PEOPLES HEALTH

Home Health Agency
Update/Recertification Form

Date: _____ Auth #: _____
Patient Name: _____ Patient #:_____
Agency: _____ Agency Representative: _____
Ordering MD: _____ Primary Diagnosis: _____
Original SOC: _____ Current Cert: _____ to _____

Check which applies: ☐ Update request ☐ Recertification request (**attach form 485 and/or 486**)

Discipline	Number of Visits With Initial Auth	Additional Visits Requested	Frequency
SN			
HHA			
PT			
OT			
ST			
MSW			
Other			

Skilled Nursing:
List names of new or changed meds within the last 30 days. Indicate N for new and C for changed: _____
_____

Exacerbation of illness, new illness, trip to ER or seen by PCP (specify): _____
_____

Was teaching completed in 30-60 days? ☐ Yes ☐ No; if "no," indicate reason: _____
_____

What teaching is new or ongoing for patient or caregiver? _____
_____

Wound Care:
Is patient or caregiver able to perform wound care? ☐ Yes ☐ No; if "no," indicate reason: _____
_____

First Wound:
Type, Location and Stage of Wound: _____Frequency: _____
Size: _____cm x _____cm x_____cm
Wound Care Orders: _____
Describe Drainage and Amount: _____

Second Wound:
Type, Location and Stage of Wound: _____ Frequency: _____
Size: _____cm x _____cm x_____cm
Wound Care Orders: _____
Describe Drainage and Amount: _____

Physical Therapy:
Have goals on 485/486 been met? ☐ Yes ☐ No; if "no," list goals that have not been met: _____
_____

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Occupational Therapy:
Have goals on 485/486 been met? ☐ Yes ☐ No; if "no," list goals that have not been met: _____

Speech Therapy:
Have goals on 485/486 been met? ☐ Yes ☐ No; if "no," list goals that have not been met: _____

Home Health Aide:
What level of care is needed for ADL or personal hygiene? **Check all that apply:**

- ☐ Minimum assistance to ambulate or transfer
- ☐ Maximum assistance, total care needed, non-ambulatory
- ☐ Moderate assistance to ambulate or transfer
- ☐ Incontinent (bowel, bladder or both)

Please list member's illness or injury that makes home health aide services reasonable and necessary:

_____

Homebound Status:
An individual shall be considered "confined to the home" (homebound) if the following two criteria are met (select all that apply):
Criteria One—**check all that apply**:

☐ Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

On the line below, please indicate which supportive device is needed (crutches, cane, wheelchair, walker); the use of special transportation (wheelchair van or ambulance); or the reason the member requires the assistance of another person to leave their place of residence.

OR

☐ Client has a condition such that leaving his or her home is medically contraindicated

Criteria Two:
☐ There is normal inability to leave home safely, AND leaving the home requires a considerable and taxing effort due to the following conditions—**check all that apply**:

- ☐ Bedbound
- ☐ Chair fast
- ☐ Blind
- ☐ Senile or confused
- ☐ Dyspneic at rest
- ☐ Dyspneic with minimal exertion
- ☐ Becomes fatigued and must rest after ambulation
- ☐ Experiences pain that impacts ability to leave home safely
- ☐ Experiences weakness that impacts ability to leave home safely
- ☐ Unable to navigate stairs safely
- ☐ Ambulation is unsteady and unsafe
- ☐ Psychiatric illness manifested by refusal to leave home (even if no physical limitations)
- ☐ Psychiatric illness of the extent it is unsafe to leave home unattended (even if no physical limitations)

If recertification is anticipated, Peoples Health must receive notification, accompanied by supporting clinical information and a physician's order, two weeks prior to the end of the current certification period. If the recertification request is not received within that time frame, the authorization will be closed.