DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0355

Survey Date:

HOME HEALTH FUNCTIONAL ASSESSMENT INSTRUMENT: MODULE A

Provider Medicare ID:

Patient HI Claim No:

PATIENT INFORMATION

A1. Patient Name

A2. Date of Birth/Age:

A3. Sex ☐ M ☐ F

A4. Referral Date

Hospital D/C Date

A5. Start of Care (SOC) Date

A6. Admitted From
☐ Hospital ☐ Nursing Home ☐ Home
☐ Other _____

A7. Patient Risk Factors related to medical diagnoses
☐ Alcoholism ☐ Obesity
☐ Heavy Smoking ☐ Drug Dependency
☐ Chronic Conditions _____
☐ None Known

A8. Family Situation/Living Arrangement
☐ Alone ☐ With Spouse ☐ Unknown
☐ Other _____

A9. Primary Informal Caregiver(s)
☐ Self ☐ Spouse ☐ Other Relative
☐ Friend ☐ None ☐ Paid Attendant
☐ Child ☐ Other Volunteer

A10. Informal caregiver(s) is (are) able to receive instructions and provide care?
☐ Yes ☐ No
☐ N/A ☐ Not Known

A11. Is there information that the patient's living environment might detract from HHA's ability to implement or complete the plan of care?
☐ Yes ☐ No

CONDITION/PROBLEM

A12. ICD-9-CM	Principal Diagnosis	Date
A13. ICD-9-CM	Surgical Procedure	Date
A14. ICD-9-CM	Other Pertinent Diagnoses	Date

A15. Impairments
☐ Speech ☐ Hearing ☐ Vision ☐ None

A16. Review medication orders. Check for notations in the record of the following situations: (Do Not list out medications)
_____ No. of medications ordered
☐ Contraindications
☐ Psychotropic mood altering drugs
☐ Other (Specify)
_____
_____
☐ HHA awareness of drug sensitivity/ allergies with specific and visible warnings on patient record.

A17. Prognosis (at start of care)
☐ Poor ☐ Guarded ☐ Fair
☐ Good ☐ Excellent

A18. Medical Condition at Review (as compared to time of admission)
☐ Improved ☐ Deteriorated
☐ Unchanged ☐ Unknown

A19. Review plan of care and interim orders for type, duration, and frequency of services ordered. Use the calendar worksheet to ensure that services were delivered as required in the plan of care. Were services delivered as ordered?
☐ Yes ☐ No

A.20 Anticipated patient care outcomes related to medical, nursing, and rehabilitative services. Patient and condition specific outcomes should be measureable and quantifiable. Include date outcome was defined and/or revised. Review forms CMS-485 - 486; other parts of the clinical records.

	Level of Achievement for Patient Care Outcome			
	Completely	Partially	Not At All	Surveyor Comments
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				

More than 6 outcomes? ☐ Yes ☐ No
(Continue on back of module)

Is there evidence of planning toward discharge?
☐ Yes ☐ No ☐ Not Appropriate

Does record contain progress notes that describe the level of achievement for anticipated outcomes?
☐ Yes ☐ Some ☐ No

SURVEYOR NOTES: