PEOPLES HEALTH

A UnitedHealthcare Company

Home Health Agency Update/Recertification Form

Date: _____ Auth #: _____

Patient Name: _____ Patient #: _____

Agency: _____ Agency Representative: _____

Ordering M.D.: _____ Primary Diagnosis: _____

Original SOC: _____ Current Cert. Period: _____ to _____

Check which applies: ☐ Update request ☐ Recertification request (attach form 485 and/or 486)

Discipline	Number of Visits for Current Certification Period	Additional Visits Requested	Frequency
SN			
PT			
OT			
ST			
HHA			
MSW			
Other			

Skilled Nursing:

Attach supporting clinical documentation, including **4 recent nursing notes**. Notes should include:

- New or changed medications
- New illnesses
- Exacerbations of existing illnesses
- Trips to the ER
- Teaching completed in past 30–60 days
- New or ongoing teaching
- Patient caregiver education
- Wound measurements
- Other documentation to support medical necessity

Physical, Occupational and Speech Therapy:

Please indicate the discipline(s) requested:

☐ Physical therapy ☐ Speech therapy ☐ Occupational therapy

Attach clinical documentation to support the medical necessity of **each therapy discipline requested**, including an **initial evaluation, daily note and reevaluation**.

Home Health Aide:

What level or type of care is needed for ADL or personal hygiene? **Check all that apply:**

☐ Minimum assistance to ambulate or transfer
☐ Moderate assistance to ambulate or transfer
☐ Maximum assistance (total care needed, non-ambulatory)
☐ Incontinence care (bowel, bladder or both)
☐ Trunk wound care

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Homebound Status:

An individual shall be considered “confined to the home” (homebound) if the following two criteria are met. **Check all that apply:**

Criteria One:

☐ Patient has a condition such that leaving the home is medically contraindicated

OR

☐ Because of illness or injury, the patient requires the aid of a supportive device (such as crutches, a cane, a wheelchair or a walker); special transportation (a wheelchair, van or ambulance); or assistance from another person to leave the place of residence.

On the lines below, please provide the following information (as applicable): which supportive device the patient requires, the special transportation required, or the reason the patient requires the assistance of another person to leave their place of residence:

_____

_____

_____

Criteria Two:

☐ There is normal inability to leave home safely **AND** leaving the home requires a considerable and taxing effort due to the following conditions **(check all that apply)**:

- ☐ Bedbound
- ☐ Becomes fatigued and must rest after ambulation
- ☐ Chair fast
- ☐ Experiences pain that impacts ability to leave home safely
- ☐ Blind
- ☐ Experiences weakness that impacts ability to leave home safely
- ☐ Senile or confused
- ☐ Unable to navigate stairs safely
- ☐ Dyspneic at rest
- ☐ Ambulation is unsteady and unsafe
- ☐ Dyspneic with minimal exertion
- ☐ Psychiatric illness manifested by refusal to leave home (even if no physical limitations)
- ☐ Psychiatric illness of the extent it is unsafe to leave home unattended (even if no physical limitations)

If recertification is anticipated, Peoples Health must receive notification two weeks prior to the end of the current certification period, accompanied by supporting clinical documentation and a physician’s order. If the recertification request is not received within that time frame, the authorization will be closed.