Health Service Certification and Plan of Care - V 15

Client:
Medicaid #:
Gender:
Facility Address:

Location:
Passport Number:
Physician:

Initial Admission:
Date of Birth:
Facility:

Allergies:

1. General

1. Facility Phone Number

2. Facility Fax Number

3. Patient Address

4. DOB:

5. Certification Period

2. Diagnoses

1. Current Diagnoses

1b. History Diagnoses

3. Past Medical History

1. Past surgical procedures and hospitalizations

2. ☐ Child has diagnosis or history of seizures

3. Last Known Seizure Date **(S)**

4. Growth Progress

1. Weight in lbs.

2. Height in inches

3. Head circumference in centimeters

4. Abdominal circumference in centimeters

7. Nutritional Requirements

1. Nutritional Considerations

2. Assistance Needed

   a) Supervision
   b) Minimal
   c) Moderate
   d) Total
   e) N/A

3. Length of Time to Feed (infants only)

   a) Greater than 30 minutes

b) Greater than 45 minutes
c) Less than 30 minutes
d) N/A

4. Reflux (as applicable)
a) Risk for
b) Occasional s/s
c) Frequent s/s
d) S/S at every feeding
e) N/A

8. Equipment/supplies

1. Equipment/Supplies

2. How much assistance is needed with setup of equipment?
a) Supervision
b) Minimal
c) Moderate
d) Total
e) N/A

3. ☐ Child has a trach or g-tube.

4. Last date the trach and/or g-tube was changed. **(S)**

9. Functional Limitations

1. Gross Motor
a) To be assessed further upon admission
b) Age-Appropriate
c) Mild Delay
d) Moderate Delay
e) Severe Delay

1e. Explain **(S)**

2. Fine Motor
a) To be assessed further upon admission
b) Age-Appropriate
c) Mild Delay
d) Moderate Delay
e) Severe Delay

2e. Explain **(S)**

3. Cognitive
a) To be assessed further upon admission
b) Age-Appropriate
c) Mild Delay
d) Moderate Delay
e) Severe Delay

3e. Explain **(S)**

4. Communication
   - a) To be assessed further upon admission
   - b) Age-Appropriate
   - c) Mild Delay
   - d) Moderate Delay
   - e) Severe Delay

4e. Explain **(S)**

5. Self-Help/Adaptive
   - a) To be assessed further upon admission
   - b) Age-Appropriate
   - c) Mild Delay
   - d) Moderate Delay
   - e) Severe Delay

5e. Explain **(S)**

5f. ☐ Child is incontinent

5g. Please explain **(S)**

6. Social/Emotional
   - a) To be assessed further upon admission
   - b) Age-Appropriate
   - c) Mild Delay
   - d) Moderate Delay
   - e) Severe Delay

6e. Explain **(S)**

7. Vision
   - a) Adequate
   - b) Poor
   - c) Uses corrective lenses
   - d) Partially Blind
   - e) Blind
   - f) Pending Test
   - g) Other (explain)

7a. additional notes **(S)**

8. Hearing
   - a) Adequate
   - b) Poor
   - c) Uses corrective aid
   - d) Partially Deaf
   - e) Deaf
   - f) Pending Test
   - g) Other (explain)

8a. additional notes **(S)**

10. Patient Activity

1. Patient Activity
    - a) up as tolerated
    - b) Restrictions

1a. Explain Restrictions **(S)**

2. Assistance with transfers
    - a) Supervision
    - b) Minimal
    - c) Moderate
    - d) Total
    - e) N/A
3. Assistance with ADL's
    - a) Supervision
    - b) Minimal
    - c) Moderate
    - d) Total
    - e) N/A
4. Other

11. Therapeutic Services

1. ☐ Physical Therapy

1a. Therapist name/agency **(S)**

1b. Frequency **(S)**

2. ☐ Occupational Therapy

2b. Therapist name/agency **(S)**

2c. Frequency **(S)**

3. ☐ Speech Therapy

3b. Therapist name/agency **(S)**

3c. Frequency **(S)**

4. ☐ Developmental Interventionist

4b. Therapist name/agency **(S)**

4c. Frequency **(S)**

5. ☐ Nutritionist

5b. Therapist name/agency **(S)**

5c. Frequency **(S)**

6. ☐ Behavior Therapy

6b. Therapist name/agency **(S)**

6c. Frequency **(S)**

7. ☐ Special Education
8. ☐ The Kidz Club will provide follow through therapy and continue to target age appropriate developmental skills as tolerated
9. ☐ Other

9a. Please explain **(S)**

10. ☐ Other

10a. Please explain **(S)**

11. Notes:

12. Mental Status

1. Mental Status

- ☐ a. Alert
- ☐ b. Occasional Decrease or Cloudiness
- ☐ c. Lethargic/Obtunded
- ☐ d. Stupor/Coma
- ☐ e. Oriented per age
- ☐ f. Limited Orientation per age
- ☐ g. Confused
- ☐ h. Confused/Safety Risk

13. Prognosis

1. Prognosis

a) Excellent
b) Good
c) Fair
d) Guarded
e) Poor
f) Uncertain

14. Goals

1. Goals

2. Additional Goals

a. Yes b. No

2a. Goals continued **(S)**

15. 90 Day Summary

1. 90 Day Summary

2. Additional 90 Day Summary Information

a. Yes b. No

2a. 90 Day Summary Continued **(S)**

3. Additional 90 Day Summary Information

a. Yes b. No

3a. 90 Day Summary Continued **(S)**

4. Additional 90 Day Summary Information

a. Yes b. No

4a. 90 Day Summary Continued **(S)**

16. Orders

Order summary is attached. By signing below I am confirming the attached orders for this certification period.<b/>

17. Rehab Potential

Rehab Potential: Good for stated goals.

18. Discharge

Discharge: When medical condition and age warrants.

19. Level

1. Level

20. Physician's Address:

1. Physician's Address

21. Physician's Signature:

1. Physician's Signature: 2. Date:

22b. Physician's License Number:

Client: **Date of Birth:**

1. Physician's License Number:

Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

22. Parent/Guardian Signature:

1. Parent/Guardian Signature:
2. Date:

23. Copy to Parent/Guardian:

1. Copy to Parent/Guardian (witness):
2. Date:

24. Certification Period

a. Certification Period

Signature **Date**