Questionnaire: Home Health Plan of Care: HHA and Skilled Nurse Visits

Home Health Plan of Care

1. *What type of requesting are you entering for this recipient?*
   (Please select one.)
   - (•) Initial, short term, 45 days or less
   - ( ) Initial, long term, 46 days or more
   - ( ) Re-certification, ongoing request
   - ( ) Change of condition, change of plan or change or types of authorized services

   If you answered "Change of condition, change of plan or change or types of authorized services " on question 1

   1.4.1. *Please explain*

2. *Is the recipient on any of the following medications?*
   - [ ] IV Medications
   - [x] Injectable Medications
   - [x] Oral Medications
   - [ ] Other
   - [ ] N/A: not on any medications

   If you answered "IV Medications" on question 2

   2.1.1. *Please list the name, dose and frequency for each IV Medication*

   2.1.2. *Have any been prescribed within 30 days of the start of this CERT period?*
   (Please select one.)
   - ( ) Yes
   - ( ) No

   If you answered "Yes" on question 2.1.2

2.1.2.1.1. *Please list those prescribed within 30 days of the start of this CERT period.*

2.1.3. *Was there a dosage change for any of the medications?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 2.1.3

2.1.3.1.1. *Please list the medications that had a dosage change.*

If you answered "Injectable Medications" on question 2

2.2.1. *Please list the name, dose and frequency for each injectable medication*

See attached med list

2.2.2. *Have any been prescribed within 30 days of the start of this CERT period?*
(Please select one.)

- ◉ Yes
- ○ No

If you answered "Yes" on question 2.2.2

2.2.2.1.1. *Please list those prescribed within 30 days of the start of this CERT period.*

Ozempic 0.25 mg or 0.5 mg (2mg/3mL) pen injector

2.2.3. *Was there a dosage change for any of the medications?*
(Please select one.)

- ○ Yes
- ◉ No

○ No

If you answered "Yes" on question 2.2.3

2.2.3.1.1. *Please list the medications that had a dosage change.*

If you answered "Oral Medications" on question 2

2.3.1. *Please list the name, dose and frequency for each oral medication*

See attached med list

2.3.2. *Have any been prescribed within 30 days of the start of this CERT period?*
(Please select one.)

◉ Yes
○ No

If you answered "Yes" on question 2.3.2

2.3.2.1.1. *Please list those prescribed within 30 days of the start of this CERT period.*

doxycycline monohydrate 100mg tablet oxycodone 5 mg tablet sennosides-docusate sodium 8.6-50 mg tablet

2.3.3. *Was there a dosage change for any of the medications?*
(Please select one.)

○ Yes
◉ No

If you answered "Yes" on question 2.3.3

2.3.3.1.1. *Please list the medications that had a dosage change.*

If you answered "Other" on question 2

If you answered "Other" on question 2

2.4.1. *Please list the name, dose and frequency for any other medication*

2.4.2. *Have any been prescribed within 30 days of the start of this CERT period?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 2.4.2

2.4.2.1.1. *Please list those prescribed within 30 days of the start of this CERT period.*

2.4.3. *Was there a dosage change for any of the medications?*
(Please select one.)

- ○ Yes
- ○ No

If you answered "Yes" on question 2.4.3

2.4.3.1.1. *Please list the medications that had a dosage change.*

3. *Medication Management*
(Please select one.)

- ○ Assistance (This includes assessment and interventions; This does not include administering medications. See #14 for medication administration)
- ◉ No assistance

If you answered "Assistance (This includes assessment and interventions; This does not include administering medications. See #14 for medication administration) " on question 3

3.1.1. *Describe assessment and interventions*

4. *DME and supplies*

(Please select between 1 and 11 items.)

- [x] Medical supplies
- [ ] Surgical supplies
- [ ] Hoyer lift
- [ ] Bedside commode
- [ ] Urinal
- [ ] Wheelchair
- [ ] Walker
- [ ] Cane
- [ ] Bathroom safety rails
- [ ] Shower chair
- [ ] Other
- [ ] None

If you answered "Medical supplies" on question 4

4.1.1. *Please describe.*

Dressing - Sterile; Gloves; Irrigation - Saline

If you answered "Surgical supplies" on question 4

4.2.1. *Please describe.*

If you answered "Hoyer lift" on question 4

4.3.1. *Please describe.*

If you answered "Bedside commode" on question 4

4.4.1. *Please describe.*

If you answered "Urinal" on question 4

4.5.1. *Please describe.*

If you answered "Wheelchair" on question 4

4.6.1. *Please describe.*

If you answered "Walker" on question 4

4.7.1. *Please describe.*

If you answered "Cane" on question 4

4.8.1. *Please describe.*

If you answered "Bathroom safety rails" on question 4

4.9.1. *Please describe.*

If you answered "Shower chair" on question 4

4.10.1. *Please describe.*

If you answered "Other" on question 4

4.11.1. *Please explain*

5. *Nutritional requirements, current diet*
(Please select one.)

