HOME HEALTH INTAKE AND REFERRAL FORM

To be used as a worksheet by office staff and the admitting clinician to capture all needed information. If information is entered directly into Horizon, those parts of this form can be left blank. Make sure that all information is recorded in Horizon. Enter information in Horizon in Customer Maintenance or Clinical Explorer/Profile.

SECTION I:

Initial Referral/Contact Date_____

Date of Referral (M104) _____ Date of Physician Ordered SOC (M102)_____

Referring Physician: _____ Phone: _____

PECOS Enrollment Status: Enrolled_____ Not Enrolled _____ Date Verified: _____

NPI: _____ Medicaid Enrolled: Yes_____ No_____ Date Verified: _____

Attending Physician: _____ Phone: _____

PECOS Enrollment Status: Enrolled _____ Not Enrolled _____ Date Verified: _____

NPI: _____ Medicaid Enrolled: Yes_____ No_____ Date Verified: _____

Face to Face Visit for Home Health DATE: _____ No Known Encounter _____
(Enter visit event in Event Menu of Customer Maintenance or Clinical Explorer.)

Patient Last Name: _____ First Name: _____ SS#: _____

DOB: _____ Gender: _____ Language: _____ Marital Status: _____ Race: _____

Physical Address: _____

_____

Patient Phone #: _____ Episode Type: _____

Referral Source: _____ Caller: _____ # _____

Insurance/Payors for Admission: _____ Insurance #: _____

_____

Is Payor a Medicare Advantage Plan? (__) Yes (__) No

Medicare # (M63) _____ (__) A (__) B (__) No Medicare

Medicaid # (M65) _____ (__) Patient First (__) No Medicaid

Patient First Physician _____

SOC Date (M30) _____ (Date of First Billable Visit)

Nurse Care Coordinator (Case Manager in Horizon): _____

Inpatient Stay Facilities within last 14 days (may list further back if relevant to POC)

Hospital (Name/Phone Number): _____ Dates (From): _____TO: _____

Nursing Home (Name/Phone Number): _____ Dates (From): _____TO: _____

Rehab Facility (Name/Phone Number): _____ Dates (From): _____TO: _____

Prior Home Health Admission? (__) Yes (__) No Agency: _____

Skilled Need/Purpose of Referral: _____

_____

Specific Orders/Misc. Notes: _____

_____

Immunizations Received: (__) Pneumonia Date: _____ (__) Influenza Date: _____
(__) Other Date: _____

Inpatient Diagnosis: _____

_____

Request From Inpatient Facility:
(Have patient to sign release, if needed)

History and Physical
MD Progress and Discharge Notes
Tests/Lab/Procedure Results
Surgery Notes (Need Procedure Codes)
Diagnosis/ICD-9 Codes Listed
Therapy Notes, As Applicable

SECTION II:

Directions to Home: _____

_____

_____

Emergency Contacts:

Caregiver: _____Phone: _____ Relationship: _____

Address: _____

Other: _____ Phone: _____ Relationship: _____

Allergies: _____ Advance Directives: _____

Pharmacy: _____ Phone: _____

Disaster Preparedness (See policy): Acuity Level _____

Patient Disaster Plan (Skilled: Safety Section of Assessment; Unskilled: 485 USAA Library Text): _____

_____

Observation of Insurance/Medicare Cards:

Spelling Differences: _____

Card Number Differences: _____

Effective Dates: _____
(Report above to Office Staff.)

Referral Not Admitted: _____ (check if not admitted)

Reason not admitted: _____

_____

MEDICARE SECONDARY PAYOR QUESTIONAIRE.
(This is mandatory for all Medicare Admissions.)

DETERMINATION OF INSURANCE BENEFITS. Answer questions in each **PART** as appropriate. Continue as directed to determine Primary and Secondary pay source.

PART I

1. Are you receiving Black Lung (BL) Benefits?
   _____ **Yes;** Date benefits began: (MM/DD/CCYY) _____
   BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.
   _____ **No.**
2. Are the services to be paid by a government research program?
   _____ **Yes.**
   GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY FOR THESE SERVICES.
   _____ **No.**
3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care from ADPH, Home Care Services?
   _____ **Yes.**
   DVA IS PRIMARY FOR THESE SERVICES.
4. Was the illness/injury due to a work-related accident/condition?
   _____ **Yes;** Date of injury/illness: (MM/DD/CCYY) _____
   Name and address of workers' compensation plan (WC): _____
   _____
   Policy or identification number: _____
   Name and address of your employer: _____
   _____
   WC IS PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS, GO TO PART III.
   _____ **No. GO TO PART II.**

PART II

1. Was illness/injury due to a non-work related accident?
   _____**Yes;** Date of accident (MM/DD/CCYY) _____
   _____ **No. GO TO PART III**
2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)
   _____ **Yes.** Name and address of the no-fault insurer(s) and no-fault insurance policy owner: _____
   _____
   _____
   Insurance claim number(s): _____
   _____ **No.**
3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)
   _____ Yes. Name and address of liability insurer(s) and responsible party: _____
   _____
   _____ Insurance Claim #: _____
   _____ **No. NO FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT. LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABILITY SETTLEMENT, JUDGMENT, OR AWARD. GO TO PART III.**

PART III

1. Are you entitled to Medicare based on:
   _____ **Age. Go to PART IV.**
   _____ **Disability. Go to PART V.**
   _____ **End-Stage Renal Disease (ERSD.) Go to PART VI.**
   Please note that both "Age" and "ERSD" or "Disability" and "ERSD" may be selected simultaneously. An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously. Please complete ALL "PARTS" associated with the patient's selections.

