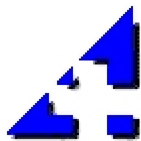

New York State Department of Health
UNINSURED CARE PROGRAMS
Empire Station . PO BOX 2052 . Albany, NY 12220
1-800-542-2437

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 Reg.	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