

Date	HOME HEALTH FUNCTIONAL ASSESSMENT PATIENT FUNCTION AND CARE SUMMARY: MODULE D	Patient HI Claim No.
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D1. HHA REVIEW AREA	SURVEYOR NOTES																																														
<p>HHA PERFORMANCE (This Patient) Check ONE Option Where Appropriate</p>																																															
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%;">Documentation</td> <td style="width:15%;">Substantially Complete</td> <td style="width:15%;">Partially Complete</td> <td style="width:15%;">Substantially Incomplete</td> <td style="width:35%;"></td> </tr> <tr> <td>Record Completeness</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Documentation</td> <td>Substantially</td> <td>Partially</td> <td>Not At All</td> <td></td> </tr> <tr> <td>Record Agrees with In-Home Observation</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>HHA Adherence to Plan</td> <td>Complete Adherence</td> <td>Partial Adherence</td> <td>No Adherence</td> <td rowspan="3">Check here if no ADL Plan of Care <input type="checkbox"/></td> </tr> <tr> <td>Medical Condition</td> <td></td> <td></td> <td></td> </tr> <tr> <td>ADL</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Patient Condition (Relative to condition at admission)</td> <td>Improved</td> <td>Unchanged</td> <td>Deteriorated</td> <td rowspan="3">Check here if ADL status and treatment are not relevant to this case. <input type="checkbox"/></td> </tr> <tr> <td>Medical Condition</td> <td></td> <td></td> <td></td> </tr> <tr> <td>ADL</td> <td></td> <td></td> <td></td> </tr> </table>	Documentation	Substantially Complete	Partially Complete	Substantially Incomplete		Record Completeness					Documentation	Substantially	Partially	Not At All		Record Agrees with In-Home Observation					HHA Adherence to Plan	Complete Adherence	Partial Adherence	No Adherence	Check here if no ADL Plan of Care <input type="checkbox"/>	Medical Condition				ADL				Patient Condition (Relative to condition at admission)	Improved	Unchanged	Deteriorated	Check here if ADL status and treatment are not relevant to this case. <input type="checkbox"/>	Medical Condition				ADL				
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SUMMARY EVALUATION OF PATIENT'S CARE <i>(Please explain all "no" answers, except where indicated.)</i>	
<p>D2. Were HHA assessments of the patient's medical, nursing, and rehabilitative needs appropriate at the start of care and as the care progressed? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>D3. Were the types and frequencies of services prescribed in the initial plan of care appropriate, given the patient's anticipated outcomes and condition(s) at admission? <i>(Note whether therapist and other HHA personnel participated in care plan, if appropriate.)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>D4. Did you see evidence that the patient's plan of care was changed appropriately during the course of care to reflect any changes in the medical, nursing and rehabilitative needs of the patients? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> No Change Required</p>	
<p>D5. Did you see evidence of coordination of services between and among the various disciplines treating this patient? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not applicable; only one discipline</p>	
<p>D6. Did orders for therapy services include the specific procedures and modalities to be used, as well as the amount, frequency, and duration of services? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not applicable; no therapy services ordered</p>	
<p>D7. Did your home visit lead you to conclude that the patient's progress <i>(or lack of progress)</i>, was appropriate given the patient's admitting and current medical and functional status? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>D8. Does the evidence from your review of the record, your conversation with HHA nurse, and your home visit lead you to conclude that the HHA intervened appropriately, and made a difference in the patient's current medical and functional capacity? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>D9. In your opinion, could the HHA have done more to assist this patient in meeting his/her medical, nursing, and rehabilitative needs within the range of usual HHA practice? If yes, record specific examples. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0355. The time required to complete this information collection is estimated to average 1 hour 10 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.