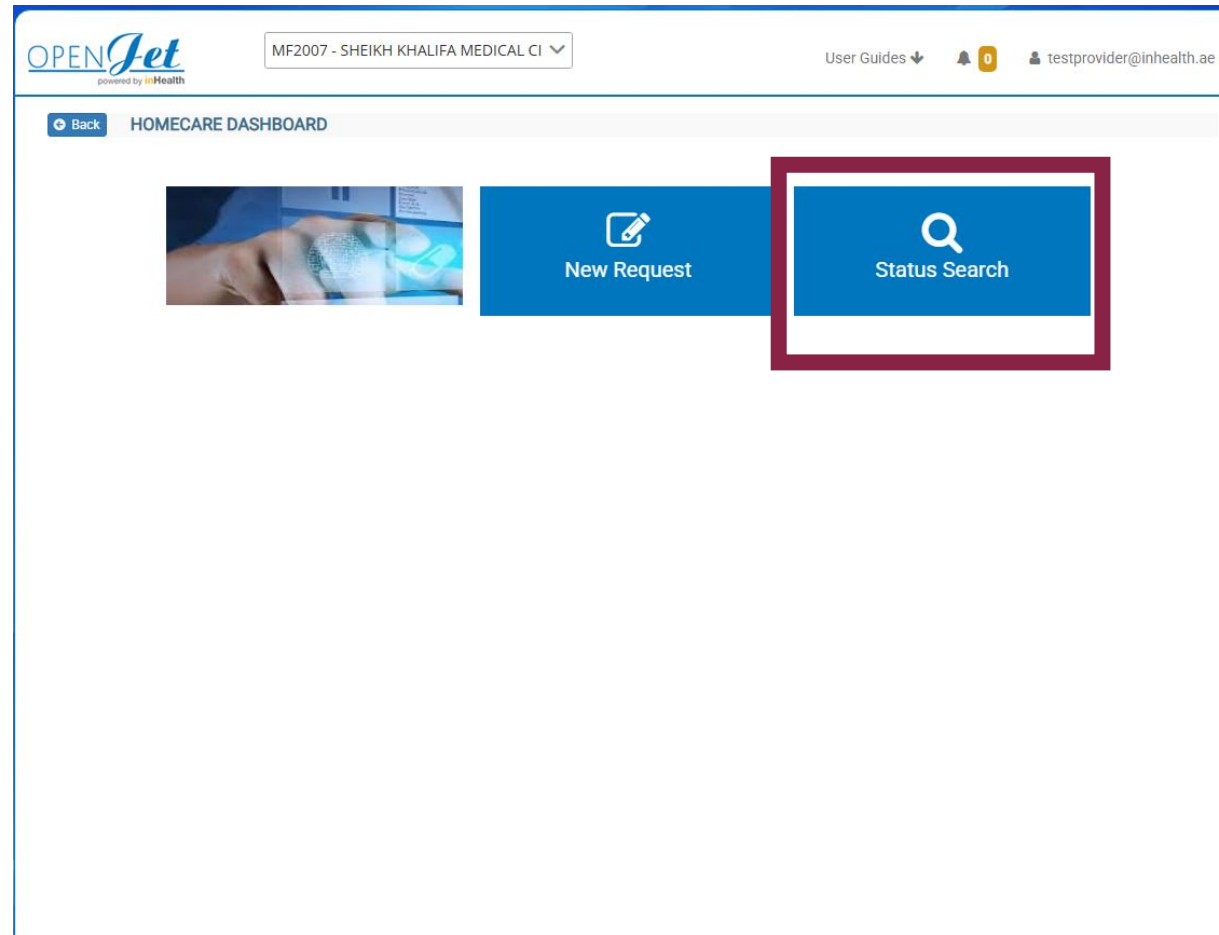
From your Openjet home page, click on “Home care” Icon



Homecare Allocation Automation Guide

Step - 2

In the current screen you can raise a new request or search for existing homecare allocation request status. You can click on status search to see the status of your current raised homecare allocation requests



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Step – 2.1

You can now search for your existing requests by date, EID, status etc.

