

**Voluntary Paper Physician Progress Note (if considering ordering Home Health Services for patient)**  
DRAFT 1.1 (01/30/2015)

NOTE: This Voluntary Paper Clinical Template is a draft and is not valid until it contains an OMB Control Number. CMS is seeking public comment on this document under the 5 CFR 1320.3(h)(8) exemption to the Paperwork Reduction Act. Comments can be sent to [HomeHealthTemplate@cms.hhs.gov](mailto:HomeHealthTemplate@cms.hhs.gov).

- *The form is DRAFT.*
- *We are not currently collecting the information on the form.*
- *The information on the form may be subject to additional change/revisions.*
- *The form is not valid until it contains an OMB control number.*
- *When OFM initiates the OMB approval process, it will announce it via the 60-day notice in the Federal Register.*

<b>SECTION A</b>	
<b>Patient Information</b> First Name: Last Name:  Date of Birth:	<b>Information for Physician Conducting the Visit</b> First Name: Last Name: Credentials: <input type="checkbox"/> MD/DO/DP <input type="checkbox"/> NP/PA <input type="checkbox"/> Other: _____ Address where visit is taking place:  NPI:
<b>SECTION B</b> (Cannot be completed by the Home Health Agency or anyone with a financial relationship to the Home Health Agency)	
1. Enter <b>date</b> of patient visit	__/__/____
2. <b>Subjective Information</b> (chief complaint and pertinent medical history)	
3. <b>Objective Information</b> (constitutional data, physical examination findings, test results)	
4. <b>Assessment</b>	
5. Is the patient <b>homebound</b> ?	<input type="checkbox"/> Yes. This patient is homebound because an illness or injury renders him/her normally unable to leave home <b>except with the assistance of another individual and leaving the home requires a considerable and taxing effort.</b> (proceed to question 6)  <input type="checkbox"/> Yes. This patient is homebound because an illness or injury renders him/her normally unable

	<p>to leave home <b>except with the assistance or the aid of a supportive device and leaving the home requires a considerable and taxing effort.</b> (proceed to question 7)</p> <p><input type="checkbox"/> Yes. This patient is homebound because an illness or injury renders him/her normally unable to leave home as it is <b>medically contraindicated and leaving the home requires a considerable and taxing effort.</b> (proceed to question 8)</p> <p><input type="checkbox"/> No. This patient can leave home without assistance and it is not medically contraindicated for him/her to do so. (Home Health Services are NOT covered by Medicare for this patient.)</p> <p><b>Medicare Definition of "homebound":</b> Per section 1835 is for Part B and section 1814 is for Part A of the Compilation of the Social Security Laws, an individual is considered to be confined to the home (homebound) if "the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that ... leaving home requires a considerable and taxing effort by the individual."</p>
<p>6. <b>Why</b> does the patient require another individual to leave home?</p>	<p>The patient needs the assistance of another individual to leave the home because: <b>(Please be specific. Do NOT simply state: "considerable and taxing effort, gait abnormality, weakness, etc.)</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(proceed to applicable "Plan" question.)</p>
<p>7. <b>Why</b> does the patient require a supportive device to leave home?</p>	<p>The patient needs the assistance of circle one: a cane / walker / wheelchair / other (describe)_____ to leave home because: <b>(Please be specific. Do NOT simply state: "considerable and taxing effort, gait abnormality, weakness, etc.)</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(proceed to applicable "Plan" question.) )</p>
<p>8. <b>Why</b> is it medically contraindicated for this patient to leave home?</p>	<p>It is medically contraindicated for this patient to leave home because: <b>(Please be specific. Do NOT simply state: "considerable and taxing effort, gait abnormality, weakness, etc.)</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(proceed to applicable "Plan" question.)</p>
<p><b>Plan:</b> 9. Why does the patient need skilled nursing?</p>	<p>The patient requires skilled nursing services to:</p> <p><input type="checkbox"/> Teach/train the patient or family to: _____</p>

Observe/assess the following condition (describe why there is a reasonable potential for a future complication or acute episode. Observation and assessment by a nurse is **not** reasonable and necessary where fluctuating signs and symptoms are part of a longstanding pattern of the patient's condition.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Administer the following medications that the patient, family, or caregiver cannot safely administer:

\_\_\_\_\_

This medication is being administered:

IV

IM

SQ

Orally. Skilled observation and assessment of oral administration is required because:

\_\_\_\_\_  
\_\_\_\_\_

Administer infusion therapy that the patient, family, or caregiver cannot safely administer.

