Montana Medicaid Home Health Certification and Plan of Care – SLTC 126

Patient Medicaid ID#	Start of Care Date	Certification Period From: To:	Medicaid ID#:	Provider ID #:

Patient's Name and Address	Provider's Name, Address and Phone Number:
Date of Birth:	Sex: ☐ Male ☐ Female

ICD-10-CM	Principal Diagnosis: Date:
ICD-10-CM	Surgical Procedures: Date:
ICD-10-CM	Other Pertinent Diagnosis: Date:

Medications: Dose/Frequency/Route (N)ew (C)hanged

DME and Supplies	Safety Measures:
Nutritional Req.:	Allergies:
Functional Limitations: ☐ Amputation ☐ Paralysis ☐ Legally Blind ☐ Bowel/Bladder ☐ Endurance ☐ Dyspnea With ☐ Contracture ☐ Ambulation Minimal Exertion ☐ Hearing ☐ Speech ☐ Other (Specify)	Activities Permitted: ☐ Complete Bedrest ☐ Partial Weight Bearing ☐ Wheel chair ☐ Bedrest BRP ☐ Independent at home ☐ Walker ☐ Up as tolerated ☐ Crutches ☐ Cane ☐ No restrictions ☐ Exercises as prescribed ☐ Other

Mental Status:
☐ Oriented ☐ Forgetful ☐ Disoriented ☐ Comatose ☐ Depressed ☐ Lethargic ☐ Agitated ☐ Other

Prognosis: ☐ Poor ☐ Guarded ☐ Fair ☐ Good ☐ Excellent

Orders for Discipline and Treatments (Specify Amount/Frequency/Duration):

Goals/Rehabilitation Potential/Discharge Plans

Nurse's Signature and Date of Verbal SOC (where applicable):	Date HHA Received Signed POT
☐ Physician's ☐ Attending Physician Name and Address:	I certify this patient is under my care and I have authorized services on this plan of care which was reviewed on _____. This patient had a face-to-face encounter with an allowed provider type on _____ and the encounter was related to the primary reason for home health care. Physician's signature: _____Date: _____