New York State Department of Health
UNINSURED CARE PROGRAMS
Empire Station . PO BOX 2052 . Albany, NY 12220
1-800-542-2437

HOME CARE | **AI485**

HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT

1. Patient's Identification Number	2. SOC Date	3. Certification Period From: To:	4. Medical Record	5. Provider No.

6. Patient's Name and Address	7. Provider's Name and Address

8. Date of Birth	9. Sex ❒ M ❒ F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-9-CM	Principal Diagnosis	Date
12. ICD-9-CM	Surgical Procedure	Date
13. ICD-9-CM	Other Pertinent Diagnoses	Date

14. DME and Supplies/Nutritional Assessment & Counseling/Lab Test	15. Safety Measures

16. Nutritional Req.	17. Allergies:

18.A Functional Limitations

1 ❒ Amputation
2 ❒ Bowel/Bladder (incontinence)
3 ❒ Contracture
4 ❒ Hearing
5 ❒ Paralysis
6 ❒ Endurance
7 ❒ Ambulation
8 ❒ Speech
9 ❒ Legally Blind
A ❒ Dyspnea With Minimal Exertion
B ❒ Other (Specify)

18.B Activities Permitted

1 ❒ Complete Bedrest
2 ❒ Bedrest BRP
3 ❒ Up as Tolerated
4 ❒ Transfer Bed/Chair
5 ❒ Exercise Prescribed
6 ❒ Partial Weight Bearing
7 ❒ Independent at Home
8 ❒ Crutches
9 ❒ Cane
A ❒ Wheelchair
B ❒ Walker
C ❒ No Restrictions
D ❒ Other (Specify)

19. Mental Status
1 ❒ Oriented 2 ❒ Comatose 3 ❒ Forgetful 4 ❒ Depressed 5 ❒ Disoriented 6 ❒ Lethargic 7 ❒ Agitated 8 ❒ Other

20. Prognosis
1 ❒ Poor 2 ❒ Guarded 3 ❒ Fair 4 ❒ Good 5 ❒ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Verbal Start of Care and Nurse's Signature and Date Where Applicable:

24. Physician's Name and Address	25. Date HHA Received Signed POT	26. I ❒ certify ❒ recertify that the above home health services are required and are authorized by me with a written plan for treatment which will be periodically reviewed by me. This patient is under my care, is confined to his/her home, and is in need of intermittent skilled nursing care and/or physical or speech therapy or has been furnished home health services based on such a need, no longer has a need for such care or therapy, continues to need occupational therapy.

27. Attending Physician's Signature (Required on 485 Kept on File in Medical Records of HHA) Date Signed