CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0355 Provider Medicare ID: **Survey Date:** HOME HEALTH FUNCTIONAL ASSESSMENT INSTRUMENT: MODULE A Patient HI Claim No: Anticipated patient care outcomes related to medical, nursing, and rehabilitative services. Patient A.20 and condition specific outcomes should be measureable and quantifiable. Include date outcome PATIENT INFORMATION CONDITION/PROBLEM 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 A13, ICD-9-CM Surgical Procedure A2. Date of Birth/Age: A3. Sex Date M ΠF A4. Referral Date A14. ICD-9-CM Other Pertinent Date 2. _____ Diagnoses A5. Start of Care (SOC) Date 3. _____ A6. Admitted From A15. Impairments ☐ Hospital ☐ Nursing Home ☐ Home ☐ Speech ☐ Hearing ☐ Vision ☐ None Other _ A7. Patient Risk Factors related to medical A16. Review medication orders. Check for diagnoses notations in the record of the following situations: (Do Not list out medications) Alcoholism Obesity Heavy Smoking Drug Dependency No. of medications 5. _____ HHA awareness ordered of drug sensitivity/ Chronic Conditions 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? ☐ Yes ☐ 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 Some No discharge? Friend None Paid Attendant Poor Guarded Fair Yes ☐ No ☐ Not Appropriate Child Other Volunteer Excellent Good A10. Informal caregiver(s) is (are) able to A18. Medical Condition at Review (as compared to **SURVEYOR NOTES:** receive instructions and provide care? time of admission) Improved Deteriorated Yes No Unknown Unchanged N/A Not Known A19. Review plan of care and interim orders for type, duration, and frequency of services A11. Is there information that the patient's 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?

delivered as ordered?

Yes

☐ No

required to complete this information collection is estimated to average 15 minutes per response, including the time

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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,

□No

Yes