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Back

STATUS SEARCH

Indicates required field *

Transaction From Date *

01/09/2024

Transaction To Date

05/02/2025

Status

9 items selected

Emirates ID

Emirates ID

Clear

Search

Submitted

Waiting HCP Allocation

Rejected

Under Review

More Information

Completed

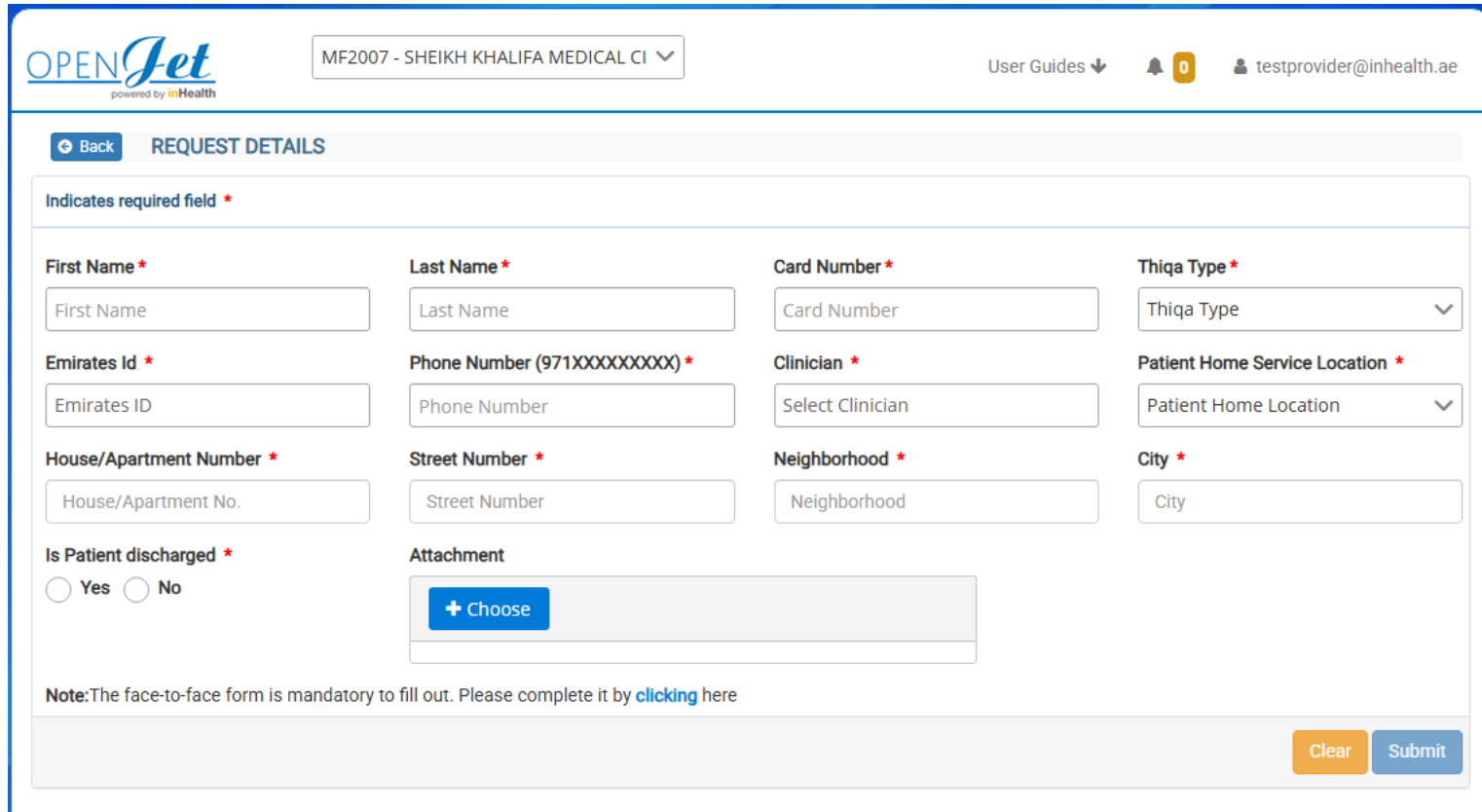
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Homecare Allocation Automation Guide

Step – 2.2

You can raise a new request from clicking on “new request” from step 2. and fill in the details.



