

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: _____ To: _____	4. Medical Record No.	5. Provider No.
6. Patient's Name and Address		7. Provider's Name, Address and Telephone Number		
8. Date of Birth		9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
11. ICD-10	Principal Diagnosis	Date		
12. ICD-10	Surgical Procedure	Date		
13. ICD-10	Other Pertinent Diagnoses	Date		
14. DME and Supplies			15. Safety Measures:	
16. Nutritional Req.			17. Allergies:	
18.A. Functional Limitations			18.B. Activities Permitted	
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing A <input type="checkbox"/> Wheelchair
2 <input type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea With Minimal Exertion	2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent At Home B <input type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input type="checkbox"/> Ambulation	B <input type="checkbox"/> Other (Specify) _____	3 <input type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches C <input type="checkbox"/> No Restrictions
4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		4 <input type="checkbox"/> Transfer Bed/Chair	9 <input type="checkbox"/> Cane D <input type="checkbox"/> Other (Specify) _____
5 <input type="checkbox"/> Exercises Prescribed				
19. Mental Status:			5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated
1 <input type="checkbox"/> Oriented 2 <input type="checkbox"/> Comatose			3 <input type="checkbox"/> Forgetful 4 <input type="checkbox"/> Depressed	6 <input type="checkbox"/> Lethargic 8 <input type="checkbox"/> Other
20. Prognosis:			3 <input type="checkbox"/> Fair	4 <input type="checkbox"/> Good 5 <input type="checkbox"/> Excellent
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)				
22. Goals/Rehabilitation Potential/Discharge Plans				
23. Nurse's Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT	
24. Physician's Name and Address			26. <small>And/or speech therapy, Medicare, Medicaid, State Health Plan, or other third party payor information.</small>	
27. Attending Physician's Signature and Date Signed			28. 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.	

