GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Fcxkf "C0Eqqm, Commissioner

"Pcvjcp"Fgcn, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

HOME HEALTH AGENCY INITIAL LICENSURE PACKET

This letter is in response to your request for information about operating a home health agency (HHA) in Georgia. The Health Care Section of the Office of Healthcare Facility Regulation (HFR) is responsible for licensing HHAs under Georgia State Law and for assisting the Centers for Medicare/Medicaid Services (CMS) in performing the certification function for those HHA providers wishing to participate in the Medicare Program. O.C.G.A. § 31-7-150 *et seq*. requires agencies to obtain a Georgia state license prior to providing home health services. A state license is also a prerequisite to obtaining Medicare certification.

Certificate of Need (CON) Requirement

Before receiving a license to operate a home health agency, you must have a Certificate of Need (CON) issued by the Department of Community Health, Division of Health Planning. To apply for a CON, contact:

Department of Community Health, Division of Health Planning
2 Peachtree Street, NW, 5th Floor
Atlanta, GA 30303-3142
(404) 656-0655

State Licensure Application Process

After you obtain a CON from the Department of Community Health, Division of Health Planning, you may begin the application process to obtain a home health agency license. Before an initial licensure survey can be conducted, the following must be received by the Healthcare Section, Healthcare Facility Regulation's Office:

1. Certificate of Need (CON) – copy
2. APPLICATION FOR A LICENSE TO OPERATE A HOME HEALTH AGENCY
3. Cashier's check or money order for $200. payable to: Department of Community Health
4. Affidavit Re: Personal Identification for Licensure/Registration

Submit to: Home Care Unit
Healthcare Facility Regulation
Healthcare Section
2 Peachtree Street, Suite 31-447
Atlanta, GA 30303

If any essential documents are determined to be absent or incorrect, the application will be considered incomplete; the application and documents will be returned to you along with information identifying the missing or incorrect documents. At that time the application will

be considered to be voluntarily withdrawn, but you may reapply when you have assembled all of the required documents.

Once the application packet has been determined by HFR staff to be complete, you will be contacted by HFR about your initial licensure inspection.

Initial Licensure On-site Survey

During the initial state licensure survey, you will be checked for compliance with the **Georgia-Rules and Regulations for HOME HEALTH AGENCIES, O.C.G.A., Chapter 290-5-8.**

If no deficiencies are cited during the survey, a license will be issued, effective the date of the survey. If deficiencies are cited, it will be necessary for you to submit an acceptable plan of correction.

Enclosures:

1. Georgia Rules and Regulations for Home Health Agencies, Chapter 290-5-8
2. Application for a Licensure to Operate a Home Health Agency
3. Affidavit Re: Personal Identification for Licensure/Registration

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Healthcare Facility Regulation Division
2 Peachtree Street, N.W., Suite 33-669
Atlanta, Georgia 30303-3189

APPLICATION FOR A LICENSE TO OPERATE A HOME HEALTH AGENCY

Pursuant to provision of O.C.G.A. §31-7-150 et.seq. application is hereby made to operate a Home Health Agency which is identified as follows:

Section A: IDENTIFICATION

Date of Application: ____________________

Type of Application: ☐ INITIAL ☐ RENEWAL ☐ CHOW

NAME OF AGENCY		COUNTY OF PARENT AGENCY
STREET ADDRESS	CITY AND ZIP CODE	TELEPHONE
NAME OF ADMINISTRATOR / DIRECTOR		TITLE
OFFICIAL NAME AND ADDRESS OF GOVERNING BODY		
NUMBER OF BRANCH OFFICES	COUNTIES SERVED (BY ENTIRE AGENCY)	

Section B: TYPE OF OWNERSHIP (Check one)

Proprietary (Profit)	**Nonprofit**	
☐ Individual	☐ State	☐ Hospital Authority
☐ Partnership	☐ County	☐ Church
☐ Corporation	☐ City	☐ Other(Specify)

Agent for Service / Name:	Address and Telephone Number:

1. List names and addresses of all owners with 5% or more interest:

____

____

____

____

____

2. Agencies Organized as a Corporation or Partnership – List names and addresses of officers of the corporation or principle partners:

____

____

____

____

Section C: HOME HEALTH SERVICES PROVIDED

"1" Provided by Agency
"2" Under Arrangement
"3" Combination

Service	Staffing (List Full-Time Equivalent)		
	Registered Nurse		
Nursing Care	Licensed Practical Nurse		
Physical Therapy	Physical Therapist		
Occupational Therapy	Occupational Therapist		
Speech Therapy	Speech Pathologist/Audiologist		
Medical Social Worker	Social Worker		
Home Health Aide	Home Health Aide		
Nutritional Guidance	Dietitian		
Pharmaceutical Services	Pharmacist		
Other (Administrative Secretary, etc.)	All Other		

Section D: CERTIFICATION

I certify that this agency will comply with the Rules and Regulations for Home Health Agencies (Chapter 290-5-38). I further certify that the above information is true and correct to the best of my knowledge.

Signature: ______________________ Title: ______________________
Administrator or Officer authorized to complete application

(TO BE COMPLETED BY DCH PERSONNEL ONLY)

Copy of Corporate Charter attached? (if applicable) ☐ YES ☐ NO
Permit Number: ______________________
Effective Date: ______________________

Copy of Certificate of Need attached? (if applicable) ☐ YES ☐ NO ☐ N/A
Licensure fee received: ☐ YES ☐ NO

Reviewed by: ______________________

Approved: ______________________
Regional Director

Section E: HOME HEALTH AGENCY AND BRANCH OFFICE ADMISSION DATA

Date: ____________________

Does you parent office directly provide clinical services? ☐ YES ☐ NO

If not, please list the address where clinical services are provided in the agency (PARENT) column below:

PLEASE PROVIDE ADMISSION DATA FOR THE PARENT AND BRANCH OFFICES FOR THE PAST 12 MONTHS	TOTAL NUMBER MEDICARE – MEDICAID ADMISSIONS (All first time admissions) IN THE PAST 12 MONTHS	TOTAL NUMBER SKILLED (All payment Sources) ADMISSIONS IN THE PAST 12 MONTHS	PLEASE CHECK EACH CATEGORY OF PAYOR SOURCE DELIVERED IN EACH SEPARATE OFFICE OR BRANCH	PLEASE PROVIDE BELOW NARRATIVE DIRECTIONS OF HOW TO REACH EACH OFFICE FROM ATLANTA
NAME OF AGENCY (Parent) ______ Address: ______ City / Zip: ______ Phone: ______ Counties Served: ______			Medicare: ______ Medicaid: ______ CCSP: ______ Insurance: ______ Private Pay ______	
1. BRANCH OFFICE ______ Address: ______ City / Zip: ______ Phone: ______ Counties Served: ______			Medicare: ______ Medicaid: ______ CCSP: ______ Insurance: ______ Private Pay ______	
2. BRANCH OFFICE ______ Address: ______ City / Zip: ______ Phone: ______ Counties Served: ______			Medicare: ______ Medicaid: ______ CCSP: ______ Insurance: ______ Private Pay ______	
3. BRANCH OFFICE ______ Address: ______ City / Zip: ______ Phone: ______ Counties Served: ______			Medicare: ______ Medicaid: ______ CCSP: ______ Insurance: ______ Private Pay ______	

(Attach extra sheets if necessary)

Return completed application and fee to:

Georgia Department of Community Heath
Healthcare Facility Regulation Division
2 Peachtree Street, N.W.
Suite 33-250
Atlanta, Georgia 30303-3142

* ATTACH DETAILED DIRECTIONS FROM ATLANTA TO AGENCY

HOME HEALTH AGENCY STATE LICENSURE RULES- VERSION 1.0

TAGS	RULES
0000 INITIAL COMMENTS	
0001 PURPOSE 290-5-38-.01	Under the authority of Georgia Laws 1980, p. 1790, et seq., the Department of Human Resources is authorized and required to establish the licensing procedure and standards of operation for Home Health Agencies operating in this State. These rules and regulations are provided for this purpose.
0002 APPLICATIONS AND LICENSES 290-5-38-.02	Each person, private or public organization, political subdivision, or other governmental agency desiring to operate a Home Health Agency, as defined herein, must first apply for and obtain a license using the forms furnished by the Department of Human Resources. A license is not assignable or transferable and is subject to suspension or revocation at any time for failure to comply with these rules and regulations.
0003 APPLICATIONS AND LICENSES 290-5-38-.02(a)1	The governing body of the Home Health Agency shall submit to the Department an application for a license of each agency and/or subunit. Such application(s) shall be signed by the executive officer of the governing body.
0004 APPLICATIONS AND LICENSES 290-5-38-.02(a)(2)	The application for a license shall be filed at least thirty (30) days prior to the anticipated date of opening and commencement of operation of a new Home Health Agency.
0005 APPLICATIONS AND LICENSES 290-5-38-.02(a)3	Corporations shall submit a copy of their charter and the name and address of all owners with five percent or more of the stock and shall identify each corporate officer.
0006 APPLICATIONS AND LICENSES 290-5-38-.02(a)4	An application or a change in service(s) for service area(s) which is subject to review under Ga. Code Chapter 88-33 and applicable rules shall be accompanied by a letter of approval from the State Health Planning and Development Agency.
0007 APPLICATIONS AND LICENSES 290-5-38-.02(b)1	To be eligible for a license, the Home Health Agency must be in satisfactory compliance with these rules and regulations and other applicable Federal, State and local laws.
0008 APPLICATIONS AND LICENSES 290-5-38-.03(b)2	The license shall be returned to the Department when the Home Health Agency ceases to operate, or is leased, or is moved to another location, or the ownership changes, or the license is suspended or revoked.
0009 APPLICATIONS AND LICENSES 290-5-38-.02(b)3	Any person or agency wishing to appeal the denial, suspension or revocation of a license is entitled to request a hearing under the provisions of the "Georgia Administrative Procedure Act."
0010 APPLICATIONS AND LICENSES 290-5-38-.02(b)4	Licenses will be renewed on an annual basis.
0011 APPLICATIONS AND LICENSES 290-5-38-.02(b)5	The license shall be prominently and appropriately displayed.
0012 CERTIFICATE OF NEED AND 1122 REVIEW 290-5-38-.03	Home Health Agencies which are required by State laws to obtain a Certificate of Need shall submit evidence that such requirements have been met when applying for a license.

TAGS	RULES
0013 EXEMPTIONS 290-5-38-.04	These rules and regulations shall not apply to services which are provided under the following conditions:
0014 EXEMPTIONS 290-5-38-.04(a)	These rules and regulations shall not apply to services which are provided under the following conditions: (a) Persons who provide personal or paraprofessional health services, either with or without compensation when there is no claim that the service is provided as a part of a licensed Home Health Agency; ...
0015 EXEMPTIONS 290-5-38-.04(b)	These rules and regulations shall not apply to services which are provided under the following conditions: ... (b) Persons who provide professional services for which they are duly licensed under Georgia laws, when there is no claim that the service is provided as a part of a licensed Home Health Agency; ...
0016 EXEMPTIONS 290-5-38-.04(c)	These rules and regulations shall not apply to services which are provided under the following conditions: (c) Services provided under the provisions of any other license issued by the State of Georgia when there is no claim that the service is provided as a part of a licensed or certified Home Health Agency; ...
0017 EXEMPTIONS 290-5-38-.04(d)	These rules and regulations shall not apply to services which are provided under the following conditions: ... (d) Any Home Health Agency certified in a Federal program for reimbursement of Medicare or Medicaid services shall be exempt from an additional on-site licensure inspection upon presentation of evidence of such certification.
0018 INSPECTIONS 290-5-38-.05	For the purpose of insuring compliance with these rules and regulations, each Home Health Agency shall be subjected to periodic inspections by an authorized representative of the Department. Such nspections shall take place during reasonable hours and, if possible, during scheduled operating hours. The administrator or his representative shall accompany the Department representative on tours of inspection and shall sign the completed checklist.
0019 DEFINITIONS 290-5-38-.06	Unless a different meaning is required or given in the context, the following terms as used in these rules and regulations shall have the meaning respectively ascribed to them:
0020 DEFINITIONS 290-5-38-.06(a)	"Administrator" means the full- time person by whatever title used, to whom the governing body has delegated the responsibility for day-to-day administration of the Home Health Agency, including the implementation of the rules and policies adopted by the governing body, and who: 1. is a licensed physician; or 2. is a registered nurse; or 3. has training and experience in health service administration and at least one (1) year of supervisory or administrative experience in home health care or related health programs.
0021 DEFINITIONS 290-5-38-.06(b)	"Board" means the Board of Human Resources.

TAGS	RULES
0022 DEFINITIONS 290-5-38-.06(c)	"Branch Office" means a location or site identified in the application or endorsement thereto from which a Home Health Agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the Home Health Agency and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently to meet the requirements of these rules and regulations.
0023 DEFINITIONS 290-5-38-.06(d)	"By-Laws" means a set of rules adopted by a Home Health Agency for governing the agency's operation.
0024 DEFINITIONS 290-5-38-.06(e)	"Certificate of Need" shall have that meaning as defined in Ga. Code Chapter 88-33 and applicable rules.
0025 DEFINITIONS 290-5-38-.06(f)	"Clinical Note" means a dated and signed written notation by the providing member of the health team of a contact with a patient containing a description of signs and symptoms, treatment and drug given, the patient's reaction, and any changes in physical or emotional condition.
0026 DEFINITIONS 290-5-38-.06(g)	"Department" means the Georgia Department of Human Resources.
0027 DEFINITIONS 290-5-38-.06(h)	"Governing Body" means the person or persons, natural or corporate, in which the ultimate responsibility, authority and accountability for the conduct of the Home Health Agency is vested.
0028 DEFINITIONS 290-5-38-.06(i)	"Health Professionals" means those professionals engaged in the delivery of health services who are currently licensed to practice in the State of Georgia, or are certified, or practice under authority consistent with Georgia laws.
0029 DEFINITIONS 290-5-38-.06(j)	"Home Health Agency" means a public, non-profit, or proprietary organization, whether owned or operated by one or more persons or legal entities, which is engaged in providing home health services.
0030 DEFINITIONS 290-5-38-.06(k)	"Home Health Services" means those items and services provided to an individual, according to a written plan of treatment signed by the patient's physician, by a Home Health Agency or others under arrangement with the Home Health Agency on a visit or hourly basis, in a place of temporary or permanent residence used as the individual's home as follows: 1. part-time or intermittent skilled nursing care as ordered by a physician and provided by or under the supervision of a registered nurse and at least one other service listed below; 2. physical, occupational, or speech therapy; 3. medical social services; 4. home health aide services.
0031 DEFINITIONS 290-5-38-.06(l)	"License" means a license issued by the Department.
0032 DEFINITIONS 290-5-38-.06(m)	"Licensee" means the individual corporation, or public entity with whom rests the ultimate responsibility for maintaining approved standards for the Home Health Agency.