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[Back](#) REQUEST DETAILS

Indicates required field *

First Name *	Last Name *	Card Number *	Thiqa Type *
<input type="text" value="First Name"/>	<input type="text" value="Last Name"/>	<input type="text" value="Card Number"/>	<input type="text" value="Thiqa Type"/>
Emirates Id *	Phone Number (971XXXXXXXX) *	Clinician *	Patient Home Service Location *
<input type="text" value="Emirates ID"/>	<input type="text" value="Phone Number"/>	<input type="text" value="Select Clinician"/>	<input type="text" value="Patient Home Location"/>
House/Apartment Number *	Street Number *	Neighborhood *	City *
<input type="text" value="House/Apartment No."/>	<input type="text" value="Street Number"/>	<input type="text" value="Neighborhood"/>	<input type="text" value="City"/>

Is Patient discharged *

☐ Yes ☐ No

Attachment

[+ Choose](#)

Note: The face-to-face form is mandatory to fill out. Please complete it by [clicking here](#)

[Clear](#) [Submit](#)

- 1) Input all the mandatory fields.
- 2) Fill in the face-to-face form by clicking the link.

Homecare Allocation Automation Guide

Step – 2.2.1

Fill in all the details in the face-to-face form.



Home Healthcare Referral/Periodic Assessment Form

The purpose of the form

☒ Referral (For initiation of Home Healthcare services)

Referring Facility Details

Facility Name *

SHEIKH KHALIFA MEDICAL CITY

Facility License *

MF2007

Personal Information

Patient Name *

Test Test

Date of Birth *

Emirates ID Number *

784-1944-1754159-9

Patient Language/s *

Choose

Gender *

Select Gender

Insurance

Type

Select Insurance

Card Number

112215

Residence

☐ Alone

☐ With Family

Patient is referred for Home Health Care from

☐ An in-patient hospital

☐ Directly from the community

☐ Long Term Facility

Submit

Home Healthcare Referral/Periodic Assessment Form

In the past two months, patient was admitted to which of the following settings other than the one mentioned in the previous point

☐ An in-patient hospital

☐ Home Health Care Services

☐ Long Term Facility

☐ Rehabilitation Hospital

☐ Other

Please Specify Diagnosis

Please Specify the diagnosis

Face-to-face encounter confirmation

A physician must order Home Health Care services and must certify a patient's eligibility for the benefit.

- The face-to-face requirement ensures that the orders and certification for Home Health Care services are based on a physician's current knowledge of the patient's clinical condition.
- Prior to certifying a patient's eligibility for the Home Health Care benefit, the referring physician must document that he or she has had a face-to-face encounter with the patient.
- Documentation regarding these face-to-face encounters must be presented on certifications for patients within 30 days prior to the start of Home Health Care, or within the 60 days after the start of care.
- As part of the certification form itself, or as an addendum to it, the physician must document when the physician saw the patient and how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.

The clinical reason for the encounter was... [brief statement on the main reason why patient was admitted]

The patient's clinical condition, as observed, during the encounter supports the patient's homebound status as follows... [brief statement on the main reason why patient is referred for care through a home health facility]

Reasons for Home Care Referral

Submit

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Step – 2.2.2

Fill in all the details in the face-to-face form.



Home Healthcare Referral/Periodic Assessment Form

Reasons for Home Care Referral

Note:

Patient can be referred to Homecare Services only if he/she is Homebound (status where patient is medically confined to his/her home and require skilled healthcare services)

• Homebound:

A status where patient is medically confined to his/her home and require skilled health care services as certified by the Referring Physician due to:

• An illness or injury resulting in the patient's inability to leave the patient's place of residence without assistance by another individual or the aid of a supportive device; or

• Having a condition such that leaving the place of residence requires a taxing effort or is medically contraindicated; and

• May only leave his/her residence or for absences that relate to seeking medical care, and concern attending religious service, family event, or memorial service.

