FORM APPROVED
OMB NO. 0938-0355

Date	HOME HEALTH FUNCTIONAL ASSESSMENT PATIENT FUNCTION AND CARE SUMMARY: MODULE D	Patient HI Claim No.

D1. HHA REVIEW AREA

SURVEYOR NOTES

HHA PERFORMANCE
(This Patient)
Check ONE Option Where Appropriate

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 ☐
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. ☐
Medical Condition				
ADL				

SUMMARY EVALUATION OF PATIENT'S CARE *(Please explain all "no" answers, except where indicated.)*

D2. Were HHA assessments of the patient's medical, nursing, and rehabilitative needs appropriate at the start of care and as the care progressed?

☐ YES ☐ NO

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? *(Note whether therapist and other HHA personnel participated in care plan, if appropriate.)*

☐ YES ☐ NO

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?

☐ YES ☐ NO ☐ No Change Required

D5. Did you see evidence of coordination of services between and among the various disciplines treating this patient?

☐ YES ☐ NO ☐ Not applicable; only one discipline

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?

☐ YES ☐ NO ☐ Not applicable; no therapy services ordered

D7. Did your home visit lead you to conclude that the patient's progress *(or lack of progress)*, was appropriate given the patient's admitting and current medical and functional status?

☐ YES ☐ NO

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?

☐ YES ☐ NO

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.

☐ YES ☐ NO

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.