Provider Toolkit

Nurse

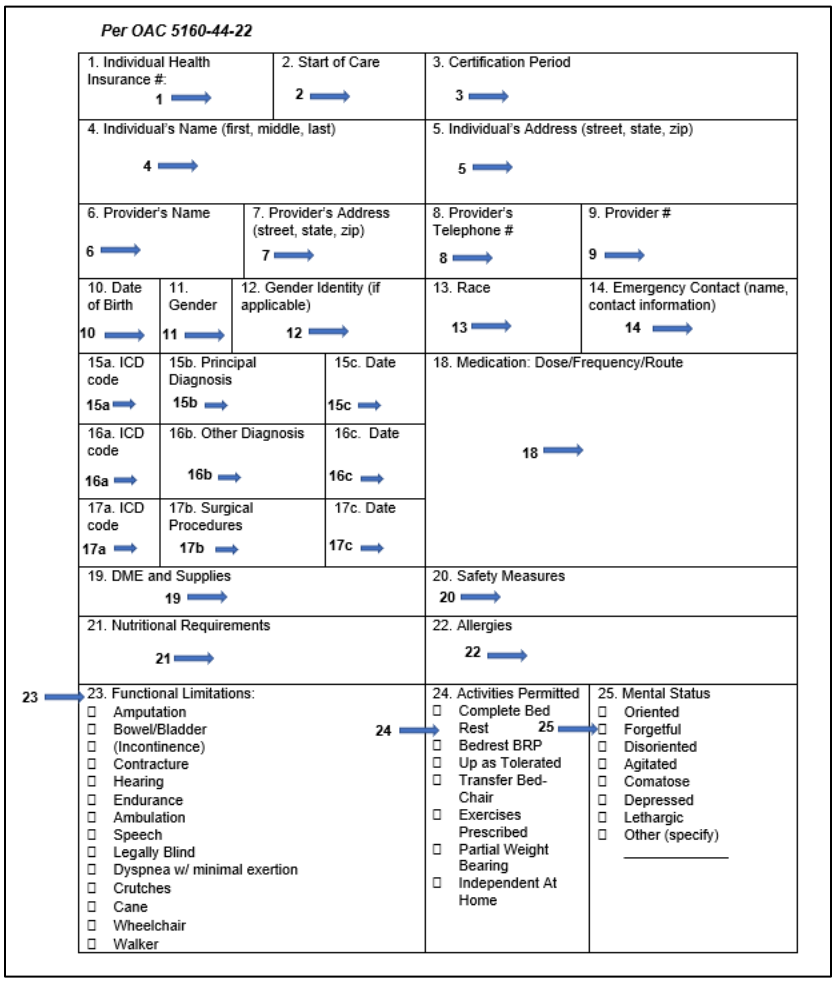
Plan of Care

Document Overview

This form can be used to document the care needs and nursing services to be provided to the individual. The Plan of Care must be authorized by the individual's treating physician according to **OAC 5160-44-22**.

Instructions

How to complete the Plan of Care:



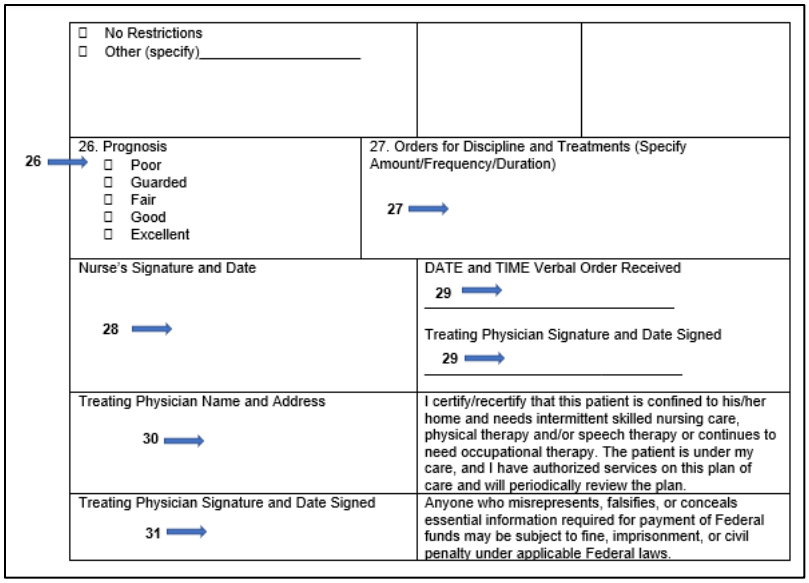
Per OAC 5160-44-22

1. Individual Health Insurance #: 1	2. Start of Care 2	3. Certification Period 3	
4. Individual's Name (first, middle, last) 4		5. Individual's Address (street, state, zip) 5	
6. Provider's Name 6	7. Provider's Address (street, state, zip) 7	8. Provider's Telephone # 8	9. Provider # 9
10. Date of Birth 10	11. Gender 11	12. Gender Identity (if applicable) 12	13. Race 13 / 14. Emergency Contact (name, contact information) 14
15a. ICD code 15a	15b. Principal Diagnosis 15b	15c. Date 15c	18. Medication: Dose/Frequency/Route 18
16a. ICD code 16a	16b. Other Diagnosis 16b	16c. Date 16c	
17a. ICD code 17a	17b. Surgical Procedures 17b	17c. Date 17c	
19. DME and Supplies 19			20. Safety Measures 20
21. Nutritional Requirements 21			22. Allergies 22