Domains of Care

(mark all required skilled services and provide duration and details on service as applicable)

Note: Please select at least one option and provide the duration.

Medication Management

Duration (in Hours)

☐ Intravenous infusion (IV)

Duration (in Hours)

☐ Intramuscular injections (IM)

Duration (in Hours)

☐ Administration of Narcotic analgesics (opioid)

Duration (in Hours)

☐ Enteral multiple medications (Minimum 3 medications)

Duration (in Hours)

Nutrition/Hydration

Duration (in Hours)

☐ Continuous NGT for feeding or patient with NGT inserted with frequent ER visits due to NGT complications

Duration (in Hours)

☐ Continuous GT, JT feeding via mechanical pump or patient with frequent ER visits due to pump complications

Duration (in Hours)

☐ IV supplement administration for patient 'at risk' nutritional status

Duration (in Hours)

☐ Total parenteral Nutrition (TPN)

Duration (in Hours)

Submit

Home Healthcare Referral/Periodic Assessment Form

☐ Total parenteral nutrition (TPN)

Duration (in Hours)

☐ Patients 'at risk' nutritional status require assessment of failure to thrive or nutritional status

Duration (in Hours)

Respiratory Care

Duration (in Hours)

☐ Initiation of and adjustment of medical gases

Duration (number)

☐ Dual O2 and BiPAP therapy at least 16 hrs./day with BiPAP

Duration (number)

☐ Insertion and replacement of tracheal cannula (Indicate frequency)

Duration (number)

☐ Frequent daily suctioning as a part of complicated tracheostomy care

Duration (number)

☐ Tracheostomy care for pediatrics less than 6 years old

Duration (number)

☐ Home Invasive Mechanical Ventilator management

Duration (number)

☐ Continuous O2 therapy (at least 16 hrs./day) with requirements for periodic assessment and monitoring

Duration (number)

☐ Pulmonary disease with history of more than one ER visit or hospital admission in last 3 months

Duration (number)

Skin & Wound Care

Duration (hours)

☐ Wound Care for Multiple >2 wounds/pressure sore stage II in various areas of the trunk and pelvis

Duration (number)

☐ Wound care for stage III or IV pressure sore

Duration (number)

☐ Complex wound care and/or sterile dressing changes for any wound or skin condition or NPWT

Duration (number)

Submit

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Step – 2.2.3

Fill in all the details in the face-to-face form.



Home Healthcare Referral/Periodic Assessment Form

☐ Complex wound care and/or sterile dressing changes for any wound or skin condition or NPWT

Duration (number)

☐ Primary dressing for therapeutic or protective covering as part of treatment for surgical wounds or wound debridement

Duration (number)

☐ Complex stoma care (infected, frequent leaking, mucocutaneous junction separation, peristomal skin damage)

Duration (number)

☐ Pressure sores at stage II for patients with spasticity or multiple joints contractures

Duration (number)

☐ Wound care of Severe Epidermolysis Bullosa (Junctional or Dystrophic)

Duration (number)

Bowel and Bladder Care

Duration (hours)

☐ Catheter care in the presence of UTI, Nephropathy or GUT abnormalities that may be affected by catheterization or requiring Catheter care with daily Bladder irrigation/wash

Duration (number)

☐ Bowel and bladder training (indicate the duration for training)

Duration (number)

☐ Rectal enemas in Inflammatory BD, Malignancy and after bowel surgery (indicate the duration for transitional/training period)

Duration (number)

☐ Indwelling catheter change (indicate frequency)

Duration (number)

☐ Peritoneal dialysis service for patient with history of peritonitis or HF and at risk of fluid overload

Duration (number)

☐ Newly Initiated Intermittent catheterization program or Sterile Intermittent catheterization for patients unable for selfcare

Duration (number)

Palliative Care

Duration (hours)

☐ Relieving pain and/or ease symptoms related to malignancy and advanced stage 'D' heart failure

Duration (number)