TAGS	RULES
0033 DEFINITIONS 290-5-38-.06(n)	"Licensed Practical Nurse or LPN" means an individual who is currently licensed as a licensed practical nurse in Georgia.
0034 DEFINITIONS 290-5-38-.06(o)	"Occupational Therapy Assistant" means a qualified individual who: 1. Is currently licensed as an occupational therapy assistant in Georgia and assists in the practice of occupational therapy under the supervision and direction of a Georgia licensed occupational therapist; and 2. Meets the Federal conditions for participation.
0035 DEFINITIONS 290-5-38-.06(p)	"Occupational Therapy Assistant" means a qualified individual who: 1. Is currently licensed as an occupational therapy assistant in Georgia and assists in the practice of occupational therapy under the supervision and direction of a Georgia licensed occupational therapist; and 2. Meets the Federal conditions of participation.
0036 DEFINITIONS 290-5-38-.06(q)	"Parent Home Health Agency" means the agency that develops and maintains administrative controls of subunits or branch offices.
0037 DEFINITIONS 290-5-38-.06(r)	"Physical Therapist: means a qualified individual who: 1. Is currently licensed as a physical therapist in Georgia; and 2. Meets the Federal conditions for participation.
0038 DEFINITIONS 290-5-38-.06(s)	"Physical Therapy Assistant" means a qualified individual who: 1. Is currently licensed as a physical therapy assistant in Georgia and assists in the practice of physical therapy under the supervision and direction of a Georgia licensed physical therapist; and 2. Meets the Federal conditions for participation.
0039 DEFINITIONS 290-5-38-.06(t)	"Physician" means an individual who is currently licensed or authorized to practice medicine and surgery in Georgia.
0040 DEFINITIONS 290-5-38-.06(u)	"Plan of Treatment" means an individual plan written, signed, and reviewed at least every sixty days by the patient's physician prescribing items and services for the patient's condition.
0041 DEFINITIONS 290-5-38-.06(v)	"Primary Home Health Agency" means the Agency (Parent or Subunit) that is responsible for the service rendered to patients and for implementation of the plan of treatment.
0042 DEFINITIONS 290-5-38-.06(w)	"Progress Note" means a dated and signed written notation by the providing member of the health team, summarizing facts about care and the patient's response during a given period of time.
0043 DEFINITIONS 290-5-38-.06(x)	"Registered Nurse or RN" means an individual who is currently licensed as a registered professional nurse in Georgia.

TAGS	RULES
0044 DEFINITIONS 290-5-38-.06(y)	"Service Area" means the geographical area in which a Home Health Agency provides services, as defined by the State Health Planning and Development Agency.
0045 DEFINITIONS 290-5-38-.06(z)	"Social Work Assistant" means an individual who meets the Federal conditions of participation and applicable Georgia Laws.
0046 DEFINITIONS 290-5-38-.06(aa)	"Social Worker" means an individual who meets the Federal conditions of participation and applicable Georgia Laws.
0047 DEFINITIONS 290-5-38-.06(bb)	"Speech Pathologist" and/or "Audiologist" means a qualified individual who: 1. Is currently licensed as a speech pathologist and/or audiologist in Georgia; and 2. Meets the Federal conditions of participation.
0048 DEFINITIONS 290-5-38-.06(cc)	"Subunit" means a semiautonomous organization, which serves patients in a geographic area different from that of the parent agency. The subunit by virtue of the distance between it and the parent agency is judged incapable of sharing administration, supervision, and services on a daily basis with the parent agency, and must, therefore, independently meet the licensing requirements for a Home Health Agency, and shall be separately licensed.
0049 DEFINITIONS 290-5-38-.06(dd)	"Supervision" means authoritative procedural guidance by a qualified person for the accomplishment of function or activity with initial direction and periodic inspection of the actual act of accomplishing the function or activity.
0050 ADMINISTRATIVE STANDARDS 290-5-38-.07(1)	Organization, Services, Administration. Organization, services provided, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be clearly set forth in written policies and procedures. Administrative and supervisory functions shall not be delegated to another agency or organization. Services not provided directly shall be monitored and controlled by the primary agency, including services provided through subunits of the parent agency. If an agency has subunits, appropriate administrative records shall be maintained for each subunit.
0051 ADMINISTRATIVE STANDARDS 290-5-38-.07(2)	Governing Body. There shall be a Governing Body which assumes full legal authority and responsibility for the operation of each Home Health Agency. The Governing Body shall appoint a qualified administrator, arrange for professional advice, adopt and periodically review written bylaws and oversee the management and fiscal affairs of the agency. The name and address of each officer, director, and owner shall be disclosed to the Department. If the agency is a corporation, all ownership interests of five (5) percent or more (direct or indirect) shall also be disclosed.
0052 ADMINISTRATIVE STANDARDS 290-5-38-.07(3)(a)	A group of professional personnel, which shall include at least one physician and one registered nurse, with appropriate representation from other professional disciplines, shall establish and annually review the policies of each Home Health Agency governing scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, personnel qualifications, and program evaluation. There must be at least one member of the group who is neither an owner nor an employee of the agency.

TAGS	RULES
0053 ADMINISTRATIVE STANDARDS 290-5-38-.07(3)(b)	The group of professional personnel shall meet at least once per quarter unless circumstances require more often to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in its community information program. The minutes shall be documented by dated minutes.
0054 ADMINISTRATIVE STANDARDS 290-5-38-.07(4)	Administrator. The administrator (who may also be the supervising physician or registered nurse), is responsible for organizing and directing the agency's ongoing functions; maintaining ongoing liaison among the Governing Body, the group of professional personnel, and the staff; employing qualified personnel and ensuring adequate staff education and evaluations; ensuring the accuracy of public information, materials and activities; and implementing an effective budgeting and accounting system. A qualified person shall be authorized in writing to act in the absence of the administrator.
0055 ADMINISTRATIVE STANDARDS 290-5-38-.07(5)	Supervising Physician or Registered Nurse. Skilled nursing and other therapeutic services provided shall be under the supervision and direction of a physician or a registered nurse. This person or similarly qualified alternate shall be available at all times during operating hours and participate in all activities relevant to the professional services provided, including the developing of qualifications and assignments of personnel.
0056 ADMINISTRATIVE STANDARDS 290-5-38-.07(6)	Personnel Policies. Personnel practices shall be supported by appropriate, written personnel policies. Individual personnel records shall include job descriptions, qualifications, licenses, performance evaluations, and health examinations, and shall be kept current. If personnel under hourly or per visit contracts are utilized by the Home Health Agency, there shall be a written contract between such personnel and the agency clearly designating: (a) that patients are accepted for care only by the primary Home Health Agency; (b) the services to be provided; (c) the necessity to conform to all applicable agency policies including personnel qualifications; (d) the responsibility for participating in developing plans of treatment; (e) the manner in which services will be controlled, coordinated, and evaluated by the primary agency; (f) the procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation; and (g) the procedure for determining charges and reimbursement.
0057 ADMINISTRATIVE STANDARDS 290-5-38-.07(7)	Planning and Budget. A Home Health Agency, under the direction of the Governing Body, shall prepare an overall plan and budget which provides for an annual operating budget. If capital expenditures are anticipated, a three-year capital expenditure plan shall be provided and updated annually. The overall plan, budget and capital expenditure plan shall be reviewed and updated at least annually.

TAGS	RULES
0058 ADMINISTRATIVE STANDARDS 290-5-38-.07(8)(a)	Evaluation. (a) A Home Health Agency shall have written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), Home Health Agency staff, and consumers; or by professional people outside the agency working in conjunction with consumers. The evaluation shall consist of an overall policy and administrative review and a clinical record review. The evaluation shall assess the extent to which the agency's program is appropriate, adequate, effective and efficient. Results of the evaluation shall be reported to the Governing Body and maintained separately as administrative records. Mechanisms shall be established in writing for the collection of pertinent data to assist in this evaluation. This data to be considered may include but is not limited to: 1. number of patients receiving each service offered; 2. number of patient visits; 3. reasons for discharge; 4. breakdown by diagnosis; 5. sources of referral; 6. number of patients not accepted with reasons; and 7. total staff days for each service offered.
0059 ADMINISTRATIVE STANDARDS 290-5-38-.07(8)(b)	At least quarterly, appropriate health professionals representing at least the scope of the program, shall review a sample of both active and closed clinical records to assure that established policies are followed in providing services (direct services as well as services under arrangement). Evidence of this review shall be documented by dated minutes.
0060 SCOPE OF SERVICES 290-5-38-.08	A Home Health Agency shall provide part-time or intermittent skilled nursing services and at least one other therapeutic service, e.g., physical, speech, or occupational therapy; medical social services; or home health aide services. Services shall be made available on a visiting basis, in a place of residence, as a patient's home.
0061 SCOPE OF SERVICES 290-5-38-.08(a)	Nursing Services. A Home Health Agency shall provide skilled nursing service by or under the supervision of a registered nurse and in accordance with the plan of treatment.
0062 SCOPE OF SERVICES 290-5-38-.08(a)1	Duties of the registered nurse (RN). A registered nurse shall make the initial evaluation visit, regularly reevaluate the patient's nursing needs, initiate the plan of treatment and necessary revisions, provide those services requiring substantial specialized nursing skill, initiate appropriate preventive and rehabilitative nursing procedures, prepare clinical and progress notes, coordinate services, inform the physician and other personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other personnel.
0063 SCOPE OF SERVICES 290-5-38-.08(a)2	Duties of the licensed practical nurse (LPN). The licensed practical nurse shall provide services in accordance with agency policies, prepare clinical and progress notes, assist the physician and/or registered nurse in performing specialized procedures, prepare equipment and materials for treatments observing aseptic technique as required and assist the patient in learning appropriate self-care techniques.

TAGS	RULES
0064 SCOPE OF SERVICES 290-5-38-.08(b)	Therapy Services. All therapy services offered by the Home Health Agency directly or under arrangement shall be given by a qualified therapist in accordance with the plan of treatment. The qualified therapist shall assist the physician in evaluating level of function, help develop the plan of treatment (revising as necessary), prepare clinical and progress notes, advise and consult with the family and other agency personnel, and participate in inservice programs. Therapy services include, but are not limited to: 1. Physical Therapy; 2. Occupational Therapy; 3. Speech Therapy; 4. Audiology.
0065 SCOPE OF SERVICES 290-5-38-.08(c)	Medical Social Services. Medical social services, when provided, shall be given by a qualified social worker in accordance with the plan of treatment. The social worker shall assist the physician and other team members in understanding the significant social and emotional factors related to the health problems, participate in the development of the plan of treatment prepare clinical and progress notes, work with the family, utilize appropriate community resources, participate in discharge planning and inservice programs, and act as a consultant to other agency personnel.
0066 SCOPE OF SERVICES 290-5-38-.08(d)1	Home health aides shall be selected on the basis of such factors as a sympathetic attitude toward the care of the sick; ability to read, write, and carry out directions; and maturity and ability to deal effectively with the demands of the job. Aides shall be carefully trained in at least the following areas: methods of assisting patients to achieve maximum self-reliance, principles of nutrition and meal preparation, the aging process and emotional problems of illness, procedures for maintaining a clean, healthful, and pleasant environment, recognizing changes in a patient's condition that should be reported, work of the agency and the health team; ethics, confidentiality, and recordkeeping. Aides shall be closely supervised to assure their competence in providing care.
0067 SCOPE OF SERVICES 290-5-38-.08(d)2	A home health aide shall be assigned to a particular patient by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse or therapist as appropriate. Home health aide duties shall be limited to the performance of simple procedures such as an extension of therapy services, personal care, ambulation and exercise household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records.
0068 SCOPE OF SERVICES 290-5-38-.08(d)3	A registered nurse, or other appropriate professional staff member, if other services are provided, shall make a supervisory visit to the patient's residence at least every two weeks, either when the aide is present to observe and assist, or when an aide is absent, to assess relationships and determine whether goals are being met. A record of the supervisory visit shall be dated and documented by a clinical note in the patient clinical record.

TAGS	RULES
0069 SCOPE OF SERVICES 290-5-38-.08(e)	Coordination of Patient Services. All personnel providing services shall maintain a liaison with the Home Health Agency to assure that their efforts effectively complement one another and support the objectives outlined in the plan of treatment. The clinical record shall contain dated minutes of case conferences verifying that effective interchange, reporting, and coordinated patient evaluation does occur. A written summary report of clinical and progress notes for each patient shall be sent to the attending physician at least every sixty (60) days and upon discharge. A copy of these reports shall become a permanent part of the patient's clinical record.
0070 SCOPE OF SERVICES 290-5-38-.08(f)	Services Under Arrangements. All services provided under arrangements shall be subject to a written contract. Contracts for home health services shall conform with the specific requirements of Rule 290-5-38-.07(6)(a) through (g).
0071 STANDARDS FOR PATIENT CARE 290-5-38-.09	Patients shall be accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Patients shall not be denied services because of their age, sex, race, religion, or national origin. Care shall follow a written plan of treatment established and periodically reviewed by a physician, and shall continue under the supervision of a physician.
0072 STANDARDS FOR PATIENT CARE 290-5-38-.09(a)	Plan of Treatment. An individual plan of treatment shall be developed for each patient in consultation with agency staff, and shall cover all pertinent diagnosis, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral, and other appropriate items. If a physician refers a patient under a plan of treatment which cannot be completed until after an evaluation visit, the physician shall be consulted to approve additions or modifications to the original plan. Orders for therapy services shall specify the procedures and modalities to be used, and the amount, frequency, and duration.
0073 STANDARDS FOR PATIENT CARE 290-5-38-.09(b)	Periodic Review of Plan of Treatment. The total plan of treatment shall be reviewed by the attending physician and Home Health Agency personnel as often as the severity of the patient's condition requires, but at least once every sixty (60) days. Date of the review and approval of the plan shall be documented by the physician's signature. Agency professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of treatment.