○ Regular	◉ Diabetic
○ Low sodium	○ Low fat
○ NG tube feeding	○ PEG tube feeding
○ G-tube	○ Other

If you answered "Other" on question 5

5.8.1. *Please explain*

6. *Functional limitations- describe each selected*
(Please select between 1 and 11 items.)

☐ Amputation	☑ Bowel/bladder incontinence	☐ Contracture
☐ Hearing	☐ Paralysis	☐ Endurance
☐ Ambulation	☐ Speech	☐ Visual impairment (glasses, poor vision)
☐ Legally blind	☐ Dyspnea with minimal exertion	☐ Other

If you answered "Amputation" on question 6

6.1.1. *Please describe.*

If you answered "Bowel/bladder incontinence" on question 6

6.2.1. *Please describe.*

Bladder incontinence, uses briefs

If you answered "Contracture" on question 6

6.3.1. *Please describe.*

If you answered "Hearing" on question 6

6.4.1. *Please describe.*

If you answered "Paralysis" on question 6

6.5.1. *Please describe.*

If you answered "Endurance" on question 6

6.6.1. *Please describe.*

If you answered "Ambulation " on question 6

6.7.1. *Please describe.*

If you answered "Speech" on question 6

6.8.1. *Please describe.*

If you answered "Visual impairment (glasses, poor vision)" on question 6

6.9.1. *Please describe.*

If you answered "Legally blind" on question 6

6.10.1. *Please describe.*

If you answered "Dyspnea with minimal exertion" on question 6

6.11.1. *Please describe.*

If you answered "Other " on question 6

6.12.1. *Please describe.*

7. *Activities permitted- describe all selected*
(Please select between 1 and 12 items.)

☐ Complete bed rest	☐ Bed rest with bathroom privileges	☑ Up as tolerated
☐ Transfer bed/chair	☐ Exercise prescribed	☐ Partial weight bearing
☐ Independent at home	☐ Crutches	☐ Cane
☐ Wheelchair	☐ Walker	☑ No restrictions
☐ Other		

If you answered "Complete bed rest" on question 7

7.1.1. *Please describe.*

7.1.1. *Please describe.*

If you answered "Bed rest with bathroom privileges " on question 7

7.2.1. *Please describe.*

If you answered "Up as tolerated" on question 7

7.3.1. *Please describe.*

Up as tolerated

If you answered "Transfer bed/chair" on question 7

7.4.1. *Please describe.*

If you answered "Exercise prescribed" on question 7

7.5.1. *Please describe.*

If you answered "Partial weight bearing" on question 7

7.6.1. *Please describe.*

If you answered "Independent at home" on question 7

If you answered "Independent at home" on question 7

7.7.1. *Please describe.*

If you answered "Crutches" on question 7

7.8.1. *Please describe.*

If you answered "Cane" on question 7

7.9.1. *Please describe.*

If you answered "Wheelchair" on question 7

7.10.1. *Please describe.*

If you answered "Walker" on question 7

7.11.1. *Please describe.*

If you answered "No restrictions" on question 7

7.12.1. *Please describe.*

No restrictions

If you answered "Other " on question 7

7.13.1. *Please describe.*

8. *Cognitive, neurological, mental health status*
(Please select between 1 and 11 items.)

- [x] Alert
- [x] Oriented to time
- [x] Oriented to place
- [x] Oriented to person
- [ ] Confused
- [ ] Disoriented
- [ ] Lethargic
- [ ] Agitated
- [ ] Mental illness
- [ ] Seizure activity
- [ ] Other

If you answered "Other" on question 8

8.11.1. *Please describe.*

9. *Prognosis*

Good

10. *Pain status*
(Please select one.)