Submit

Home Healthcare Referral/Periodic Assessment Form

☐ Relieving pain and/or ease symptoms related to malignancy and advanced stage 'D' heart failure

Duration (number)

Observation and/or Close Monitoring Services

Duration (hours)

☐ Patient at high risk of serious physical harm due to severe spasticity refractory to medication (MAS >3/4)

Duration (number)

☐ Patient with status of intractable epilepsy refractory to multiple antiepileptic medication with respiratory status at risk requiring observation and monitoring

Duration (number)

☐ Patient with fluctuating vital signs, symptoms of drug toxicity, abnormal/fluctuating lab values related to acute episode of illness requiring observation and monitoring

Duration (number)

Post-Hospital Discharge Transitional Care/Training Period

Duration (hours)

☐ Newly inserted feeding tube for bolus feeding for transitional care/training period (indicate the duration for transitional/training period)

Duration (number)

☐ New Colostomy, Urostomy or Cystostomy management for transitional care and training for ostomy care (indicate the duration for transitional/training period)

Duration (number)

☐ Newly initiated Peritoneal dialysis for transitional care/training period (indicate the duration for transitional/training period)

Duration (number)

☐ Assess the patient respiratory status and technique for patient recently discharged to home with respiratory care & equipment for a transitional/training period (indicate the duration for transitional/training period)

Duration (number)

☐ Ensuring cardiorespiratory stability for patient recently discharged post critical care requiring a transitional period (indicate the duration for transitional period)

Duration (number)

Palliative Care

Duration (hours)

☐ Daily care for patient with advanced stage D Heart Failure

Duration (number)

Submit

Homecare Allocation Automation Guide

Step – 2.2.4

Fill in all the details in the face-to-face form.



Home Healthcare Referral/Periodic Assessment Form

Palliative Care

☐ Relieving pain and/or ease symptoms related to malignancy and advanced stage 'D' heart failure

Duration (hours)

Duration (number)

Observation and/or Close Monitoring Services

☐ Patient at high risk of serious physical harm due to severe spasticity refractory to medication (MAS >3/4)

Duration (number)

☐ Patient with status of intractable epilepsy refractory to multiple antiepileptic medication with respiratory status at risk requiring observation and monitoring

Duration (number)

☐ Patient with fluctuating vital signs, symptoms of drug toxicity, abnormal/fluctuating lab values related to acute episode of illness requiring observation and monitoring

Duration (number)

Post-Hospital Discharge Transitional Care/Training Period

☐ Newly inserted feeding tube for bolus feeding for transitional care/training period (indicate the duration for transitional/training period)

Duration (number)

☐ New Colostomy, Urostomy or Cystostomy management for transitional care and training for ostomy care (indicate the duration for transitional/training period)

Duration (number)

☐ Newly initiated Peritoneal dialysis for transitional care/training period (indicate the duration for transitional/training period)

Duration (number)

☐ Assess the patient respiratory status and technique for patient recently discharged to home with respiratory care & equipment for a transitional/training period (indicate the duration for transitional/training period)

Duration (number)

☐ Ensuring cardiorespiratory stability for patient recently discharged post critical care requiring a transitional period (indicate the duration for transitional period)

Duration (number)

Palliative Care

☐ Daily care for patient with advanced stage D Heart Failure

Duration (hours)

Duration (number)

Submit

Home Healthcare Referral/Periodic Assessment Form

Palliative Care

☐ Daily care for patient with advanced stage D Heart Failure

Duration (hours)

Duration (number)

☐ Daily Assessment and symptoms relief for patient with terminal illness includes the use of Narcotics for pain management

Duration (number)

Physiotherapy & Rehabilitation Services

☐ Patient require physical therapy with reasonable expectation of significant improvement in a predictable and reasonable time (Indicate the expected outcome and estimated frame time)

Duration (number)

☐ Patient require speech therapy & regular assessment by speech language pathologist (Indicate the expected outcome and estimated frame time)

Duration (number)

☐ Patient require occupational therapy to improve functions with set clear goals (Indicate the expected outcome and estimated frame time)

Duration (number)