TAGS	RULES
0074 STANDARDS FOR PATIENT CARE 290-5-38-.09(c)	Conformance with Physician's Orders. Drugs and treatments shall be administered by agency staff only as ordered by the physician. The nurse or therapist shall immediately record and sign oral orders and forward the written order within five (5) business days to the physician for countersignature. Documentation of the physician's countersignature must appear in the patient's medical record within thirty (30) days of the verbal order. Professional agency staff shall check all medicines a patient may be taking to identify possibly ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication, and shall promptly report any problems to the physician. (April 12, 1998) Revised.
0075 STANDARDS FOR PATIENT CARE 290-5-38-.09(d)1	Clinical Records. 1. A clinical record shall be established and maintained on each patient in accordance with accepted professional standards and shall contain: (i) pertinent past and current findings; (ii) plan of treatment; (iii) appropriate identifying information; (iv) name of physician; (v) drug, dietary, treatment and activity orders; (vi) signed and dated clinical and progress notes (clinical notes are written the day service is rendered by the providing member of the health team and incorporated no less often than weekly); (vii) copies of case conferences; (viii) copies of summary reports sent to the physician; and (ix) a discharge summary.
0076 STANDARDS FOR PATIENT CARE 290-5-38-.09(d)2	If a patient transfers to another Home Health Agency or a health facility, a copy of the record or abstract shall be furnished to accompany the patient.
0077 STANDARDS FOR PATIENT CARE 290-5-38-.09(d)3	Sufficient space and equipment for record processing, storage and retrieval shall be provided.
0078 STANDARDS FOR PATIENT CARE 290-5-38-.09(d)4	Policies and procedures shall be written and implemented to assure organization and continuous maintenance of the clinical records system.
0079 STANDARDS FOR PATIENT CARE 290-5-38-.09(e)	Retention of Records. Clinical records shall be retained for a period of six years after the last patient encounter for adults, and for six years after a minor reaches the age of majority. These records may be retained as originals, microfilms, or other usable forms and shall afford a basis for complete audit of professional information. If the Home Health Agency dissolves or changes ownership, a plan for record retention shall be developed and placed into effect. The Department shall be advised of the disposition and/or location of said records.
0080 STANDARDS FOR PATIENT CARE 290-5-38-.09(f)	Protection of Records. Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern the use and removal of records and conditions for release of information. A patient's written consent is required for release of information not authorized by law.

TAGS	RULES
0081 PENALTIES 290-5-38-.10	Any person who operates a Home Health Agency without first obtaining a license pursuant to the provisions of the Georgia Home Health Agency Act shall be deemed guilty of a misdemeanor, and upon conviction shall be fined not to exceed $500.00 or imprisoned for a period not to exceed six months or both.
0082 FEES 290-5-38-.11	Each application for initial and annual renewal licenses shall be accompanied by a fee as prescribed by the Department.
0083 ENFORCEMENT 290-5-38-.12	The administration and enforcement of these rules and regulations shall be as prescribed in the "Georgia Administrative Procedure Act," Acts 1964, p. 338, et seq., as amended.
0084 APPLICABILITY OF REGULATIONS 290-5-38-.13	These regulations are applicable only to Home Health Agencies as defined herein and the services they provide, and do not modify or revoke any of the provisions of other published rules of the Department.
0085 SEVERABILITY 290-5-38-.14	In the event that any rule, sentence, clause or phrase of any of these rules and regulations may be construed by any court of competent jurisdiction to be invalid, illegal, unconstitutional or otherwise unenforceable, such determination or adjudication shall in no manner affect the remaining rules or portions thereof and such remaining rules or portions thereof shall remain of full force and effect, as if such rule or portions thereof so determined, declared or adjudged invalid or unconstitutional were not originally a part hereof. It is the intent of the Board of Human Resources to establish rules and regulations that are constitutional and enforceable so as to safeguard the health and well-being of the people of the State.
0900 ENFORCEMENT 290-1-6-.04(a)	The department shall have the authority to impose any one or more of the sanctions enumerated in paragraphs (1) and (2) of Rule .05, Sanctions, upon a finding that an applicant or licensee has: knowingly made any verbal or written false statement of material fact: 1)in connection with the application for a license; 2) on documents submitted to the department as part of any inspection or investigation; or 3) in the falsification or alteration of facility records made or maintained by the facility;
9999 FINAL OBSERVATIONS	

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Fcxkf "C0Eqqm, Commissioner *Pcvjcp"Fgcn, Governor*

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia,gov

HOME HEALTH AGENCY INITIAL MEDICARE CERTIFICATION PACKET

This letter is in response to your request for information about the requirements and procedures through which an agency in Georgia may be approved to participate as a Medicare provider of home health agency (HHA) services. The Health Care Section of the Health Care Facility Regulation Division (HFRD) is contracted by the Centers for Medicare/Medicaid Services (CMS) to perform initial and periodic surveys and to certify whether providers of services meet the HHA Medicare Conditions of Participation. Compliance with HHA Conditions of Participation is a requirement to participate in Medicare. Such Medicare approval, when required, is a prerequisite to qualifying to participate in the State Medicaid program as well.

APPLICATION PROCESS

Medicare Enrollment Requirement

As part of your request to participate in Medicare, you must enroll with the fiscal intermediary (FI). Provider enrollment applications (855 forms) are available for downloading at http://www.cms.hhs.gov/forms along with a user's guide providing instructions for downloading and completing the forms. The provider enrollment application must be submitted directly to Palmetto Government Benefits Administration, the FI assigned to Georgia HHA providers. The contact at the FI is Marlene Frierson, who can be reached at (803) 764-5506. If you require help or assistance in completing the CMS 855 form, contact the FI, not HFR. The FI will notify HFR of its recommendation for approval or denial of enrollment for your agency. HFR cannot conduct the initial Medicare survey until HFRD receives an approval for enrollment for your HHA from the FI.

Enclosed are other CMS forms which you must complete if you desire to participate in the Medicare program. Complete and return the forms promptly to HFR at the address above in order to avoid unnecessarily delaying approval, since your agency cannot claim provider reimbursement for services furnished prior to approval. If the forms are not self-explanatory, you may contact Shunda Dennison at 404-657-1509 for assistance.

Please complete two (2) Health Insurance Benefits Agreements (CMS-1561) with original signatures on both agreements. The Health Insurance Benefits Agreement is your contract with CMS. On the second line of the Health Insurance Benefits Agreement, after the term, Social Security Act, enter the entrepreneurial name of the enterprise, followed by the trade name (if different from the entrepreneurial name). Ordinarily this is the same as the business name used on all official IRS correspondence concerning payroll withholding taxes, such as the W-9 or 941 forms. For example, the ABC Corporation, owner of the Community General Hospital, would enter on the agreement, "ABC Corporation d/b/a Community General Hospital." A partnership of several persons might complete the agreement to read: "Robert Johnson, Louis Miller and Paul Allen, ptr. d/b/a "Easy Care Home Health Services." A sole proprietorship would complete the agreement to read: "John Smith d/b/a Mercy

Hospital." The person signing the Health Insurance Benefits Agreement must be someone who has the authorization of the owners of the HHA to enter into this agreement.

Civil Rights Requirement
CMS is required to obtain information from new providers related to their compliance with civil rights requirements. Included in this packet are two (2) HHS 690 forms, entitled **Assurance of Compliance;** the **Medicare Certification Civil Rights Information Request Form,** along with a list of materials that need to be completed and returned to the HFR along with the rest of the application package. HFR will forward the completed forms to the regional Office for Civil Rights (OCR) for review. In practice, CMS Regional Offices will approve a provider's initial certification pending clearance from OCR. On rare occasions, OCR informs CMS that clearance has been denied or that the required assurances have not been submitted.

Outcome and Assessment Information Set (OASIS) Requirement

CMS requires a licensed home health agency to successfully transmit an OASIS Comprehensive Assessment (at the start-of-care or resumption-of-care) electronically to the state repository before an onsite initial Medicare certification survey is conducted. OASIS data is collected and then encoded and transmitted to the state by computer. To access detailed information about the OASIS requirement, you may visit the federal OASIS Internet Website homepage at
http://www.cms.hhs.gov/oasis
You may contact the OASIS Educational Coordinator in the Healthcare Section, Healthcare Facility Regulation Division.

Laboratory Services
If you anticipate that your agency will be performing any clinical laboratory testing or specimen collection, you need to contact the **Diagnostic Services Unit at (404) 657-5450**. This unit will assist you in determining whether there are additional Federal and State laboratory requirements that your facility will have to meet.

Medicare Survey Process
Before HFR surveyors can conduct an initial Medicare survey to determine whether Medicare Conditions of Participation are met, the HHA must have obtained a state license (see separate packet for licensure instructions), submitted all required *CMS forms to HFR, obtained approval from the FI of their Medicare provider enrollment application, successfully transmitted a test OASIS assessment and be fully operational.*

The HHA must have provided skilled home health services to a minimum of 10 patients before a survey is conducted. At least 7 of the 10 required patients should be receiving care from the HHA at the time of the initial Medicare survey.

At the time your HHA is fully operational and ready for the initial Medicare survey, a request for an initial Medicare survey is required to be made in writing to HFR (See enclosed survey request form). In accordance with CMS policy, all certification surveys will be **UNANNOUNCED**.

At the time of the Medicare survey, it will be determined whether or not your HHA meets the Conditions of Participation for the Medicare program. If you are found to be in full compliance with the Medicare Conditions of Participation, HFRD will *recommend* to CMS that you be certified in the Medicare program, effective the date of the survey.

If deficiencies below the condition level are identified during the course of the survey, you will be given an opportunity to submit an **acceptable plan of correction**. Upon receipt of the acceptable plan of correction, HFR will *recommend* to CMS that your HHA be certified effective the date that you submitted your acceptable plan of correction.

If condition level deficiencies are identified during the course of the survey, HFR will *recommend* to CMS that your application to participate in the Medicare program be **denied**. If CMS accepts this recommendation, CMS will send a notice giving the reasons for denial and informing you of your right to appeal the denial.

The federal conditions of participation for HHAs are available at:

http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html

Issuance of Provider Number

After a determination is made that all requirements for participation in the Medicare program are met, CMS will assign a Medicare provider number. CMS will notify you and your FI, Palmetto Government Benefits Administration, of your assigned provider number. The FI will subsequently contact you with information about submitting reimbursement claims for Medicare services. Your HHA **cannot claim provider reimbursement for services rendered to Medicare patients prior to the effective date of your provider number**.

Change of Ownership:

If operation of the HHA is later transferred to another owner, ownership group, or a lessee, the Medicare agreement will usually be automatically assigned to the successor. (If the new owner does not wish to accept assignment of the Medicare number, the new owner must make a specific request for a new provider number to CMS in writing). You are required to notify CMS through the HFR at the time you plan such a change of ownership. Please note that under state law and regulations, you must notify HFR at least 30 days in advance of any change in ownership.

Enclosures:

1. CMS 1561 – Health Insurance Benefit Agreement (2)
2. CMS 1572 – Home Health Agency Request for Certification in the Medicare Program
3. HHS 690 – Assurance of Compliance/Civil Rights (2)
4. Medicare Certification Civil Rights Information Request Form with attachment list
5. Request for Medicare Survey memo

FORM APPROVED
OMB N0. 0938-0355

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

1. Name of Facility:

11. Provider No.: ☐☐☐☐☐☐

2. Street Address:

12. Type of Survey:

☐ Initial (G2) ☐ Resurvey (G3)

1 = Standard
2 = Partial Extended
3 = Extended
4 = 1 and 2
5 = 1 and 3
6 = 1, 2 and 3

3. City and/or County:

4. State:

5. Zip Code:

6. Telephone No. (G4)

7. State/County Code: (G5)

8. State/Region Code: (G6)

13. Eligibility: (G7)

☐ 1 = Medicare
2 = Medicaid
3 = Both

9. Name of Administrator:

10. Discipline of Administrator: (G8)

☐
1 = RN/LPN
2 = Physician
3 = PT/OT
4 = Speech Path/Audiologist
5 = Medical/License Social Worker
6 = Pub Adm/MBA/ACCT
7 = Lawyer
8 = Proprietor
9 = Other

14. Has there been a change of ownership since last survey? (G9)

☐ Yes ☐ No

15. A. Is this home health agency also a Medicare certified hospice? (G10) ☐ Yes ☐ No

If yes, give the hospice Medicare provider number: (G11) ☐☐☐☐☐☐

B. Does this home health agency operate sub-units? (G12) ☐ Yes ☐ No

If yes, how many: (G13) ☐☐

C. Is this home health agency a sub-unit? (G14) ☐ Yes ☐ No

If yes, parent agency provider number: (G15) ☐☐☐☐☐☐

D. Does this home health agency or sub-unit operate branch(es)? (G16) ☐ Yes ☐ No

If yes, how many: (G17) ☐☐

If yes, give official name and mailing address of each branch (include street, state and zip code):

☐ If more space is needed, check here, use a separate page and attach.

16. Type of Agency: (G18)

☐☐
01 = VNA
02 = Combination Government Voluntary
03 = Official Health Agency
04 = Rehab based program*
05 = Hospital based program*
06 = Skilled Nursing Facility/Nursing Facility based program*
07 = Other

*If Medicare/Medicaid certified give the provider number: (G19)

☐☐☐☐☐☐

17. Type of Control: (G20)

☐☐

Voluntary Non-Profit
01 = Religious Affiliation
02 = Private
03 = Other

For Profit
04 = Proprietary

Government
05 = State/County
06 = Combination Govt. and Voluntary
07 = Local Government

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT
(continued)

18. Services Offered: (G21)
1 = Provided by Agency Staff
2 = Under Arrangement
3 = Combination

☐ 01 = Nursing Care
☐ 02 = Physical Therapy
☐ 03 = Occupational Therapy
☐ 04 = Speech Therapy
☐ 05 = Medical Social Worker
☐ 06 = Home Health Aide
☐ 07 = Intern/Resident
☐ 08 = Nutritional Guidance
☐ 09 = Pharmaceutical Services
☐ 10 = Appliance and Equipment Service
☐ 11 = Vocational Guidance
☐ 12 = Laboratory Services
☐ 13 = Other

19. Staffing (List full-time equivalent):

					•		
Registered Nurse (G22)					•		
Licensed Practical Nurse (G23)					•		
Physical Therapist (G24)					•		
Occupational Therapist (G25)					•		
Speech Pathologist/Audiologist (G26)					•		
Social Worker (G27)					•		
Home Health Aide (G28)					•		
Pharmacist (G29)					•		
Dietitian (G30)					•		
All Others (G31)					•		

20. Home Health Agency provides directly: (G32)

☐ 1 = Home Health aide training program
2 = Home Health aide competency evaluation program
3 = Both
4 = Neither

21. Number records reviewed with home visits (G33) ☐☐
Number records reviewed, no home visits (G34) ☐☐
Number of home visits with no records review (G35) ☐☐
Total records reviewed (G36) ☐☐
Total home visits (G37) ☐☐

22. Patient census since last standard survey:

Admissions:
(G38) _____ Unduplicated admissions
(G39) _____ Readmissions

Discharges
(G40) _____ Hospital discharges
(G41) _____ Nursing home discharges
(G42) _____ Goals met discharges
(G43) _____ Death discharges
(G44) _____ Total discharges

23. Surveyor summary: Based on the reviews of the patients from this home health agency including all information surveyed in the standard survey and using the Functional Assessment Instrument (FAI), this home health agency: (G45)

☐ 1. Provides care that promotes a high potential for reaching the highest attainable levels of functioning for its patients. There is no evidence of need for a partial extended or extended survey.

