HOME HEALTH INITIAL ASSESSMENT/TELEHEALTH

Patient Name:_____ DOB:_____ Gender: ❍ Male ❍ Female

Phone:_____ Address:_____

Date of Telehealth Initial Assessment:_____ Referral date:_____ Inpatient D/C date:_____

Call Completed Using: ❍ Audio only ❍ Audio/video device, method (i.e., Facetime):_____

_____

Call Initiated by: ❍ Clinician ❍ RN ❍ PT ❍ OT ❍ SLP

Allowed Clinician who performed the assessment (Print Name/Title):_____

Participants of encounter: ❑ Patient ❑ Caregiver _____

❑ Representative (if any):_____ ❑ Other:_____

Relationship to patient:_____

INITIAL ASSESSMENT

PRIMARY DIAGNOSIS for admission:_____

_____

that requires the patient's need for home health services. (Discuss primary diagnosis provided by physician/NPP. Interview for other diagnoses.)

(Check all that apply)

CONFINED TO HOME (homebound): ❍ No ❍ Yes, and the patient either

1. Criteria One: because of illness or injury, (must choose at least one):

❑ Dependent upon adaptive device(s)

Check all that apply: ❑ Crutches ❑ Canes ❑ Walker ❑ Wheelchair: ❑ manual ❑ motorized

❑ Prosthetic limb ❑ Scooter ❑ a Helper ❑ Other:_____

❑ Needs special transportation as indicated by:_____

❑ Needs physical assist to leave as indicated by:_____

AND/OR

❑ Leaving home is medically contraindicated due to:_____

❑ This patient has a chronic condition or immunodeficiency making it unsafe to leave home in the COVID-19 emergency.

❑ This patient has been exposed to COVID-19 or is currently infected/manifesting signs and symptoms of COVID-19.

2. Criteria Two:

❑ There exists a normal inability to leave the home as indicated by:_____

_____

AND

❑ Leaving home requires a considerable and taxing effort due to functional impairment caused by diagnosis, as indicated by effort such as:_____

SKILLED NEED:_____

_____

_____

_____

_____

HOME HEALTH INITIAL ASSESSMENT/TELEHEALTH

Start of Care Comprehensive Assessment planned for date:_____

❑ Patient ❑ Caregiver ❑ Representative Agrees: ❍ No ❍ Yes

If non-admit, explain reason:_____

_____

This form may be used as supplemental information to the physician/NPP's own Face-to-Face Encounter documentation. If this form is used as a supplement, the physician/NPP should sign and acknowledge.

Signature of the physician or NPP acknowledging the information above as qualifying this patient for home health. The physician/NPP agrees to incorporate this form into the medical record.

Name/Title:_____ Date:_____

SIGNATURE AND DATE OF QUALIFIED ASSESSING CLINICIAN WHO PERFORMED INITIAL ASSESSMENT

I certify that this patient had an Initial Assessment via telehealth/telephone to determine immediate needs and eligibility for home health on (date):_____

Name/Title:_____ Date:_____

The initial assessment visit must be done within 48 hours of the patient's referral to home care or return home from the inpatient facility, or on the physician-ordered start of care date. ***This waiver for the COVID-19 PHE allows the agency to carry out the initial assessment via phone call to the patient or by medical record review instead of making an actual in-person to the patient's home.*** *This determination must still be done within the 48 hours following referral or return home but does not require a home visit within that time period.*

The Start of Care (SOC) comprehensive assessment is the ***required in-person clinical assessment of the patient's physical, functional, mental, psychosocial, and cognitive status*** to identify the needs of the patient and caregiver that will be addressed by the home health agency's services. This comprehensive assessment at SOC includes the collection of OASIS data. This comprehensive assessment must be completed within a specific time frame after the SOC date (first reimbursable visit). Prior to the COVID-19 PHE, agencies had a 5-day window to complete data collection for the SOC comprehensive assessment – ***under the COVID-19 PHE changes, that time frame has been extended to 30 days following the SOC date.***