☐ Patient with high potential to develop complications require maintenance physiotherapy training period (indicate the duration for training)

Duration (number)

☐ Patient require respiratory therapy sessions as performed by respiratory therapists with set clear goals as recommended by specialist within the scope of practice

Duration (number)

Devices and Aids Needed

☐ Patient needs devices and aids

Duration(In Hours)

☐ Patient does not need devices and aids

Duration(In Hours)

Needs the following devices:

Respiratory Care Cardiac and Vascular Care Nutritional and Fluid Management Diagnostic Tests

Submit

Homecare Allocation Automation Guide

Step – 2.2.5

Fill in all the details in the face-to-face form.



Home Healthcare Referral/Periodic Assessment Form

Respiratory Care

Choose

Cardiac and Vascular Care

Choose

Nutritional and Fluid Management

Choose

Diagnostic Tools

Choose

Renal Care

Choose

Mobility and Patient Support

Choose

General Monitoring and Support

Choose

Other Medical Information

The clinical reason for the encounter was... [brief statement on the main reason why patient was admitted]

The patient's clinical condition, as observed, during the encounter supports the patient's homebound status as follows... [brief statement on the main reason why patient is referred for care through a home health facility]

Other Diagnosis, comorbidities and complications not covered in previous points:

Addition details on required care/service

Required Home Healthcare Services

Required services	Frequency	Maximum number of hours	Duration
Skilled Nursing Services *	Select Frequency		Select Duration
Physiotherapy	Select Frequency		Select Duration

Submit

Home Healthcare Referral/Periodic Assessment Form

Required Home Healthcare Services

Required services	Frequency	Maximum number of hours	Duration
Skilled Nursing Services *	Select Frequency		Select Duration
Physiotherapy	Select Frequency		Select Duration
Occupational Therapy	Select Frequency		Select Duration
Speech Therapy	Select Frequency		Select Duration
Respiratory Therapy	Select Frequency		Select Duration

Date of the next assessment/follow up

Homecare Discharge Plan

Discharge Plan for services require transitional/training period, for services with set goals/outcomes to be achieved within estimated and defined timeline, or as indicated by the treating physician/referring physician.

After completion of transitional period

After completion of training period

Other reason to plan for discharge:

other reason

Extension of Home care Service

Extension of Home care Service

Submit

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Step – 2.2.6

Fill in all the details in the face-to-face form.

☐ Extension of Home care Service

I certify that a face-to-face encounter was performed on the above-named patient on [date] by [physician name].

Expected date (duration) to discharge from home care service



Treating Physician

Name *

Specialty *

License Number *

Referring Physician

Name *

Specialty *

License Number *

Submit

Note :- Without filling in all the details in face-to-face form, you cannot proceed with submission of the request.

Homecare Allocation Automation Guide

Step – 2.3

Once all the details have been filled in correctly , the submit button will become active

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REQUEST DETAILS

Indicates required field *

First Name *

Last Name *

Card Number *

Thiqa Type *

Test

Test

112215

C2

Emirates Id *

Phone Number (971XXXXXXXX) *

Clinician *

Patient Home Service Location *

784-1944-1754159-9

971506682286

LATHIKA . MENON(GD11093)

Abu Dhabi

House/Apartment Number *

Street Number *

Neighborhood *

City *

101

40

Al Shamnkha

Abu Dhabi

Is Patient discharged *

Attachment

☐ Yes ☒ No

+ Choose

Re Allocation Flow.pdf 48.089 KB

Note:The face-to-face form is mandatory to fill out. Please complete it by [clicking](#) here

Clear

Submit

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Note :- Each allocation request should be accompanied by the following documents :-

- 1) Updated Periodic assessment form
- 2) Updated Medical report.

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Step – 3

Important to note

- 1) Only one active request can be submitted for a patient.
- 2) A request become closed if it has been rejected or a homecare provider has been allocated.
- 3) For re-allocation of ongoing homecare allocation cases, the provider should reach out to Daman contact center.
- 4) Any requests without the above-mentioned attachments will be rejected automatically.

Thank you