☐ 2. Provides care that promotes a moderate potential for reaching the highest level of functioning for some but not all of its patients. There are standard level deficiencies and need for a partial extended survey. If no conditions are out of compliance, a Plan of Correction will be requested for the standard level deficiencies.

☐ 3. Provides substandard care. There are condition level deficiencies in one or more Conditions of Participation. There is an immediate need for an extended survey.

O.C.G.A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for a **license, permit or registration**, as referenced in O.C.G.A. § 50-36-1, from the **Department of Community Health, State of Georgia**, the undersigned applicant verifies one of the following with respect to my application for a public benefit:

1) _________ I am a United States citizen.

2) _________ I am a legal permanent resident of the United States.

3) _________ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is:____________________.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as:
____.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in ___________________ (city), __________________(state).

____
Signature of Applicant

____
Printed Name of Applicant

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
___ DAY OF ___________, 20____

____
NOTARY PUBLIC
My Commission Expires:

INSTRUCTIONS FOR COMPLETING AFFIDAVIT REQUIRED TO BECOME LICENSED

In order to obtain a license from the Department of Community Health to operate your business, Georgia law requires every applicant to complete an affidavit (sworn written statement) before a Notary Public that establishes that you are lawfully present in the United States of America. This affidavit is a material part of your application and must be completed truthfully. Your application for licensure may be denied or your license may be revoked by the Department if it determines that you have made a material misstatement of fact in connection with your application to become licensed. If a corporation will be serving as the governing body of the licensed business, the individual who signs the application on behalf of the corporation is required to complete the affidavit. Please follow the instructions listed below.

1. **Review the list of Secure and Verifiable Documents under O.C.G.A. §50-36-2 which follows these instructions. This list contains a number of identification sources to choose from that are considered secure and verifiable that you can use to establish your identity, such as a U.S. driver's license or a U.S. passport. Locate one original document on the list to bring to the Notary Public to establish your identity.**

2. **Print out the affidavit. (If you do not have access to a printer, you can go to your local library or an office supply store to print out the document for a small fee.)**

3. **Fill in the blanks on the Affidavit above the signature line only—BUT DO NOT SIGN THE AFFIDAVIT at this time. (You will sign the affidavit in front of the Notary Public.) Fill in the name of the secure and verifiable document (for example, Georgia driver's license, U.S. passport) that you will be presenting to the Notary Public as proof of your identity. CAUTION: Put your initials in front of only ONE of the choices listed on the affidavit and described here below:**

   - **Option 1) is to be initialed by you if you are a United States citizen; or**
   - **Option 2) is to be initialed by you if you are a legal permanent resident of the United States. You are not a U.S. citizen but you have a green card; or**
   - **Option 3) is to be initialed by you if you are a qualified alien or non-immigrant (but not a U.S. citizen or a legal permanent resident) with an alien number issued by the Department of Homeland Security or other federal immigration agency. Fill in the alien number, as well.**

4. **Find a Notary Public in your area. Check the yellow pages, the internet or with a local business, such as a bank.**

5. **Bring your affidavit and the identification you selected (from the list of Secure and Verifiable Documents) to appear before the Notary Public.**

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G. A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/ind/ex.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Certificate of Citizenship issued by the United Stated Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-08

DATE: **November 12, 2004**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Clarification of Survey Agency Responsibilities in Obtaining Information For Civil Rights Clearances For Initial Certifications And Changes of Ownership (CHOW)

Letter Summary

- The purpose of this letter is to remind state survey agencies (SAs) of their role in the Office for Civil Rights (OCR) clearance process
- SAs are to include the OCR questionnaires and attestation forms with their initial enrollment package that is sent to a new provider or to a provider undergoing a CHOW.
- The role of the SA and the Centers for Medicare & Medicaid Services (CMS) is limited to obtaining the forms for OCR.

Section 2010 of the State Operations Manual (SOM) requires CMS to obtain information from new providers and those who have undergone CHOWs related to their compliance with civil rights requirements. The HHS Office for Civil Rights must make a determination that the provider is in compliance with the Civil Rights Act and other relevant statutes. In practice, CMS Regional Offices (ROs) will approve a provider's initial certification or a CHOW pending clearance from OCR. On rare occasions, OCR informs CMS that clearance has been denied or that the required assurances have not been submitted.

The SOM at section 2010 states: "The SA provides potential providers with required forms for OCR clearance and forwards the completed forms to the RO upon receipt."

- SAs are to include the OCR questionnaires and attestation forms with their initial enrollment package that is sent to a new provider or to a provider undergoing a CHOW.
- Completed forms must be returned by the provider to the SA with the rest of the application package.

- SAs should ascertain that completed OCR forms are included in the package before forwarding it to their CMS RO.
- If the provider does not include the OCR forms, inform the provider that the application will not be forwarded to CMS until the forms have been completed and returned to the SA.

Upon receipt of the OCR forms, the CMS RO forwards them to the Office for Civil Rights for processing and clearance. **The role of the SA and CMS is limited to obtaining the forms for OCR.**

Copies of the current version of the OCR forms are included with this transmittal. Effective immediately, SAs must include these forms with their initial certification and CHOW packages. Questions concerning the forms should be referred to your regional HHS Office for Civil Rights.

Effective Date: Immediately. The state agency should disseminate this information within 30 days of the date of this letter.

Training: The information contained in this announcement should be shared with all survey and certification staff and with managers who have responsibility for processing initial Medicare certifications and CHOW.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachments

Office for Civil Rights

Medicare Certification

Nondiscrimination Policies and Notices

Please note that documents in PDF format require Adobe's Acrobat Reader.

The regulations implementing Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 require health and human service providers that receive Federal financial assistance from the Department of Health and Human Services to provide notice to patients/residents, employees, and others of the availability of programs and services to all persons without regard to race, color, national origin, disability, or age.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.6(d) Information to beneficiaries and participants. Each recipient shall make available to participants, beneficiaries, and other interested persons such information regarding the provisions of this regulation and its applicability to the program for which the recipient receives Federal financial assistance, and make such information available to them in such manner, as the responsible Department official finds necessary to apprise such persons of the protections against discrimination assured them by the Act and this regulation.

Go to 45 CFR Part 80 for the full regulation.

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§ 84.8 Notice. (a) A recipient that employs fifteen or more persons shall take appropriate initial and continuing steps to notify participants, beneficiaries, applicants, and employees, including those with impaired vision or hearing, and unions or professional organizations holding collective bargaining or professional agreements with the recipient that it does not discriminate on the basis of handicap in violation of section 504 and this part. The notification shall state, where appropriate, that the recipient does not discriminate in admission or access to, or treatment or employment in, its programs and activities. The notification shall also include an identification of the responsible employee designated pursuant to **§**84.7(a). A recipient shall make the initial notification required by this paragraph within 90 days of the effective date of this part. Methods of initial and continuing notification may include the posting of notices, publication in newspapers and magazines, placement of notices in

recipients' publication, and distribution of memoranda or other written communications.

(b) If a recipient publishes or uses recruitment materials or publications containing general information that it makes available to participants, beneficiaries, applicants, or employees, it shall include in those materials or publications a statement of the policy described in paragraph (a) of this section. A recipient may meet the requirement of this paragraph either by including appropriate inserts in existing materials and publications or by revising and reprinting the materials and publications.

Go to 45 CFR Part 84 for the full regulation.

Age Discrimination Act: 45 CFR Part 91

§ 91.32 Notice to subrecipients and beneficiaries. (b) Each recipient shall make necessary information about the Act and these regulations available to its program beneficiaries in order to inform them about the protections against discrimination provided by the Act and these regulations.

Go to 45 CFR Part 91 for the full regulation.

Policy Examples

Example One (for posting in the facility and inserting in advertising or admissions packages):

NONDISCRIMINATION POLICY

As a recipient of Federal financial assistance, (insert name of provider) does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by (insert name of provider) directly or through a contractor or any other entity with which (insert name of provider) arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Provider Name:

Contact Person/Section 504 Coordinator:

Telephone number:

TDD or State Relay number:

Example Two (for use in brochures, pamphlets, publications, etc.):

(Insert name of provider) does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: (insert name of Section 504 Coordinator, phone number, TDD/State Relay).

Medicare Certification

Communication with Persons Who Are Limited English Proficient

Please note that documents in PDF format require Adobe's Acrobat Reader.

In certain circumstances, the failure to ensure that Limited English Proficient (LEP) persons can effectively participate in, or benefit from, federally-assisted programs and activities may violate the prohibition under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, and the Title VI regulations against national origin discrimination. Specifically, the failure of a recipient of Federal financial assistance from HHS to take reasonable steps to provide LEP persons with a meaningful opportunity to participate in HHS-funded programs may constitute a violation of Title VI and HHS's implementing regulations. It is therefore important for recipients of Federal financial assistance, including Part A Medicare providers, to understand and be familiar with the requirements.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.3 Discrimination prohibited.

(a) General. No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies.
(b) Specific discriminatory actions prohibited. (1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, color, or national origin:

(i) Deny an individual any service, financial aid, or other benefit under the program;
(ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program;
(iii) Subject an individual to segregation or separate treatment in any matter related to his receipt of any service, financial aid, or other benefit under the program;
(iv) Restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program;
(v) Treat an individual differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service, financial aid, or other benefit provided under the program;
(vi) Deny an individual an opportunity to participate in the program through the provision of services or otherwise or afford him an opportunity to do so which is different from that afforded others under the program (including the opportunity to participate in the program as

an employee but only to the extent set forth in paragraph (c) of this section).
(vii) Deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

(2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program, or the class of individuals to whom, or the situations in which, such services, financial aid, other benefits, or facilities will be provided under any such program, or the class of individuals to be afforded an opportunity to participate in any such program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.

Go to 45 CFR Part 80 for the full regulation.

Resources

For further guidance on the obligation to take reasonable steps to provide meaningful access to LEP persons, see HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at http://www.hhs.gov/ocr/lep/. This guidance is also available at http://www.lep.gov/, along with other helpful information pertaining to language services for LEP persons.

"I Speak" Language Identification Flashcard (PDF) From the Department of Commerce, Bureau of the Census, the "I Speak" Language Identification Flashcard is written in 38 languages and can be used to identify the language spoken by an individual accessing services provided by federally assisted programs or activities.

Technical Assistance for Medicare and Medicare+Choice organizations from the Centers for Medicare and Medicaid for Designing, Conducting, and Implementing the 2003 National Quality Assessment and Performance Improvement (QAPI) Program Project on Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services-
http://www.cms.hhs.gov/healthplans/quality/project03.asp

Examples of Vital Written Materials

Vital written materials could include, for example:

- Consent and complaint forms.
- Intake forms with the potential for important consequences.
- Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings.

- Notices advising LEP persons of free language assistance.
- Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required.
- Applications to participate in a recipient's program or activity or to receive recipient benefits or services.

Nonvital written materials could include:

- Hospital menus.
- Third party documents, forms, or pamphlets distributed by a recipient as a public service.
- For a non-governmental recipient, government documents and forms.
- Large documents such as enrollment handbooks (although vital information contained in large documents may need to be translated).
- General information about the program intended for informational purposes only.

Medicare Certification

Auxiliary Aids and Services for Persons With Disabilities

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§84.3 Definitions

(h) Federal financial assistance – means any grant, loan … or any other arrangement by which [DHHS] makes available … funds; services …

(j) Handicapped person – means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

(k) Qualified handicapped person means - (4) With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.

§84.4 Discrimination prohibited

(1) General. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

Discriminatory actions prohibited –

(1) A recipient, in providing any aid, benefits, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded other;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any

class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit, or service to beneficiaries of the recipients program;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

Subpart F – Health, Welfare and Social Services

§84.51 Application of this subpart

Subpart F applies to health, welfare, or other social service programs and activities that receive or benefit from Federal financial assistance …

§84.52 Health, welfare, and other social services.

(a) *General.* In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap:

(1) Deny a qualified handicapped person these benefits or services;

(2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered non-handicapped persons;

(3) Provide a qualified handicapped person with benefits or services that are not as effective (as defined in **§** 84.4(b)) as the benefits or services provided to others;

(4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or

(5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

(b) Notice. A recipient that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified handicapped persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their handicap.

(c) ***Auxiliary aids.*** (1) A recipient with fifteen or more employees "shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such person an equal opportunity to benefit from the service in question." (2) Pursuant to the Department's discretion, recipients with fewer than fifteen employees may be required "to provide auxiliary aids where the provision of aids would not significantly impair the ability of the recipient to provide its benefits or services." (3) "Auxiliary aids may include brailed and taped material, interpreters, and other aids for persons with impaired hearing or vision."

Go to 45 CFR Part 84 for the full regulation.

504 Notice

The regulation implementing Section 504 requires that an agency/facility "that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified disabled persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their disability." **(45 CFR §84.52(b))**

Note that it is necessary to note each area of the consent, such as:

1. Medical Consent

2. Authorization to Disclose Medical Information

3. Personal Valuables

4. Financial Agreement

5. Assignment of Insurance Benefits

6. Medicare Patient Certification and Payment Request

Resources:

U.S. Department of Justice Document:

ADA Business Brief: Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings

ADA Document Portal
A new on-line library of ADA documents is now available on the Internet. Developed by Meeting the Challenge, Inc., of Colorado Springs with funding from the National Institute on Disability and Rehabilitation Research, this website makes available more than 3,400 documents related to the ADA, including those issued by Federal agencies with responsibilities

under the law. It also offers extensive document collections on other disability rights laws and issues. By clicking on one of the general categories in the left column, for example, you will go to a catalogue of documents that are specific to the topic.

Medicare Certification

Requirements for Facilities with 15 or More Employees

Please note that documents in PDF format require Adobe's Acrobat Reader.

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973:

45 CFR Part 84§84.7 Designation of responsible employee and adoption of grievance procedures.

(a) *Designation of responsible employee.* A recipient that employs fifteen or more persons shall designate at least one person to coordinate its efforts to comply with this part.