- ( ) No pain
- ( ) Intermittent pain
- (•) Constant pain

If you answered "Intermittent pain" on question 10

10.2.1. *Pain location*

- [ ] Joint pain
- [ ] Back pain
- [ ] Lower extremity pain
- [ ] Upper extremity pain
- [ ] Generalized pain
- [ ] Arthritis pain
- [ ] Other

If you answered "Joint pain" on question 10.2.1

10.2.1.1.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Back pain" on question 10.2.1

10.2.1.2.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Lower extremity pain" on question 10.2.1

10.2.1.3.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Upper extremity pain" on question 10.2.1

10.2.1.4.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Generalized pain" on question 10.2.1

10.2.1.5.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Arthritis pain" on question 10.2.1

10.2.1.6.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Other " on question 10.2.1

10.2.1.7.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Constant pain " on question 10

10.3.1. *Pain location*

- ☐ Joint pain
- ☐ Back pain
- ☐ Lower extremity pain
- ☐ Upper extremity pain
- ☐ Generalized pain
- ☐ Arthritis pain
- ☑ Other

If you answered "Joint pain" on question 10.3.1

10.3.1.1.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Back pain" on question 10.3.1

10.3.1.2.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Lower extremity pain" on question 10.3.1

10.3.1.3.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Upper extremity pain" on question 10.3.1

10.3.1.4.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Generalized pain" on question 10.3.1

10.3.1.5.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Arthritis pain" on question 10.3.1

10.3.1.6.1. *Please describe nursing assessment and interventions related to pain*

If you answered "Other " on question 10.3.1

10.3.1.7.1. *Please describe nursing assessment and interventions related to pain*

takes oral meds for pain related to groin wound; takes tylenol and advil before wound dressing changes

11. *Respiratory status*

(Please select between 1 and 8 items.)

- [x] No respiratory problems
- [ ] Dyspnea with ambulation or while performing ADL"s
- [ ] Tracheotomy
- [ ] Requires oxygen therapy PRN
- [ ] Requires continues oxygen therapy
- [ ] Vent dependency
- [ ] Respiratory treatments: Inhaler, nebulizer
- [ ] Other

If you answered "Dyspnea with ambulation or while performing ADL's" on question 11

11.2.1. *Respiratory status, please describe assessment and interventions.*

If you answered "Tracheotomy" on question 11

11.3.1. *Respiratory status, please describe assessment and interventions.*

If you answered "Requires oxygen therapy PRN" on question 11

11.4.1. *Respiratory status, please describe assessment and interventions.*

If you answered "Requires continues oxygen therapy " on question 11

11.5.1. *Respiratory status, please describe assessment and interventions.*

If you answered "Vent dependency " on question 11

11.6.1. *Respiratory status, please describe assessment and interventions.*

If you answered "Respiratory treatments: Inhaler, nebulizer" on question 11

11.7.1. *Respiratory status, please describe assessment and interventions.*

If you answered "Other " on question 11

11.8.1. *Respiratory status, please describe assessment and interventions.*

Help here please

12. *Wound/skin care: Please describe all selections*
(Please select between 1 and 6 items.)

- ☐ Surgical incision
- ☐ Open wound
- ☐ Pressure ulcer
- ☐ Wound vac
- ☐ Ostomy care
- ☐ Other
- ☐ No wound/skin care requires

If you answered "Surgical incision " on question 12

12.1.1. *Describe location*

12.1.2. *Describe measurement*

12.1.3. *Describe treatment*

If you answered "Open wound" on question 12

12.2.1. *Describe location*

12.2.2. *Describe measurement*

12.2.3. *Describe treatment*

If you answered "Pressure ulcer" on question 12

If you answered "Pressure ulcer" on question 12

12.3.1. *Describe location*

12.3.2. *Describe measurement*

12.3.3. *Describe treatment*

If you answered "Wound vac" on question 12

12.4.1. *Describe location*

12.4.2. *Describe measurement*

12.4.3. *Describe treatment*

If you answered "Ostomy care" on question 12

12.5.1. *Describe location*

12.5.2. *Describe measurement*

12.5.3. *Describe treatment*

If you answered "Other" on question 12

12.6.1. *Describe location*

12.6.2. *Describe measurement*

12.6.3. *Describe treatment*

13. *Skilled nursing visits ordered?*
(Please select one.)
- ◉ Yes
- ○ No

If you answered "Yes" on question 13

13.1.1. *Visit frequency per week*
(Please select one.)

○ 1x per week	○ 2x per week
◉ 3x per week	○ 4x per week
○ 5x per week	○ 6x per week
○ 7x per week	○ Other

If you answered "1x per week" on question 13.1.1

13.1.1.1.1. *Please indicate number of weeks ordered*

13.1.1.1.2. *Daily visit frequency*
(Please select one.)