23 — 23. Functional Limitations:
- ☐ Amputation
- ☐ Bowel/Bladder (Incontinence)
- ☐ Contracture
- ☐ Hearing
- ☐ Endurance
- ☐ Ambulation
- ☐ Speech
- ☐ Legally Blind
- ☐ Dyspnea w/ minimal exertion
- ☐ Crutches
- ☐ Cane
- ☐ Wheelchair
- ☐ Walker

24 — 24. Activities Permitted
- ☐ Complete Bed Rest
- ☐ Bedrest BRP
- ☐ Up as Tolerated
- ☐ Transfer Bed-Chair
- ☐ Exercises Prescribed
- ☐ Partial Weight Bearing
- ☐ Independent At Home

25 — 25. Mental Status
- ☐ Oriented
- ☐ Forgetful
- ☐ Disoriented
- ☐ Agitated
- ☐ Comatose
- ☐ Depressed
- ☐ Lethargic
- ☐ Other (specify) _____



1. Enter the individual's health insurance identification number
2. Enter the date that services originally started
3. Enter the timeframe that is covered by this plan of care. Enter the first day of the plan of care (mm/dd/yyyy) through the last day of the plan of care (mm/dd/yyyy). This period should not exceed sixty calendar days.
4. Enter the individual's first name, middle name, and last name
5. Enter the individual's address (street, state, and zip code) where care is provided
6. Enter provider name and other nurse(s) identified to provide care
7. Enter provider address (street, state, and zip code) and other nurse(s) identified to provide care
8. Enter provider telephone number and other nurse(s) identified to provide care
9. Enter provider Medicaid number and other nurse(s) identified to provide care
10. Enter the individual's date of birth
11. Enter the individual's gender
12. Enter the gender in which individual identify (if applicable)
13. Enter the individual's race
14. Enter the name and telephone number for the individual's emergency contacts
15. Enter all the information as seen below:
    a. Enter the valid ICD diagnosis code of primary diagnosis
    b. Enter the diagnosis that is the primary and/or most acute reason for home health services
    c. Enter the date of onset of diagnosis (mm/dd/yyyy)
16. Enter all the information as seen below:
    a. Enter the valid ICD diagnosis code of all other pertinent diagnoses
    b. Enter all other pertinent diagnoses relevant to care being provided
    c. Enter the date of onset of diagnosis (mm/dd/yyyy)
17. Enter all the information as seen below:
    a. Enter the valid ICD surgical code for surgical procedures
    b. Enter surgical procedures relevant to the care being provided
    c. Enter the date of the surgical procedure with at least the month and year (mm/yyyy)
18. Enter all individual's medications including over-the-counter medication. Enter the dosage, frequency, and route.

19. List the individual's supplies and equipment needed for care
20. List any instructions for safety measures identified by you and/or the individual's treating physician
21. Enter the individual's diet according to physician's orders including therapeutic diets; specific dietary requirements; as well as fluid restrictions or requirements.
22. Enter any allergies to medicine or other allergies for individual. Enter "NKA" if there are no known allergies.
23. Check any limitations for the individual assessed by you and/or physician. If "other" is checked, please provide details.
24. Check all activities for the individual that are allowed by physician
25. Check the most appropriate criteria to describe the individual's mental status. If "other" is checked, please provide details.
26. Check the most appropriate prognosis for the individual
27. List all the services and treatments to be provided by each discipline. List the frequency and duration of visits for each discipline.
    - Frequency is the number of visits to be provided, stated in days, weeks, or months
    - Duration is the length of time the services will be delivered, stated in days, weeks, or months
28. Enter provider name and the date this document was signed. Please note that by signing the provider is verifying that provider obtained the authorization from the individual's treating physician to provide services.
29. Enter the date and time that verbal authorization to provide service was received (if applicable). The treating physician must sign and date to verify verbal authorization was given.
30. Enter the name and address of the individual's treating physician.
31. The treating physician must sign and date. The plan of care must be signed and dated by the treating physician on or before the first day of the certification period.

Plan of Care

Per OAC 5160-44-22

<table>
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</table>

☐ Wheelchair ☐ Walker ☐ No Restrictions ☐ Other (specify)_____		

26. Prognosis ☐ Poor ☐ Guarded ☐ Fair ☐ Good ☐ Excellent	27. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

Nurse's Signature and Date	DATE and TIME Verbal Order Received _____ Treating Physician Signature and Date Signed _____
Treating Physician Name and Address	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 services on this plan of care and will periodically review the plan.
Treating Physician Signature and Date Signed	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.