(b) *Adoption of grievance procedures.* A recipient that employs fifteen or more persons shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of complaints alleging any action prohibited by this part. Such procedures need not be established with respect to complaints from applicants for employment or from applicants for admission to postsecondary educational institutions.

Go to 45 CFR Part 84 for the full regulation.

Policy Example

The following procedure incorporates appropriate minimum due process standards and may serve as a model or be adapted for use by recipients in accordance with the Departmental regulation implementing Section 504 of the Rehabilitation Act of 1973.

SECTION 504 GRIEVANCE PROCEDURE

It is the policy of (**insert name of facility/agency**) not to discriminate on the basis of disability. (**Insert name of facility/agency**) has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 states, in part, that "no otherwise qualified handicapped individual...shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance..." The Law and Regulations may be examined in the office of (**insert name, title, tel. no. of Section 504 Coordinator**), who has been designated to coordinate the efforts of (**insert name of facility/agency**) to comply with Section 504.

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for (**insert name of facility/agency**) to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 504 Coordinator within (**insert time frame**) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of (**insert name of facility/agency**)

relating to such grievances.

- The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.
- The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the (**Administrator/Chief Executive Officer/Board of Directors/etc.**) within 15 days of receiving the Section 504 Coordinator's decision.
- The (**Administrator/Chief Executive Officer/Board of Directors/etc.**) shall issue a written decision in response to the appeal no later than 30 days after its filing.
- The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

(**Insert name of facility/agency**) will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

Medicare Certification

Age Discrimination Act Requirements

Please note that documents in PDF format require Adobe's Acrobat Reader.

The Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS) has the responsibility for the Age Discrimination Act as it applies to Federally funded health and human services programs. The general regulation implementing the Age Discrimination Act requires that age discrimination complaints be referred to a mediation agency to attempt a voluntary settlement within sixty **(60)** days. If mediation is not successful, the complaint is returned to the responsible Federal agency, in this case the Office for Civil Rights, for action. OCR next attempts to resolve the complaint through informal procedures. If these fail, a formal investigation is conducted. When a violation is found and OCR cannot negotiate voluntary compliance, enforcement action may be taken against the recipient institution or agency that violated the law.

The Age Discrimination Act permits certain exceptions to the prohibition against discrimination based on age. These exceptions recognize that some age distinctions in programs may be necessary to the normal operation of a program or activity or to the achievement of any statutory objective expressly stated in a Federal, State, or local statute adopted by an elected legislative body.

Applicable Regulatory Citations:

45 CFR Part 91: Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance From HHS

§ 91.3 To what programs do these regulations apply?

(a) The Act and these regulations apply to each HHS recipient and to each program or activity operated by the recipient which receives or benefits from Federal financial assistance provided by HHS.
(b) The Act and these regulations do not apply to:
(1) An age distinction contained in that part of a Federal, State, or local statute or ordinance adopted by an elected, general purpose legislative body which:
(i) Provides any benefits or assistance to persons based on age; or
(ii) Establishes criteria for participation in age-related terms; or
(iii) Describes intended beneficiaries or target groups in age-related terms.

Subpart B-Standards for Determining Age Discrimination

§ 91.11 Rule against age discrimination.

The rules stated in this section are limited by the exceptions contained in §§91.13 and 91.14 of these regulations.

(a) General rule: No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.
(b) Specific rules: A recipient may not, in any program or activity receiving Federal financial assistance, directly or through contractual licensing, or other arrangements, use age distinctions or take any other actions which have the effect, on the basis of age, of:
(1) Excluding individuals from, denying them the benefits of, or subjecting them to discrimination under, a program or activity receiving Federal financial assistance.
(2) Denying or limiting individuals in their opportunity to participate in any program or activity receiving Federal financial assistance.
(c) The specific forms of age discrimination listed in paragraph (b) of this section do not necessarily constitute a complete list.

§ 91.13 Exceptions to the rules against age discrimination: Normal operation or statutory objective of any program or activity.

A recipient is permitted to take an action, otherwise prohibited by § 91.11, if the action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity. An action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity, if:

(a) Age is used as a measure or approximation of one or more other characteristics; and
(b) The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and
(c) The other characteristic(s) can be reasonably measured or approximated by the use of age; and
(d) The other characteristic(s) are impractical to measure directly on an individual basis.

§ 91.14 Exceptions to the rules against age discrimination: Reasonable factors other than age.

A recipient is permitted to take an action otherwise prohibited by § 91.11 which is based on a factor other than age, even though that action may have a disproportionate effect on persons of different ages. An action may be based on a factor other than age only if the factor bears a direct and substantial relationship to the normal operation of the program or activity or to the achievement of a statutory objective.

§ 91.15 Burden of proof.

The burden of proving that an age distinction or other action falls within the exceptions

outlined in §§ 91.13 and 91.14 is on the recipient of Federal financial assistance.

For the full regulation, go to 45 CFR Part 91.

OMB Number: 0990-0243
Expiration Date: 06/30/2007

Medicare Certification Civil Rights Information Request Form

Please return the completed, signed Civil Rights Information Request form and the required attachments with your other Medicare Provider Application Materials.

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THE FACILITY:

a. **CMS Medicare Provider Number:**________________________________

b. **Name and Address of Facility:** __________________________________

____

____

c. **Administrator's Name** ____

d. **Contact Person** ____
(If different from Administrator)

e. **Telephone** _____________________ **TDD** _________________________

f. **E-mail** _________________________ **FAX** ________________________

g. **Type of Facility** ____
(e.g., Home Health Agency, Hospital, Skilled Nursing Facility, etc.)

h. **Number of employees:** _______________

i. **Corporate Affiliation** ______________________________________ (if the facility is now or will be owned and operated by a corporate chain or multi-site business entity, identify the entity.)

j. **Reason for Application** ____
(Initial Medicare Certification, change of ownership, etc.)

PLEASE RETURN THE FOLLOWING MATERIALS WITH THIS FORM.

To ensure accuracy, please consult the technical assistance materials (www.hhs.gov/ocr/crclearance.html) **in developing your responses.**

<table>
<tr><th>√</th><th>No.</th><th>REQUIRED ATTACHMENTS</th></tr>
<tr><td></td><td>1.</td><td>Two original signed copies of the form HHS-690, Assurance of Compliance (www.hhs.gov/ocr/ps690.pdf).
A copy should be kept by your facility.</td></tr>
<tr><td colspan="3">Nondiscrimination Policies and Notices
Please see Nondiscrimination Policies and Notices (www.hhs.gov/ocr/nondiscriminpol.html) for the regulations and technical assistance.</td></tr>
<tr><td></td><td>2.</td><td>A copy of your written notice(s) of nondiscrimination, that provide for admission and services without regard to race, color, national origin, disability, or age, as required by Federal law. Generally, an EEO policy is not sufficient to address admission and services.</td></tr>
<tr><td></td><td>3.</td><td>A description of the methods used by your facility to disseminate your nondiscrimination notice(s) or policy. If published, also identify the extent to which and to whom such policies/notices are published (e.g., general public, employees, patients/residents, community organizations, and referral sources) consistent with requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.</td></tr>
<tr><td></td><td>4.</td><td>Copies of brochures or newspaper articles. If publication is one of the methods used to disseminate the policies/notices, these copies must be attached.</td></tr>
<tr><td></td><td>5.</td><td>A copy of facility admissions policy or policies.</td></tr>
<tr><td colspan="3">Communication with Persons Who Are Limited English Proficient (LEP)
Please see Communication with Persons Who Are Limited English Proficient (LEP) (www.hhs.gov/ocr/commune.html) for technical assistance. For information on the obligation to take reasonable steps to provide meaningful access to LEP persons, including guidance on what constitutes vital written materials, and HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at www.hhs.gov/ocr/lep . This guidance is also available at http://www.lep.gov/ , along with other helpful information pertaining to language services for LEP persons.</td></tr>
<tr><td></td><td>6.</td><td>A description (or copy) of procedures used by your facility to effectively communicate with persons who have limited English proficiency, including:
1. How you identify individuals who are LEP and in need of language assistance.
2. How language assistance measures are provided (for both oral and written communication) to persons who are LEP, consistent with Title VI requirements.
3. How LEP persons are informed that language assistance services are available.</td></tr>
<tr><td></td><td>7.</td><td>A list of all vital written materials provided by your facility, and the languages for which they are available. Examples of such materials may include consent and complaint forms; intake forms with the potential for important consequences; written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services; applications to participate in a recipient's program or activity or to receive recipient benefits or service; and notices advising LEP persons of free language assistance.</td></tr>
</table>

√	No.	REQUIRED ATTACHMENTS
Auxiliary Aids and Services for Persons with Disabilities Please see Auxiliary Aids and Services for Persons with Disabilities (www.hhs.gov/ocr/auxaids.html) for technical assistance.		
	8.	A description (or copy) of the procedures used to communicate effectively with individuals who are deaf, hearing impaired, blind, visually impaired or who have impaired sensory, manual or speaking skills, including: 1. *How you identify such persons and how you determine whether interpreters or other assistive services are needed.* 2. *Methods of providing interpreter and other services during all hours of operation as necessary for effective communication with such persons.* 3. *A list of available auxiliary aids and services, and how persons are informed that interpreters or other assistive services are available.* 4. *The procedures used to communicate with deaf or hearing impaired persons over the telephone, including TTY/TDD or access to your State Relay System, and the telephone number of your TTY/TDD or your State Relay System.*
	9.	Procedures used by your facility to disseminate information to patients/residents and potential patients/residents about the existence and location of services and facilities that are accessible to persons with disabilities.
Requirements for Facilities with 15 or More Employees Please see Requirements for Facilities with 15 or More Employees (www.hhs.gov/ocr/reqfacilities.html) for technical assistance.		
	10.	For recipients with 15 or more employees: the name/title and telephone number of the Section 504 coordinator.
	11.	For recipients with 15 or more employees: A copy or description of your facility's procedure for handling disability discrimination grievances.
Age Discrimination Act Requirements Please see Age Discrimination Act Requirements (www.hhs.gov/ocr/agediscrim.html) for technical assistance, and for information on permitted exceptions.		
	12.	A description or copy of any policy (ies) or practice(s) restricting or limiting admissions or services provided by your facility on the basis of age. *If such a policy or practice exists, please submit an explanation of any exception/exemption that may apply. In certain narrowly defined circumstances, age restrictions are permitted.*

After review, an authorized official must sign and date the certification below. Please ensure that complete responses to all information/data requests are provided. Failure to provide the information/data requested may delay your facility's certification for funding.

***Certification*: I certify that the information provided to the Office for Civil Rights is true and correct to the best of my knowledge.**

Signature of Authorized Official: ________________________________

Title of Authorized Official: ____

Date: _________________

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

____________ Date

______________________________ Signature and Title of Authorized Official

______________________________ Name of Applicant or Recipient

______________________________ Street

______________________________ City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

FORM APPROVED
OMB No. 0938-0832

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between
THE SECRETARY OF HEALTH AND HUMAN SERVICES
and

____

doing business as (D/B/A) ________________________

In order to receive payment under title XVIII of the Social Security Act, ________________________________

D/B/A ____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name ________________________ Title ________________________

Date ________________________

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0832. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

HOME HEALTH AGENCY FEDERAL RULES AND INTERPRETIVE GUIDELINES, V10.03

TAGS	RULES	INTERPRETIVE GUIDELINES
0000 INITIAL COMMENTS		
0101 PATIENT RIGHTS 484.10	The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights.	The HHA has a responsibility to inform the patient of his or her rights. Patient rights should be explained to ALL patients admitted to the HHA. However, HHAs treat patients whose physical, mental, and emotional status varies widely. Overall, there should be evidence that the HHA has conscientiously tried, within the constraints of the individual situation, to inform the patient in writing, and orally (§484.10(e)), of his/her rights. If in a particular situation the HHA determines that the patient, despite the HHA's best efforts, is unable to understand these rights, a notation describing the circumstances should be placed in the patient's clinical record. The notation should be consistent with the patient's diagnosis, general state of physical or mental health and/or other recorded clinical information, environmental information, or observations. Question clear patterns of seemingly routine notations that patients could not understand their rights. During home visits, ask patients if the HHA informed them of their rights, and, if so, how. They should be able to give, in their own words, examples of how the rights apply to the HHA care being received and any concerns they have about financial implications of the items or services being received. They should also be able to explain how to access information, services, and the HHA hotline. If the patient is vague in answering questions, ask for written information about his or her rights that the HHA may have given him or her as resource material. Reviewing the written statement with the patient during the home visit may help the patient remember the HHA's patient rights instructions.

TAGS	RULES	INTERPRETIVE GUIDELINES
0102 NOTICE OF RIGHTS 484.10(a)(1)	The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment.	Look for notations in the stratified sample of clinical records selected for review that a statement of the patient's rights has been given to the patient by the HHA staff prior to care being initiated. This written notice must have been provided during admission, the patient's initial evaluation visit or the patient's first professional visit. The documentation maintained by an HHA to show that the patient was informed of the patient's rights might include a patient rights statement, signed and dated by the patient or some other documentation consistent with the HHA's policies and procedures. If a home visit is made, the verification could also include a conversation with the patient and any material on patient rights that the patient has received from the HHA. A notation in the clinical record might also include a statement regarding any limitations the patient had in being able to understand the information. PROBE: How do HHA employees, and staff used by the HHA under an arrangement or contract, implement HHA procedures for informing patients of their rights?
0103 NOTICE OF RIGHTS 484.10(a)(2)	The HHA must maintain documentation showing that it has complied with the requirements of this section.	Look for notations in the stratified sample of clinical records selected for review that a statement of the patient's rights has been given to the patient by the HHA staff prior to care being initiated. This written notice must have been provided during admission, the patient's initial evaluation visit or the patient's first professional visit. The documentation maintained by an HHA to show that the patient was informed of the patient's rights might include a patient rights statement, signed and dated by the patient or some other documentation consistent with the HHA's policies and procedures. If a home visit is made, the verification could also include a conversation with the patient and any material on patient rights that the patient has received from the HHA. A notation in the clinical record might also include a statement regarding any limitations the patient had in being able to understand the information. PROBE: How do HHA employees, and staff used by the HHA under an arrangement or contract, implement HHA procedures for informing patients of their rights?
0104 EXERCISE OF RIGHTS AND RESPECT FOR PROP 484.10(b)(1)&(2)	The patient has the right to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent.	
0105 EXERCISE OF RIGHTS AND RESPECT FOR PROP 484.10(b)(3)	The patient has the right to have his or her property treated with respect.	