PART IV-AGE

1. Are you currently employed?
   _____**Yes.** Name and address of your employer: _____
   _____
   _____
   _____ **No.** If applicable, date of retirement: (MM/DD/CCYY) _____
   _____ **No.** Never Employed.
2. Do you have a spouse who is currently employed?
   _____ **Yes.** Name and address of your spouse's employer: _____
   _____
   _____
   _____ **No.** If applicable, date of retirement: (MM/DD/CCYY) _____
   _____ **No.** Never Employed.

   IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. STOP.
3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?
   _____ **Yes, both.**
   _____ **Yes, self.**
   _____ **Yes, spouse.**
   _____ **No. STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**
4. If you have GHP coverage based on your own current employment, does your employer employ more than 20 employees?
   _____**Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.** Name and address of GHP: _____
   _____
   _____
   Policy #: _____ Group #: _____ Membership #: _____
   Name of policy holder/named insured: _____
   Relationship to patient: _____
   _____ **No.**
5. If you have GHP coverage based on your spouse's current employment, does your spouse's employer employ more than 20 employees?
   _____ **Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.** Name and address of GHP: _____
   _____
   _____
   Policy #: _____ Group #: _____ Membership #: _____
   Name of policyholder/insured: _____ Relationship to patient: _____
   _____ **No.**

   IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 4 AND 5, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART V-DISABILITY

1. Are you currently employed?
   _____ **Yes.**
   Name and address of your employer: _____
   _____
   _____ **No.** If applicable, date of retirement: (MM/DD/CCYY) _____
   _____ **No.** Never Employed.
2. Do you have a spouse who is currently employed?
   _____ **Yes.** Name and address of your spouse's employer: _____
   _____
   _____ **No.** If applicable, date of retirement: (MM/DD/CCYY) _____
   _____ **No.** Never Employed.
3. Do you have group health plan (GHP) coverage based on your own or on a spouse's current employment?
   _____ **Yes,** both.
   _____ **Yes,** self.
   _____ **Yes,** spouse.
   _____ **No.**
4. Are you covered under the GHP of a family member other than your spouse?
   _____ **Yes.** Name and address of your family member's employer: _____
   _____
   _____ **No. IF THE PATIENT ANSWERED "NO" TO QUESTIONS 1, 2, 3, AND 4, STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR PART II.**
5. If you have GHP coverage based on your own current employment, does your employer employ more than 100 employees?
   _____ **Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.** Name and address of GHP: _____
   _____
   Policy #: _____ Group #: _____
   Name of policyholder/named insured: _____
   Relationship to patient: _____ Membership #: _____
   _____ **No.**
6. If you have GHP coverage based on your spouse's current employment, does your spouse's employer employ 100 or more employees?
   _____ **Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.** Name and address of GHP: _____
   _____
   Policy #: _____ Group #: _____
   Membership #: _____ Name of policyholder/named insured: _____
   _____
   Relationship to patient: _____
   _____ **No.**
7. If you have GHP coverage based on a family member's current employment, does your family member's employer employ 100 or more employees?
   _____ **Yes. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.** Name and address of GHP: _____
   _____
   Policy identification #: _____ Group #: _____
   Membership #: _____ Name of Policyholder/name insured: _____
   Relationship to patient: _____
   _____ **No. IF THE PATIENT ANSWERED "NO" TO QUESTIONS 5, 6, AND 7, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

PART VI-ERSD

1. Do you have group health plan (GHP) coverage?
   _____ **Yes.** Go to next page.
   IF APPLICABLE, YOUR GHP INFORMATION: Name and address of GHP: _____
   _____
   _____
   Policy #: _____ Group #: _____
   Membership #: _____ Name of policyholder/insured: _____
   Relationship to patient: _____ Name and address of employer, if any, from which you receive GHP coverage: _____
   _____
   IF APPLICABLE, YOUR SPOUSE'S GHP INFORMATION: Name and address of GHP: _____
   _____
   _____
   Policy #: _____ Group #: _____
   Membership #: _____ Name of policyholder/insured: _____
   Relationship to patient: _____
   Name and address of employer, if any, from which your spouse receives GHP coverage: **IF APPLICABLE, YOUR FAMILY MEMBER'S GHP INFORMATION:** Name and address of GHP:
   _____
   _____
   _____ **No. STOP. MEDICARE IS PRIMARY.**
2. Have you received maintenance dialysis treatments?
   _____ **Yes.** Date of transplant: (MM/DD/CCYY) _____
   _____ **No.**
3. Have you received maintenance dialysis treatments?
   _____ **Yes.** Date dialysis began: (MM/DD/CCYY) _____
   _____ **No.**
4. Are you within the 30-month coordination period that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis.) If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)
   _____ **Yes.**
   _____ **No. STOP. MEDICARE IS PRIMARY.**
5. Are you entitled to Medicare on the basis of either ERSD and age or ERSD and disability?
   _____ **Yes.**
   _____ **No.**
6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ERSD?
   _____ **Yes. STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
   _____ **No. INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**
7. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement?)
   _____ **Yes. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**
   _____ **No. MEDICARE CONTINUES TO PAY PRIMARY.**

   If no MSP data are found in the Common Working File (CWF) for the beneficiary, the provider still asks the types of questions above and provides MSP information on the bill using the proper uniform billing codes. This information will then be used to update the CWF through the billing process.