- ○ QD
- ○ BID
- ○ Other

If you answered "Other" on question 13.1.1.1.2

13.1.1.1.2.3.1. *Please describe other*

If you answered "2x per week" on question 13.1.1

13.1.1.2.1. *Please indicate number of weeks ordered*

13.1.1.2.2. *Daily visit frequency*
(Please select one.)

- ○ QD
- ○ BID
- ○ Other

If you answered "Other" on question 13.1.1.2.2

13.1.1.2.2.3.1. *Please describe other*

If you answered "3x per week" on question 13.1.1

13.1.1.3.1. *Please indicate number of weeks ordered*

9 weeks ordered

13.1.1.3.2. *Daily visit frequency*

(Please select one.)

- ○ QD
- ○ BID
- ◉ Other

If you answered "Other" on question 13.1.1.3.2

13.1.1.3.2.3.1. *Please describe other*

Visits are one per day, 3 days a week.

If you answered "4x per week" on question 13.1.1

13.1.1.4.1. *Please indicate number of weeks ordered*

13.1.1.4.2. *Daily visit frequency*

(Please select one.)

- ○ QD
- ○ BID
- ○ Other

If you answered "Other" on question 13.1.1.4.2

13.1.1.4.2.3.1. *Please describe other*

If you answered "5x per week" on question 13.1.1

13.1.1.5.1. *Please indicate number of weeks ordered*

13.1.1.5.2. *Daily visit frequency*

(Please select one.)

- ○ QD
- ○ BID

- ○ Other

If you answered "Other" on question 13.1.1.5.2

13.1.1.5.2.3.1. *Please describe other*

If you answered "6x per week" on question 13.1.1

13.1.1.6.1. *Please indicate number of weeks ordered*

13.1.1.6.2. *Daily visit frequency*
(Please select one.)

- ○ QD
- ○ BID
- ○ Other

If you answered "Other" on question 13.1.1.6.2

13.1.1.6.2.3.1. *Please describe other*

If you answered "7x per week" on question 13.1.1

13.1.1.7.1. *Please indicate number of weeks ordered*

13.1.1.7.2. *Daily visit frequency*
(Please select one.)

- ○ QD
- ○ BID
- ○ Other

If you answered "Other" on question 13.1.1.7.2

13.1.1.7.2.3.1. *Please describe other*

If you answered "Other" on question 13.1.1

13.1.1.8.1. *Please indicate number of weeks ordered*

13.1.1.8.2. *Daily visit frequency*
(Please select one.)

- ○ QD
- ○ BID
- ○ Other

If you answered "Other" on question 13.1.1.8.2

13.1.1.8.2.3.1. *Please describe other*

14. *Treatment/procedures. Skilled observation and assessment excludes the initial/start of care (admission) and discharge assessments*

☑ Skilled observation and assessment	☐ Medication administration	☑ Instruct in disease process	☐ Instruct in medication regimen
☑ Instruct in diet/nutrition	☐ Instruct/perform glucose monitoring	☑ Instruct/perform wound care	☐ Instruct/perform tube feedings/care
☐ Instruct/perform colostomy and/or ileostomy care	☐ Instruct/perform bowel program	☐ Instruct/perform tracheotomy care	☐ Insert, remove and/or irrigate catheters
☑ Management of incontinence	☐ Perform lab draws/venipuncture	☑ Monitor medical compliance	☐ Other

If you answered "Skilled observation and assessment" on question 14

14.1.1. *Please describe.*

See plan of care

If you answered "Medication administration " on question 14

14.2.1. *Please describe.*

If you answered "Instruct in disease process" on question 14

14.3.1. *Please describe.*

See plan of care

If you answered "Instruct in medication regimen" on question 14

14.4.1. *Please describe.*

If you answered "Instruct in diet/nutrition" on question 14

14.5.1. *Please describe.*

See plan of care

If you answered "Instruct/perform glucose monitoring" on question 14

14.6.1. *Please describe.*

If you answered "Instruct/perform wound care" on question 14

14.7.1. *Please describe.*

See plan of care

If you answered "Instruct/perform tube feedings/care" on question 14

14.8.1. *Please describe.*

If you answered "Instruct/perform colostomy and/or ileostomy care " on question 14

14.9.1. *Please describe.*

If you answered "Instruct/perform bowel program" on question 14

14.10.1. *Please describe.*

If you answered "Instruct/perform tracheotomy care" on question 14

14.11.1. *Please describe.*

If you answered "Insert, remove and/or irrigate catheters" on question 14

14.12.1. *Please describe.*

If you answered "Management of incontinence " on question 14

14.13.1. *Please describe.*

See plan of care

If you answered "Perform lab draws/venipuncture" on question 14

14.14.1. *Please describe.*

If you answered "Monitor medical compliance" on question 14

14.15.1. *Please describe.*

See plan of care

If you answered "Other " on question 14

14.16.1. *Please describe.*

15. *Laboratory tests cannot be performed elsewhere other than the recipients home due to the following*

(Please select one.)