TAGS	RULES	INTERPRETIVE GUIDELINES
0106 EXERCISE OF RIGHTS AND RESPECT FOR PROP 484.10(b)(4)	The patient has the right to voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.	During home visits, ask the patient, the patients's family or guardian if they have any comments or concerns, or have registered any grievances or complaints about the HHA or its services. Also, note any patient-described problems recorded in the clinical records during your stratified sample clinical record review. Review the agency's compliance with its statedprocedures for grievance/complaint investigations and resolution. If resolution of the problem was not possible, the actions that were attempted and the outcomes should be documented by the HHA. PROBES: 1- How does the HHA receive, record, investigate, and resolve patient grievances and complaints? 2- Who in the HHA is ultimately accountable for receiving and resolving any patient concerns or problems that cannot be resolved at the staff level? 3- During home visits, ask patients how they would express a grievance or problem should one occur. If one had already occurred, ask how it was handled and what were the results or outcomes.
0107 EXERCISE OF RIGHTS AND RESPECT FOR PROP 484.10(b)(5)	The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.	During home visits, ask the patient, the patients's family or guardian if they have any comments or concerns, or have registered any grievances or complaints about the HHA or its services. Also, note any patient-described problems recorded in the clinical records during your stratified sample clinical record review. Review the agency's compliance with its stated procedures for grievance/complaint investigations and resolution. If resolution of the problem was not possible, the actions that were attempted and the outcomes should be documented by the HHA. PROBES: 1- How does the HHA receive, record, investigate, and resolve patient grievances and complaints? 2- Who in the HHA is ultimately accountable for receiving and resolving any patient concerns or problems that cannot be resolved at the staff level? 3- During home visits, ask patients how they would express a grievance or problem should one occur. If one had already occurred, ask how it was handled and what were the results or outcomes.

TAGS	RULES	INTERPRETIVE GUIDELINES
0108 RIGHT TO BE INFORMED AND PARTICIPATE 484.10(c)(1)	The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished. The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made.	During home visits, discuss the services that the patient is receiving specific to the medical plan of care. Determine if the patient response shows that the HHA has offered specific instructions in areas mentioned in the standard. For example, if the patient is recovering from a fractured hip and has been receiving physical therapy services for several weeks, ask the patient to show or explain to you what exercises he or she has been doing, how often they are to be done and what results are anticipated. Also, ask how often the physical therapist comes, when the therapist is expected next, and how plans for therapy have changed as the condition has changed. If the patient responds that he/she has written instructions telling him or her what to do, request to see them. Ask the patient how he or she participated in developing the plan of care to be furnished by the HHA and when he/she was told about changes in the plan of care. The HHA may discuss changes with the patient by telephone prior to the HHA visit or at the time of the visit, but the patient should feel that he or she has time to consider the implications of the change(s) and concur or object to them prior to implementation. Advance directives generally refer to written statements, completed in advance of a serious illness, about how an individual wants medical decisions made. The two most common forms of advance directives are a living will and a durable medical power of attorney for health care. Section 1866(a)(1)(Q), as implemented by 42 CFR 484.10(c)(2)(ii), requires HHAs to maintain written policies and procedures regarding advance directives. The specific requirements HHAs must meet with respect to advance directives are set forth at 42 CFR 489, Subpart I. Under these provisions, the HHA must: 1) provide all adult individuals with written information about their rights under State law to: (a) make decisions about their medical care; (b) accept or refuse medical or surgical treatment; and (c) formulate, at the individual's option, an advanced directive; 2) inform patients about the HHA's written policies on implementing advance directives; 3) document in the patient's medical record whether he or she has executed an advanced directive; 4) not condition the provision of care or otherwise discriminate against an individual based on whether he or she has executed an advanced directive; 5) ensure compliance with the related State requirements on advanced directives; and 6) provide staff and community education on issues concerning advanced directives. This information must be furnished in advance of the individual coming under the care of the HHA and may be provided during admission, the patient's initial evaluation, or the patient's first professional visit. PROBES: 1- What documentation in the clinical records indicates that the HHA advised the patient, in advance, of his or her right to participate in planning the care or treatment to be provided? What documentation indicates that the

TAGS	RULES	INTERPRETIVE GUIDELINES
0109 RIGHT TO BE INFORMED AND PARTICIPATE 484.10(c)(2)	The patient has the right to participate in the planning of the care. The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.	During home visits, discuss the services that the patient is receiving specific to the medical plan of care. Determine if the patient response shows that the HHA has offered specific instructions in areas mentioned in the standard. For example, if the patient is recovering from a fractured hip and has been receiving physical therapy services for several weeks, ask the patient to show or explain to you what exercises he or she has been doing, how often they are to be done and what results are anticipated. Also, ask how often the physical therapist comes, when the therapist is expected next, and how plans for therapy have changed as the condition has changed. If the patient responds that he/she has written instructions telling him or her what to do, request to see them. Ask the patient how he or she participated in developing the plan of care to be furnished by the HHA and when he/she was told about changes in the plan of care. The HHA may discuss changes with the patient by telephone prior to the HHA visit or at the time of the visit, but the patient should feel that he or she has time to consider the implications of the change(s) and concur or object to them prior to implementation. Advance directives generally refer to written statements, completed in advance of a serious illness, about how an individual wants medical decisions made. The two most common forms of advance directives are a living will and a durable medical power of attorney for health care. Section 1866(a)(1)(Q), as implemented by 42 CFR 484.10(c)(2)(ii), requires HHAs to maintain written policies and procedures regarding advance directives. The specific requirements HHAs must meet with respect to advance directives are set forth at 42 CFR 489, Subpart I. Under these provisions, the HHA must: 1) provide all adult individuals with written information about their rights under State law to: (a) make decisions about their medical care; (b) accept or refuse medical or surgical treatment; and (c) formulate, at the individual's option an advance directive; 2) inform patients about the HHA's written policies on implementing advance directives; 3) document in the patient's medical record whether he or she has executed an advance directive; 4) not condition the provision of care or otherwise discriminate against an individual based on whether he or she has executed an advance directive; 5) ensure compliance with the related State requirements on advance directives; and 6) provide staff and community education on issues concerning advance directives. This information must be furnished in advance of the individual coming under the care of the HHA and may be provided during admission, the patient's initial evaluation, or the patient's first professional visit. PROBES: 1- What documentation in the clinical records indicates that the HHA advised the patient, in advance, of his or her right to participate in planning the care or treatment to be provided? What documentation indicates that the HHA informed the patient about the types of services to be provided, the disciplines involved, the frequency of the services and the anticipatedoutcomes? 2- How does the HHA inform the patient about changes

TAGS	RULES	INTERPRETIVE GUIDELINES
0110 RIGHT TO BE INFORMED AND PARTICIPATE 484.10(c)(2)(ii)	The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.	During home visits, discuss the services that the patient is receiving specific to the medical plan of care. Determine if the patient response shows that the HHA has offered specific instructions in areas mentioned in the standard. For example, if the patient is recovering from a fractured hip and has been receiving physical therapy services for several weeks, ask the patient to show or explain to you what exercises he or she has been doing, how often they are to be done and what results are anticipated. Also, ask how often the physical therapist comes, when the therapist is expected next, and how plans for therapy have changed as the condition has changed. If the patient responds that he/she has written instructions telling him or her what to do, request to see them. Ask the patient how he or she participated in developing the plan of care to be furnished by the HHA and when he/she was told about changes in the plan of care. The HHA may discuss changes with the patient by telephone prior to the HHA visit or at the time of the visit, but the patient should feel that he or she has time to consider the implications of the change(s) and concur or object to them prior to implementation. Advance directives generally refer to written statements, completed in advance of a serious illness, about how an individual wants medical decisions made. The two most common forms of advance directives are a living will and a durable medical power of attorney for health care. Section 1866(a)(1)(Q), as implemented by 42 CFR 484.10(c)(2)(ii), requires HHAs to maintain written policies and procedures regarding advance directives. The specific requirements HHAs must meet with respect to advance directives are set forth at 42 CFR 489, Subpart I. Under these provisions, the HHA must: 1) provide all adult individuals with written information about their rights under State law to: (a) make decisions about their medical care; (b) accept or refuse medical or surgical treatment; and (c) formulate, at the individual's option an advance directive; 2) inform patients about the HHA's written policies on implementing advance directives; 3) document in the patient's medical record whether he or she has executed an advance directive; 4) not condition the provision of care or otherwise discriminate against an individual based on whether he or she has executed an advance directive; 5) ensure compliance with the related State requirements on advance directives; and 6) provide staff and community education on issues concerning advance directives. This information must be furnished in advance of the individual coming under the care of the HHA and may be provided during admission, the patient's initial evaluation, or the patient's first professional visit. PROBES: 1- What documentation in the clinical records indicates that the HHA advised the patient, in advance, of his or her right to participate in planning the care or treatment to be provided? What documentation indicates that the HHA informed the patient about the types of services to be provided, the disciplines involved, the frequency of the services and the anticipated outcomes? 2- How does the HHA inform the patient about changes

TAGS	RULES	INTERPRETIVE GUIDELINES
0111 CONFIDENTIALITY OF MEDICAL RECORDS 484.10(d)	The patient has the right to confidentiality of the clinical records maintained by the HHA.	PROBES: 1- How does the HHA ensure the confidentiality of the patient's clinical record? 2- If the HHA leaves a portion of the clinical record in the home (such as in some high-technology situations when frequent clinical entries are important), how does the HHA instruct the patient or caretaker about protecting the confidentiality of the record? 3- What documentation in the clinical record indicates that the HHA informed the patient of the HHA's policies and procedures concerning clinical record disclosure?
0112 CONFIDENTIALITY OF MEDICAL RECORDS 484.10(d)	The HHA must advise the patient of the agency's policies and procedures regarding disclosure of clinical records.	PROBES: 1- How does the HHA ensure the confidentiality of the patient's clinical record? 2- If the HHA leaves a portion of the clinical record in the home (such as in some high-technology situations when frequent clinical entries are important), how does the HHA instruct the patient or caretaker about protecting the confidentiality of the record? 3- What documentation in the clinical record indicates that the HHA informed the patient of the HHA's policies and procedures concerning clinical record disclosure?

TAGS	RULES	INTERPRETIVE GUIDELINES
0113 PATIENT LIABILITY FOR PAYMENT 484.10(e)(1)	The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient.	During home visits, ask the patient whether the HHA has notified him or her of covered and noncovered services. Also, discuss whether the HHA has described any services for which the patient might have to pay and how payment sources might change (or have changed) during the course of care. Changes in any prior payment information given to the patient should have been given to the patient, orally and in writing, no later than 30 calendar days from the date the HHA became aware of the change. Again, consider the patient's ability to understand and retain payment information. The subject of payment for home care services is often complex and confusing, particularly early in the course of treatment when the patient's illness or limitations appears to be the more pressing problem. Look for a written statement in the home that might serve as a resource or reminder to the patient about the information the HHA has presented. Also, note whether there are subsequent written statements about payments for items or services of which the HHA has become aware. In your evaluation of compliance with this standard, consider whether the HHA is making a reasonable attempt to help the patient understand how the charges for HHA services will be covered or not covered over the course of treatment. Based on the information provided by the HHA, do you believe that the patient has a reasonable understanding of how payment for home care services will likely occur and can make reasonable, informed decisions about financial matters related to the HHA's care and treatment of him or her. Do NOT try to explain to or advise the patient about financial, coverage, or payment issues. PROBES: 1. What process is followed by the HHA to inform the patient of home care charges and probable payment sources, patient's payment liability (if any), and of changes in payment sources and patient liabilities? 2. What documentation in the clinical record indicates that the HHA informed the patient of Federally-funded or aided covered and noncovered services?

TAGS	RULES	INTERPRETIVE GUIDELINES
0114 PATIENT LIABILITY FOR PAYMENT 484.10(e)(1(i-iii)	Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay.	During home visits, ask the patient whether the HHA has notified him or her of covered and noncovered services. Also, discuss whether the HHA has described any services for which the patient might have to pay and how payment sources might change (or have changed) during the course of care. Changes in any prior payment information given to the patient should have been given to the patient, orally and in writing, no later than 30 calendar days from the date the HHA became aware of the change. Again, consider the patient's ability to understand and retain payment information. The subject of payment for home care services is often complex and confusing, particularly early in the course of treatment when the patient's illness or limitations appears to be the more pressing problem. Look for a written statement in the home that might serve as a resource or reminder to the patient about the information the HHA has presented. Also, note whether there are subsequent written statements about payments for items or services of which the HHA has become aware. In your evaluation of compliance with this standard, consider whether the HHA is making a reasonable attempt to help the patient understand how the charges for HHA services will be covered or not covered over the course of treatment. Based on the information provided by the HHA, do you believe that the patient has a reasonable understanding of how payment for home care services will likely occur and can make reasonable, informed decisions about financial matters related to the HHA's care and treatment of him or her. Do NOT try to explain to or advise the patient about financial, coverage, or payment issues. PROBES: 1. What process is followed by the HHA to inform the patient of home care charges and probable payment sources, patient's payment liability (if any), and of changes in payment sources and patient liabilities? 2. What documentation in the clinical record indicates that the HHA informed the patient of Federally-funded or aided covered and noncovered services?

TAGS	RULES	INTERPRETIVE GUIDELINES
0115 PATIENT LIABILITY FOR PAYMENT 484.10(e)(2)	The patient has the right to be advised orally and in writing of any changes in the information provided in accordance with paragraph (e)(1) of this section when they occur. The HHA must advise the patient of these changes orally and in writing as soon as possible, but no later than 30 calendar days from the date that the HHA becomes aware of a change.	During home visits, ask the patient whether the HHA has notified him or her of covered and noncovered services. Also, discuss whether the HHA has described any services for which the patient might have to pay and how payment sources might change (or have changed) during the course of care. Changes in any prior payment information given to the patient should have been given to the patient, orally and in writing, no later than 30 calendar days from the date the HHA became aware of the change. Again, consider the patient's ability to understand and retain payment information. The subject of payment for home care services is often complex and confusing, particularly early in the course of treatment when the patient's illness or limitations appears to be the more pressing problem. Look for a written statement in the home that might serve as a resource or reminder to the patient about the information the HHA has presented. Also, note whether there are subsequent written statements about payments for items or services of which the HHA has become aware. In your evaluation of compliance with this standard, consider whether the HHA is making a reasonable attempt to help the patient understand how the charges for HHA services will be covered or not covered over the course of treatment. Based on the information provided by the HHA, do you believe that the patient has a reasonable understanding of how payment for home care services will likely occur and can make reasonable, informed decisions about financial matters related to the HHA's care and treatment of him or her. Do NOT try to explain to or advise the patient about financial, coverage, or payment issues. PROBES: 1. What process is followed by the HHA to inform the patient of home care charges and probable payment sources, patient's payment liability (if any), and of changes in payment sources and patient liabilities? 2. What documentation in the clinical record indicates that the HHA informed the patient of Federally-funded or aided covered and noncovered services?

