Mennonite Home Health & Senior Services of
Mennonite Home Communities of Ohio

# REQUEST FOR HOME HEALTH SERVICES

Phone: 419-358-1015, ext. 300
Fax: 419-358-4269

**Mennonite Home Health and Senior Services** provides Skilled Nursing, Physical, Occupational, and Speech Therapy in the patient's home. This document serves as a request to provide skilled services to the patient with a current need and the list below is to classify the need of service. Patient must be homebound in order for us to start the care and proceed with the service. Please check the appropriate service the patient requires and provide supporting document with this form.

Patient: _____ DOB: _____ Date: _____

Upon my assessment, this patient has a **Primary Diagnosis** of: _____,
which is causing a functional decline in the following areas:

CMS has initiated Patient Driven Grouping Model (PDGM) effective January 1, 2020. With this initiative patients receiving home health services must have a primary diagnosis to support their need for services. No longer with CMS accept symptom disease management.

| SKILLED NURSING | PHYSICAL THERAPY | OCCUPATIONAL THERAPY | SPEECH THERAPY |
|---|---|---|---|
| ___ Medication Management | ___ Gait Disturbance | ___ Decline in ADL's | ___ Swallowing Difficulties |
| ___ Pain Management | ___ Abnormality of Gait | ___ Decline in IADL's | ___ Communication Deficits |
| ___ Wound Care | ___ Difficulty in Walking | ___ DME Recommendations | ___ Word Finding Problems |
| ___ Foley Management | ___ Balance Deficits | ___ Decline in Self-Feeding | ___ Inability to Express Wants/Needs |
| ___ Post-Surgical Care | ___ Decline in Transfers | ___ Decline in Light Meal Prep | ___ Acute Decline in Cognition causing a functional deficit in the following areas: |
| ___ Re-Hospitalization Prevention r/t: _____ | ___ Recommendation for Assistive Device | ___ Decline in Light Housekeeping | ___ Medication Mgmt |
| ___ Disease Process Education: | ___ Proper use of Assistive Device | ___ Energy Conservation | ___ ADL Performance |
| ___ CHF | ___ Fall(s) (how many ___) | ___ Other: _____ | ___ Safety awareness |
| ___ Diabetes | ___ Fall Risk | **OT CANNOT BE THE ONLY DISCIPLINE AT SOC** | ___ Sequencing |
| ___ COPD | | | ___ Other: _____ |
| ___ Hypertension | | | |
| ___ CVA | | | |
| ___ Other: _____ | | | |

**ENCOUNTER DATE: _____/_____/_____**

***Please include face sheet, H&P, current office visit note that supports the primary diagnosis for home health services, copy of insurance card and medication list with this form when faxing to our office. Thank you!***

MD signature: _____ Date: _____

Printed name: _____

****THIS DOCUMENT DOES NOT REPLACE THE FACE TO FACE REQUIREMENT SET FORTH BY MEDICARE****

*Medicare Certified Home Health Agency*