Administer tube feedings that the patient, family, or caregiver cannot safely administer.

Perform skilled wound care, catheter, and ostomy care that the patient, family, or caregiver cannot safely administer.

Provide NG and tracheostomy aspiration/care that the patient or family, or caregiver cannot safely administer.

Provide NG tube feeding that the patient, family, or caregiver cannot safely administer.

Conduct psychiatric evaluation and psychotherapy (must be provided by a psychiatrically trained nurse)

Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Manage a complex care plan. The patient has the following underlying unstable condition or complication that requires the skills of a registered nurse to ensure that non-skilled care is achieving its purpose:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

	<p style="text-align: center;">_____ CERTIFYING PHYSICIAN'S SIGNATURE (If ordering management of a complex care plan)</p> <p style="text-align: right;">_/_/_/ DATE</p> <p><input type="checkbox"/> The patient does NOT need skilled nursing services.</p>
<p><b>Plan:</b></p> <p>10. Why does the patient need physical therapy?</p>	<p>The patient requires physical therapy services to:</p> <p><input type="checkbox"/> Restore patient function.</p> <p><input type="checkbox"/> Establish/perform maintenance therapy. (Explain why the skills of a qualified therapist are necessary for the performance of maintenance therapy)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> The patient does NOT need physical therapy.</p>
<p><b>Plan:</b></p> <p>11. Why does the patient need occupational therapy?</p>	<p>The patient requires occupational therapy services to:</p> <p><input type="checkbox"/> Restore patient function.</p> <p><input type="checkbox"/> Establish/perform maintenance therapy. (Explain why the skills of a qualified therapist are necessary for the performance of maintenance therapy)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> The patient does NOT need occupational therapy.</p>
<p><b>Plan:</b></p> <p>12. Why does the patient need speech-language pathology services?</p>	<p>The patient requires speech-language pathology services to:</p> <p><input type="checkbox"/> Restore patient function.</p> <p><input type="checkbox"/> Establish/perform maintenance therapy. (Explain why the skills of a qualified therapist are necessary for the performance of maintenance therapy)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

	<input type="checkbox"/> The patient does NOT need speech-language pathology services.
<b>Plan:</b>  13. Why does the patient need other services (e.g., home health aide, medical social services, etc.)?	The patient requires other services (describe) _____ to:  _____ _____ _____
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Cannot be completed by the Home Health Agency or anyone with a financial relationship to the Home Health Agency):  NAME: _____ TITLE: _____ Employer: _____  SIGNATURE: _____	
<b>SECTION C: Provider Signature/Date</b>	
_____ PHYSICIAN'S SIGNATURE	____/____/____ DATE

**SECTION A: (May be completed by someone other than the Provider)**

**PATIENT INFORMATION:** Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form. Indicate patient's date of birth (MM/DD/YY)

**PROVIDER INFORMATION:** Indicate the Provider's name and complete mailing address where the exam is taking place. Accurately indicate the ordering Provider's National Provider Identification number (NPI)

**SECTION B: (Cannot be completed by the home health agency. While this section may be completed by a non-Provider clinician, or a Provider employee, it must be reviewed and signed (in Section C) by the ordering Provider.)**

This section is used to gather clinical information to determine whether the patient is home bound. Answer each question, checking "Y" for yes, "N" for no, or fill in the blank if other information is requested.

**SECTION C: (To be completed by the Physician)**

**PROVIDER SIGNATURE AND DATE:** After completion and/or review by the Physician of Sections A, B and C, the Physician must sign and date the progress note in Section C.