TAGS	RULES	INTERPRETIVE GUIDELINES
0116 HOME HEALTH HOTLINE 484.10(f)	The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.	During home visits, ask the patient for the number of the HHA State hotline, when she/he would use it, and what she/he would expect as a result of its use. If the patient has difficulty answering questions about the hotline, ask the patient for a copy of the written information that the HHA has provided. Federal facilities are not required to participate in the HHA State hotline.
0117 COMPLIANCE W/ FED, STATE, LOCAL LAWS 484.12		
0118 COMPLIANCE WITH FED, STATE, LOCAL LAWS 484.12(a)	The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure.	Failure of the HHA to meet a Federal, State or local law may only be cited under the following circumstances: 1. When the Federal, State or local authority having jurisdiction has both made a determination of non-compliance and has taken a final adverse action as a result; or 2. When the language of the Federal regulation requires compliance with explicit Federal, State or local laws and codes as a criterion for compliance. If State law provides for the licensure of HHAs, request to see a copy of the current license. Publicly-operated HHAs, such as public health agencies, or HHAs based in a public hospital, are examples of agencies that a State may exempt from State licensure. Notify the RO if you suspect that you have observed non-compliance with an applicable Federal law related to the provider's HHA program. The RO will notify the appropriate Federal agency of your observations. PROBE: How does the HHA ensure that all professional employees and personnel used under arrangement and by contract have current licenses and/or registrations if they are required?

TAGS	RULES	INTERPRETIVE GUIDELINES
0119 DISCLOSURE OF OWNERSHIP 484.12(b)	The HHA must comply with the requirements of Part 420, Subpart C of this chapter.	Review the CMS-1513 carefully for completeness and compliance with this standard. Information required to be disclosed in this standard, but not required on the CMS-1513, such as whether any person with an ownership interest in an HHA is related to another such individual, should be disclosed to the State survey agency by the HHA in writing and attached to the CMS-1513. A "managing employee" is a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the HHA. The HHA administrator (§484.14(b)) and the supervisory physician or supervisory registered nurse (§484.14(d)) would meet the definition of a managing employee. PROBES: 1- Is the information on the CMS-1513, and in the disclosure letter previously submitted to the State, consistent with information you find in the agency's organizational structure (i.e., organizational charts and lines of authority, management contracts, bylaws, minutes of board meetings)? 2- How does the HHA implement its policy or procedure for reporting changes in ownership and management information to the State?
0120 DISCLOSURE OF OWNERSHIP & MANAGEMENT 484.12(b)	The HHA also must disclose the following information to the State survey agency at the time of the HHA's initial request for certification, for each survey, and at the time of any change in ownership or management: (1) The name and address of all persons with an ownership or control interest in the HHA as defined in §§420.201,420.202, and 420.206 of this chapter. (2) The name and address of each person who is an officer, a director, an agent or a managing employee of the HHA as defined in §§420.201, 420.202, and 420.206 of this chapter. (3) The name and address of the corporation, association, or other company that is responsible for the management of the HHA, and the name and address of the chief executive officer and the chairman of the board of directors of that corporation, association, or other company responsible for the management of the HHA.	Review the CMS-1513 carefully for completeness and compliance with this standard. Information required to be disclosed in this standard, but not required on the CMS-1513, such as whether any person with an ownership interest in an HHA is related to another such individual, should be disclosed to the State survey agency by the HHA in writing and attached to the CMS-1513. A "mnaging employee" is a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of the HHA. The HHA administrator (§484.14(b)) and the supervisory physician or supervisory registered nurse (§484.14(d)) would meet the definition of a managing employee. PROBES: 1- Is the information on the CMS-1513, and in the disclosure letter previously submitted to the State, consistent with information you find in the agency's organizational structure (i.e., organizational charts and lines of authority, management contracts, bylaws, minutes of board meetings)? 2- How does the HHA implement its policy or procedure for reporting changes in ownership and management information to the State?

TAGS	RULES	INTERPRETIVE GUIDELINES
0121 COMPLIANCE W/ ACCEPTED PROFESSIONAL STD 484.12(c)	The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.	The accepted professional standards and principles that the HHA and its staff must comply with include, but are not limited to, the HHA Federal regulations, State practice acts, commonly accepted health standards established by national organizations, boards, and councils (i.e., the American Nurses' Association standards) and the HHA's own policies and procedures. An HHA may be surveyed for compliance with State practice acts for each relevant discipline. Any deficiency cited as a violation of a State practice act must reference the applicable section of the State practice act which is allegedly violated and a copy of that section of the act must be provided to the HHA along with the statement of deficiencies. Any deficiency cited as a violation of accepted standards and principles must have a copy of the applicable standard provided to the HHA along with the statement of deficiencies. If an HHA has developed professional practice standards and principles for its program staff, there should be information available which demonstrates that the HHA monitors its staff for compliance and takes corrective action as needed. PROBES: 1- How does the HHA monitor its employees and personnel serving the HHA under arrangement or contract to ensure that services provided to patients are within acceptable professional practice standards for each discipline? 2- How does the HHA monitor the professional skills of its staff to determine if skills are appropriate for the care required by the patients the HHA admits?
0122 ORGANIZATION, SERVICES & ADMINISTRATION 484.14		

TAGS	RULES	INTERPRETIVE GUIDELINES
0123 ORGANIZATION, SERVICES & ADMINISTRATION 484.14	Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable.	The HHA's policies and procedures, disclosure information required for §484.12, or other forms of documentation (e.g., organizational charts) should be used to determine compliance with this condition. A local (city or county) health department may specify that the entire department or subdivision of the department is the HHA. If the entire department is identified as the HHA, the organizational structure, as documented, should specify: o Where primary supervisory responsibility rests; o How various divisions and bureaus are involved; o Who has responsibility for the division or the bureau; and o Where the focal point is for HHA relationships with the State agency and intermediary. Similarly, a hospital-based HHA that reports through the hospital's organizational structure to several administrators and/or departments should specify the same points previously mentioned. (Refer to §2186 of the SOM.) The same points of clarification would be necessary for any HHA which has entered into agreements, contracts or mergers with one or more corporate entities. Regardless of the formal organizational structure, the overall responsibility for all services provided, whether directly, through arrangements or contracts, rests with the HHA that has assumed responsibility for admitting patients and implementing plans of care. Examples: o An HHA may, in arranging or contracting for a service such as physical therapy, require the other party to do the day-by-day professional evaluation of the therapy service. However, the HHA may not delegate its overall administrative and supervisory responsibilities. The contract should specify how HHA supervision will occur. o An HHA may not use a full-time employee of another legal entity to fulfill its supervisory or administrative functions concurrently. For example: A freestanding HHA locates at a hospital and names a full-time hospital employee as the HHA supervisor. The HHA does not pay the nursing supervisor a salary for the HHA-related services. Because the hospital continues the nursing supervisor in its employ, this arrangement clearly delegates HHA supervisory functions to another legal entity, i.e., the hospital. The HHA would not meet the supervisory requirement of §484.12. Use §2182, Certification Process, State Operations Manual, to help make determinations regarding branches and/or subunits. Remember that these determinations must be made on a case-by-case basis using the definitions contained in §484.2 and the additional criteria described in §2182. Request information that helps you decide if the organizational entity is "sufficiently" close to the parent agency that it is not impractical for it to share administration, supervision, and services from the parent agency on a day-to-day basis. If so, the organizational entity may be classified as a branch. Because circumstances may vary widely among regions and among States within regions, it is inappropriate to set criteria such as mileage or time for purposes of determining branch or subunit status. If there is doubt as to the appropriateness of branch and subunit delineation, a visit to the branch for further evaluation is encouraged.

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0124 ORGANIZATION, SERVICES & ADMINISTRATION 484.14	Administrative and supervisory functions are not delegated to another agency or organization.	The HHA's policies and procedures, disclosure information required for §484.12, or other forms of documentation (e.g., organizational charts) should be used to determine compliance with this condition. A local (city or county) health department may specify that the entire department or subdivision of the department is the HHA. If the entire department is identified as the HHA, the organizational structure, as documented, should specify: o Where primary supervisory responsibility rests; o How various divisions and bureaus are involved; o Who has responsibility for the division or the bureau; and o Where the focal point is for HHA relationships with the State agency and intermediary. Similarly, a hospital-based HHA that reports through the hospital's organizational structure to several administrators and/or departments should specify the same points previously mentioned. (Refer to §2186 of the SOM.) The same points of clarification would be necessary for any HHA which has entered into agreements, contracts or mergers with one or more corporate entities. Regardless of the formal organizational structure, the overall responsibility for all services provided, whether directly, through arrangements or contracts, rests with the HHA that has assumed responsibility for admitting patients and implementing plans of care. Examples: o An HHA may, in arranging or contracting for a service such as physical therapy, require the other party to do the day-by-day professional evaluation of the therapy service. However, the HHA may not delegate its overall administrative and supervisory responsibilities. The contract should specify how HHA supervision will occur. o An HHA may not use a full-time employee of another legal entity to fulfill its supervisory or administrative functions concurrently. For example: A freestanding HHA locates at a hospital and names a full-time hospital employee as the HHA supervisor. The HHA does not pay the nursing supervisor a salary for the HHA-related services. Because the hospital continues the nursing supervisor in its employ, this arrangement clearly delegates HHA supervisory functions to another legal entity, i.e., the hospital. The HHA would not meet the supervisory requirement of §484.12. Use §2182, Certification Process, State Operations Manual, to help make determinations regarding branches and/or subunits. Remember that these determinations must be made on a case-by-case basis using the definitions contained in §484.2 and the additional criteria described in §2182. Request information that helps you decide if the organizational entity is "sufficiently" close to the parent agency that it is not impractical for it to share administration, supervision, and services from the parent agency on a day-to-day basis. If so, the organizational entity may be classified as a branch. Because circumstances may vary widely among regions and among States within regions, it is inappropriate to set criteria such as mileage or time for purposes of determining branch or subunit status. If there is doubt as to the appropriateness of branch and subunit delineation, a visit to the branch for further evaluation is encouraged

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0125 ORGANIZATION, SERVICES & ADMINISTRATION 484.14	All services not furnished directly, including services provided through subunits are monitored and controlled by the parent agency.	The HHA's policies and procedures, disclosure information required for §484.12, or other forms of documentation (e.g., organizational charts) should be used to determine compliance with this condition. A local (city or county) health department may specify that the entire department or subdivision of the department is the HHA. If the entire department is identified as the HHA, the organizational structure, as documented, should specify: o Where primary supervisory responsibility rests; o How various divisions and bureaus are involved; o Who has responsibility for the division or the bureau; and o Where the focal point is for HHA relationships with the State agency and intermediary. Similarly, a hospital-based HHA that reports through the hospital's organizational structure to several administrators and/or departments should specify the same points previously mentioned. (Refer to §2186 of the SOM.) The same points of clarification would be necessary for any HHA which has entered into agreements, contracts or mergers with one or more corporate entities. Regardless of the formal organizational structure, the overall responsibility for all services provided, whether directly, through arrangements or contracts, rests with the HHA that has assumed responsibility for admitting patients and implementing plans of care. Examples: o An HHA may, in arranging or contracting for a service such as physical therapy, require the other party to do the day-by-day professional evaluation of the therapy service. However, the HHA may not delegate its overall administrative and supervisory responsibilities. The contract should specify how HHA supervision will occur. o An HHA may not use a full-time employee of another legal entity to fulfill its supervisory or administrative functions concurrently. For example: A freestanding HHA locates at a hospital and names a full-time hospital employee as the HHA supervisor. The HHA does not pay the nursing supervisor a salary for the HHA-related services. Because the hospital continues the nursing supervisor in its employ, this arrangement clearly delegates HHA supervisory functions to another legal entity, i.e., the hospital. The HHA would not meet the supervisory requirement of §484.12. Use §2182, Certification Process, State Operations Manual, to help make determinations regarding branches and/or subunits. Remember that these determinations must be made on a case-by-case basis using the definitions contained in §484.2 and the additional criteria described in §2182. Request information that helps you decide if the organizational entity is "sufficiently" close to the parent agency that it is not impractical for it to share administration, supervision, and services from the parent agency on a day-to-day basis. If so, the organizational entity may be classified as a branch. Because circumstances may vary widely among regions and among States within regions, it is inappropriate to set criteria such as mileage or time for purposes of determining branch or subunit status. If there is doubt as to the appropriateness of branch and subunit delineation, a visit to the branch for further evaluation is encouraged.

