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

Survey Date: Provider Medicare ID: HOME HEALTH FUNCTIONAL ASSESSMENT INSTRUMENT: MODULE A Patient HI Claim No: Anticipated patient care outcomes related to medical, nursing, and rehabilitative services. Patient PATIENT INFORMATION CONDITION/PROBLEM A.20 and condition specific outcomes should be measureable and quantifiable. Include date outcome was defined and/or revised. Review the plan of care; other parts of the clinical records. Level of Achievement for Patient Care Outcome A1. Patient Name A12. ICD-9-CM Principal Diagnosis Date Completely Partially Not At All Surveyor Comments 1. _____ Surgical Procedure A2. Date of Birth/Age: A3. Sex A13. ICD-9-CM Date M F A4. Referral Date A14. ICD-9-CM Other Pertinent Date 2. _____ Diagnoses Hospital D/C Date A5. Start of Care (SOC) Date 3. _____ A15. Impairments A6. Admitted From _____ Hospital Nursing Home Home Speech Hearing Vision None Other _ A7. Patient Risk Factors related to medical A16. Review medication orders. Check for 4. _____ diagnoses notations in the record of the following situations: (Do Not list out medications) Alcoholism Obesity Heavy Smoking Drug Dependency No. of medications HHA awareness 5. _____ ordered Chronic Conditions of drug sensitivity/ _____ allergies with specific and Contraindications None Known visible warnings 6. _____ on patient record. A8. Family Situation/Living Arrangement Psychotropic mood altering drugs Alone With Spouse Unknown Other (Specify) Other _____ More than 6 outcomes? \Box Yes \Box No Does record contain progress notes that (Continue on back of module) describe the level of achievement for A9. Primary Informal Caregiver(s) anticipated outcomes? Self Spouse Other Relative A17. Prognosis (at start of care) Is there evidence of planning toward Yes Some No discharge? Friend None Paid Attendant Poor Guarded Fair Yes No Not Appropriate Child Other Volunteer Excellent Good A18. Medical Condition at Review (as compared to A10. Informal caregiver(s) is (are) able to SURVEYOR NOTES: receive instructions and provide care? time of admission) Deteriorated Improved Yes No Unknown Unchanged N/A Not Known A19. Review plan of care and interim orders for A11. Is there information that the patient's type, duration, and frequency of services ordered. Use the calendar worksheet to living environment might detract from ensure that services were delivered as HHA's ability to implement or According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless required in the plan of care. Were services it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0355. The time complete the plan of care? required to complete this information collection is estimated to average 1 hour 10 minutes per response, including the time to delivered as ordered? review instructions, searching existing data resources, gather the data needed, and complete and review the information Yes No No Yes 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.