- ○ Ambulatory status
- ○ Lack of transportation
- ○ Needs assistance from house to vehicle
- ◉ Other

If you answered "Other " on question 15

15.4.1. *Please describe.*

Labs not ordered at this time

Labs not ordered at this time

Help here please

16. *Please describe recipients current ability to perform treatment/procedures independently*

17. *Does the recipient have a caregiver available for support and assistance when home care services are not present?*
(Please select one.)
- (●) Yes
- ( ) No

If you answered "Yes" on question 17

17.1.1. *Describe the support the caregiver is able to provide*

Intermittent assistance from daughter

18. *Are Home Health Aide (HHA) visits ordered?*
(Please select one.)
- ( ) Yes
- (●) No

If you answered "Yes" on question 18

18.1.1. *Type of assistance to be provided by HHA*
(Please select between 1 and 12 items.)

☐ Bathing	☐ Dressing	☐ Oral care
☐ Skin care	☐ Foot care	☐ Assistance with ambulation
☐ Assistance with transfers	☐ Incontinence care	☐ Perineal care
☐ Shave	☐ Obtain TPR	☐ Other

If you answered "Other" on question 18.1.1

18.1.1.12.1. *Please describe.*

18.1.2. *Visit frequency per week*
(Please select one.)

(Please select one.)

- ○ 1x per week ○ 2x per week
- ○ 3x per week ○ 4x per week
- ○ 5x per week ○ 6x per week
- ○ 7x per week ○ Other

If you answered "1x per week" on question 18.1.2

18.1.2.1.1. *Please indicate number of weeks ordered*

If you answered "2x per week" on question 18.1.2

18.1.2.2.1. *Please indicate number of weeks ordered*

If you answered "3x per week" on question 18.1.2

18.1.2.3.1. *Please indicate number of weeks ordered*

If you answered "4x per week" on question 18.1.2

18.1.2.4.1. *Please indicate number of weeks ordered*

If you answered "5x per week" on question 18.1.2

18.1.2.5.1. *Please indicate number of weeks ordered*

If you answered "6x per week" on question 18.1.2

18.1.2.6.1. *Please indicate number of weeks ordered*

If you answered "7x per week" on question 18.1.2

18.1.2.7.1. *Please indicate number of weeks ordered*

If you answered "Other" on question 18.1.2

18.1.2.8.1. *Please indicate number of weeks ordered*

18.1.3. *Daily visit frequency*
(Please select one.)

- ○ QD
- ○ BID
- ○ Other

If you answered "Other" on question 18.1.3

18.1.3.3.1. *Please describe other*

19. *Has the recipient been hospitalized in the past 60 days? (This includes Emergency Room to hospital admissions)*
(Please select one.)

- ◉ Yes
- ○ No

If you answered "Yes" on question 19

19.1.1. *Describe the reason for the hospitalization(s). Include diagnosis code(s).*

Labial abscess and AKI; diagnoses E11.65, N76.82, N17.9, E89.0, F31.70

20. *Has the recipient been seen in the emergency room in the past 60 days and not admitted to the hospital?*
(Please select one.)
   - ○ Yes
   - ◉ No

If you answered "Yes" on question 20

20.1.1. *Please describe the reason for the emergency room visit(s)*

21. *Is this an initial or re-certification request?*
(Please select one.)
   - ◉ Initial request
   - ○ Re-certification request

If you answered "Initial request" on question 21

21.1.1. *Start of care date (the date that your agency began providing services to the recipient)*
Date: 05/23/2024

21.1.2. *Initial nursing assessment date*
Date: 05/23/2024

If you answered "Re-certification request " on question 21

21.2.1. *For recertification requests: Date of most recent nursing assessment.*

22. *Comments about prior authorization request?*

23. *Signed HH certification and Plan of Care and any other documentation that may be needed to support your request must be submitted. Documentation submitted with this request?*

(Please select one.)

- (●) Yes
- ( ) No

If you answered "No" on question 23

23.2.1. *Please indicate why required documents were not submitted. Include when documents will be forwarded for review.*