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0126 ORGANIZATION, SERVICES & ADMINISTRATION 484.14	If an agency has subunits, appropriate administrative records are maintained for each subunit.	The HHA's policies and procedures, disclosure information required for §484.12, or other forms of documentation (e.g., organizational charts) should be used to determine compliance with this condition. A local (city or county) health department may specify that the entire department or subdivision of the department is the HHA. If the entire department is identified as the HHA, the organizational structure, as documented, should specify: o Where primary supervisory responsibility rests; o How various divisions and bureaus are involved; o Who has responsibility for the division or the bureau; and o Where the focal point is for HHA relationships with the State agency and intermediary. Similarly, a hospital-based HHA that reports through the hospital's organizational structure to several administrators and/or departments should specify the same points previously mentioned. (Refer to §2186 of the SOM.) The same points of clarification would be necessary for any HHA which has entered into agreements, contracts or mergers with one or more corporate entities. Regardless of the formal organizational structure, the overall responsibility for all services provided, whether directly, through arrangements or contracts, rests with the HHA that has assumed responsibility for admitting patients and implementing plans of care. Examples: o An HHA may, in arranging or contracting for a service such as physical therapy, require the other party to do the day-by-day professional evaluation of the therapy service. However, the HHA may not delegate its overall administrative and supervisory responsibilities. The contract should specify how HHA supervision will occur. o An HHA may not use a full-time employee of another legal entity to fulfill its supervisory or administrative functions concurrently. For example: A freestanding HHA locates at a hospital and names a full-time hospital employee as the HHA supervisor. The HHA does not pay the nursing supervisor a salary for the HHA-related services. Because the hospital continues the nursing supervisor in its employ, this arrangement clearly delegates HHA supervisory functions to another legal entity, i.e., the hospital. The HHA would not meet the supervisory requirement of §484.12. Use §2182, Certification Process, State Operations Manual, to help make determinations regarding branches and/or subunits. Remember that these determinations must be made on a case-by-case basis using the definitions contained in §484.2 and the additional criteria described in §2182. Request information that helps you decide if the organizational entity is "sufficiently" close to the parent agency that it is not impractical for it to share administration, supervision, and services from the parent agency on a day-to-day basis. If so, the organizational entity may be classified as a branch. Because circumstances may vary widely among regions and among States within regions, it is inappropriate to set criteria such as mileage or time for purposes of determining branch or subunit status. If there is doubt as to the appropriateness of branch and subunit delineation, a visit to the branch for further evaluation is encouraged

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0127 SERVICES FURNISHED 484.14(a)	Part-time or intermittent skilled nursing services and at least one other therapeutic service (physical, speech or occupational therapy; medical social services; or home health aide services) are made available on a visiting basis, in a place of residence used as a patient's home. An HHA must provide at least one of the qualifying services directly through agency employees, but may provide the second qualifying service and additional services under arrangements with another agency or organization.	An HHA is considered to provide a service "directly" when the person providing the service for the HHA is an HHA employee. For purposes of meeting 42 CFR 484.14(a), an individual who works for the HHA on an hourly or per-visit basis may be considered an agency employee if the HHA is required to issue a form W-2 on his/her behalf. An HHA is considered to provide a service "under arrangements" when the HHA provides the service through contractual or affiliation arrangements with other agencies or organizations, or with an individual(s) who is not an HHA employee. PROBE: How do the terms of the HHA agreements/contracts ensure that the HHA has the requisite control over its provision of services?
0128 GOVERNING BODY 484.14(b)	A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency.	An HHA may use the services of a management company to strengthen its own administrative services. An HHA's documented agreement with a management company or employee leasing company must specify that the legal authority and full control of the HHA's operation remain with the HHA and that the HHA's governing body retains the responsibilities specified in §484.14(b). This means that the HHA, through the governing body (or designated persons so functioning), must assume the full legal authority and responsibility for the operations of the agency, including its policies, procedures, services, organization, and budget preparation. These responsibilities must be clearly defined in the written agreement with the management or employee leasing company. PROBE: How does the governing body exercise its responsibility for the overall operation of the HHA, including the HHA's budget and capital expenditure plan, and the overall management, supervision, and evaluation of the HHA and its patients' outcomes? (Review documents which outline these responsibilities.)

TAGS	RULES	INTERPRETIVE GUIDELINES
0129 GOVERNING BODY 484.14(b)	The governing body appoints a qualified administrator.	An HHA may use the services of a management company to strengthen its own administrative services. An HHA's documented agreement with a management company or employee leasing company must specify that the legal authority and full control of the HHA's operation remain with the HHA and that the HHA's governing body retains the responsibilities specified in §484.14(b). This means that the HHA, through the governing body (or designated persons so functioning), must assume the full legal authority and responsibility for the operations of the agency, including its policies, procedures, services, organization, and budget preparation. These responsibilities must be clearly defined in the written agreement with the management or employee leasing company. PROBE: How does the governing body exercise its responsibility for the overall operation of the HHA, including the HHA's budget and capital expenditure plan, and the overall management, supervision, and evaluation of the HHA and its patients' outcomes? (Review documents which outline these responsibilities.)
0130 GOVERNING BODY 484.14(b)	The governing body arranges for professional advice as required under §484.16.	An HHA may use the services of a management company to strengthen its own administrative services. An HHA's documented agreement with a management company or employee leasing company must specify that the legal authority and full control of the HHA's operation remain with the HHA and that the HHA's governing body retains the responsibilities specified in §484.14(b). This means that the HHA, through the governing body (or designated persons so functioning), must assume the full legal authority and responsibility for the operations of the agency, including its policies, procedures, services, organization, and budget preparation. These responsibilities must be clearly defined in the written agreement with the management or employee leasing company. PROBE: How does the governing body exercise its responsibility for the overall operation of the HHA, including the HHA's budget and capital expenditure plan, and the overall management, supervision, and evaluation of the HHA and its patients' outcomes? (Review documents which outline these responsibilities.)

TAGS	RULES	INTERPRETIVE GUIDELINES
0131 GOVERNING BODY 484.14(b)	The governing body adopts and periodically reviews written bylaws or an acceptable equivalent.	An HHA may use the services of a management company to strengthen its own administrative services. An HHA's documented agreement with a management company or employee leasing company must specify that the legal authority and full control of the HHA's operation remain with the HHA and that the HHA's governing body retains the responsibilities specified in §484.14(b). This means that the HHA, through the governing body (or designated persons so functioning), must assume the full legal authority and responsibility for the operations of the agency, including its policies, procedures, services, organization, and budget preparation. These responsibilities must be clearly defined in the written agreement with the management or employee leasing company. PROBE: How does the governing body exercise its responsibility for the overall operation of the HHA, including the HHA's budget and capital expenditure plan, and the overall management, supervision, and evaluation of the HHA and its patients' outcomes? (Review documents which outline these responsibilities.)
0132 GOVERNING BODY 484.14(b)	The governing body oversees the management and fiscal affairs of the agency.	An HHA may use the services of a management company to strengthen its own administrative services. An HHA's documented agreement with a management company or employee leasing company must specify that the legal authority and full control of the HHA's operation remain with the HHA and that the HHA's governing body retains the responsibilities specified in §484.14(b). This means that the HHA, through the governing body (or designated persons so functioning), must assume the full legal authority and responsibility for the operations of the agency, including its policies, procedures, services, organization, and budget preparation. These responsibilities must be clearly defined in the written agreement with the management or employee leasing company. PROBE: How does the governing body exercise its responsibility for the overall operation of the HHA, including the HHA's budget and capital expenditure plan, and the overall management, supervision, and evaluation of the HHA and its patients' outcomes? (Review documents which outline these responsibilities.)
0133 ADMINISTRATOR 484.14(c)	The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.	PROBES: 1- How do the specific administrative activities identified in the standard impact on the services of the HHA? 2- What individual is authorized to act in the absence of the administrator?

TAGS	RULES	INTERPRETIVE GUIDELINES
0134 ADMINISTRATOR 484.14(c)	The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.	PROBES: 1- How do the specific administrative activities identified in the standard impact on the services of the HHA? 2- What individual is authorized to act in the absence of the administrator?
0135 ADMINISTRATOR 484.14(c)	The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, ensures the accuracy of public information materials and activities.	PROBES: 1- How do the specific administrative activities identified in the standard impact on the services of the HHA? 2- What individual is authorized to act in the absence of the administrator?
0136 ADMINISTRATOR 484.14(c)	The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, implements an effective budgeting and accounting system.	PROBES: 1- How do the specific administrative activities identified in the standard impact on the services of the HHA? 2- What individual is authorized to act in the absence of the administrator?
0137 ADMINISTRATOR 484.14(c)	A qualified person is authorized in writing to act in the absence of the administrator.	PROBES: 1- How do the specific administrative activities identified in the standard impact on the services of the HHA? 2- What individual is authorized to act in the absence of the administrator?
0138 SUPERVISING PHYSICIAN OR REGIS. NURSE 484.14(d)	The skilled nursing and other therapeutic services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least 1 year of nursing experience and is a public health nurse).	"Available at all times during operating hours" means being readily available on the premises or by telecommunications. How the supervising physician or supervising registered nurse structures his or her availability is a management decision for the HHA.
0139 SUPERVISING PHYSICIAN OR REGIS. NURSE 484.14(d)	Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse). This person, or similarly qualified alternate, is available at all times during operating hours.	"Available at all times during operating hours" means being readily available on the premises or by telecommunications. How the supervising physician or supervising registered nurse structures his or her availability is a management decision for the HHA.

TAGS	RULES	INTERPRETIVE GUIDELINES
0140 SUPERVISING PHYSICIAN OR REGIS. NURSE 484.14(d)	Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse). This person, or similarly qualified alternate, participates in all activities relevant to the professional services furnished, including the development of qualifications and the assignment of personnel.	"Available at all times during operating hours" means being readily available on the premises or by telecommunications. How the supervising physician or supervising registered nurse structures his or her availability is a management decision for the HHA.
0141 PERSONNEL POLICIES 484.14(e)	Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current.	The numbers and qualifications of personnel available to provide services must be sufficient to implement the plans of care and the medical, nursing, and rehabilitative needs of the patients admitted by the HHA. PROBES: 1- What does the HHA include in the personnel records about the qualifications and licensure of its employees? 2- If the HHA does not keep duplicate personnel records of staff hired under arrangement, how does it ensure that records are kept current?
0142 PERSONNEL HOURLY/PER VISIT CONTRACT 484.14(f)	If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: (1) Patients are accepted for care only by the primary HHA. (2) The services to be furnished. (3) The necessity to conform to all applicable agency policies, including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA. (6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.	If an HHA, which has been established as hospital-based for Medicare payment purposes, has arranged with the hospital to provide the second qualifying service or other HHA services (see 42 CFR 484.14(a)) through hospital employees, the HHA would not be required to have an hourly or per visit contract with these hospital employees. The HHA should identify in its records the names of these employees and the amount of time they spend at the HHA. However, if these hospital employees provide services to the HHA outside of their own usual working hours or shifts (i.e., "moonlight" as HHA employees, as opposed to working overtime for the hospital), a contract as specified in standard (f) applies. PROBES: 1- How does the HHA orient contractual personnel to HHA objectives, policies, procedures, and programs? 2- How does the HHA evaluate whether contractual personnel inform the patient of his/her rights prior to the beginning of care or when there are changes in care? 3- How are contractual personnel monitored by the HHA to confirm that the care provided is consistent with the plans of care and that their services meet the terms of the contract? 4- Who reviews the 2-month recertification requests to determine if continuing patient care is indicated as a probable medical necessity?

TAGS	RULES	INTERPRETIVE GUIDELINES
0143 COORDINATION OF PATIENT SERVICES 484.14(g)	All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.	PROBES: 1- What is the HHA's policy related to facilitating exchange of information among staff? 2- How does coordination of care among staff and/or contract personnel providing services to individual patients occur? 3- How does the HHA ensure that patients' written summary reports sent to attending physicians every 62 days meet the regulatory requirements of §484.2? Refer to §484.48 regarding guidelines for the attending physician's written summary report.
0144 COORDINATION OF PATIENT SERVICES 484.14(g)	The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.	PROBES: 1- What is the HHA's policy related to facilitating exchange of information among staff? 2- How does coordination of care among staff and/or contract personnel providing services to individual patients occur? 3- How does the HHA ensure that patients' written summary reports sent to attending physicians every 62 days meet the regulatory requirements of §484.2? Refer to §484.48 regarding guidelines for the attending physician's written summary report.
0145 COORDINATION OF PATIENT SERVICES 484.14(g)	A written summary report for each patient is sent to the attending physician at least every 60 days.	PROBES: 1- What is the HHA's policy related to facilitating exchange of information among staff? 2- How does coordination of care among staff and/or contract personnel providing services to individual patients occur? 3- How does the HHA ensure that patients' written summary reports sent to attending physicians every 62 days meet the regulatory requirements of §484.2? Refer to §484.48 regarding guidelines for the attending physician's written summary report.
0146 SERVICES UNDER ARRANGEMENTS 484.14(h)	Services furnished under arrangements are subject to a written contract conforming with the requirements specified in paragraph (f) of this section and with the requirements of section 1861(w) of the Act (42 U.S.C 1495x(w)).	Section 1861(w) of the Act states that an HHA may have others furnish covered items or services through arrangements under which receipt of payment by the HHA for the services discharges the liability of the beneficiary or any other person to pay for the services. This holds true whether the services and items are furnished by the HHA itself or by another agency under arrangements. Both must agree not to charge the patient for covered services and items and to return money incorrectly collected.

TAGS	RULES	INTERPRETIVE GUIDELINES
0147 INSTITUTIONAL PLANNING 484.14(i)	The HHA, under the direction of the governing body, prepares an overall plan and a budget that includes an annual operating budget and capital expenditure plan. (1) Annual operating budget. There is an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. However, it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense. (2) Capital expenditure plan. (i) There is a capital expenditure plan for at least a 3-year period, including the operating budget year. The plan includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure of more than $600,000 for items that would under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds $600,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions that are separated in time, but are components of an overall plan or patient care objective, are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds. (ii) If the anticipated source of financing is, in any part, the anticipated payment from title V (Maternal and Child Health and Crippled Children's Services) or title XVIII (Medicare) or title XIX (Medicaid) of the Social Security Act, the plan specifies the following: (A) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. (B) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval in accordance with section 1122 of the Act (42 U.S.C. 1320a-1) and implementing regulations. (C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency.	An HHA with branches and/or subunits requires only one overall plan and one budget which should include the resources and expenditures of all branches and subunits.

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0148 INSTITUTIONAL PLANNING 484.14(i)	The overall plan and budget is prepared under the direction of the governing body of the HHA by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the HHA.	An HHA with branches and/or subunits requires only one overall plan and one budget which should include the resources and expenditures of all branches and subunits.
0149 INSTITUTIONAL PLANNING 484.14(i)	The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (i)(3) of this section under the direction of the governing body of the HHA.	An HHA with branches and/or subunits requires only one overall plan and one budget which should include the resources and expenditures of all branches and subunits.

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0150 LABORATORY SERVICES 484.14(j)	(1) If the HHA engages in laboratory testing outside of the context of assisting an individual in self-administering a test with an appliance that has been cleared for that purpose by the FDA, such testing must be in compliance with all applicable requirements of part 493 of this chapter. (2) If the HHA chooses to refer specimens for laboratory testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the applicable requirements of part 493 of this chapter.	Determine if the HHA is providing laboratory testing as set forth at 42 CFR 493. If the HHA is performing testing, request to see the CLIA certificate for the level of testing being performed, i.e., a certificate of waiver, certificate for physician-performed microscopy procedures, certificate of accreditation, certificate of registration or certificate for moderate or high complexity testing. HHAs holding a certificate of waiver are limited to performing only those tests determined to be in the waived category. These are: o Dipstick/tablet reagent urinalysis (includes 10 analytes); o Fecal occult blood; o Ovulation test kits - visual color comparison tests for human luteinizing hormone; o Urine pregnancy test - visual color comparison tests; o Erythrocyte sedimentation rate (non-automated); o Hemoglobin - copper sulfate (non-automated); o Blood glucose by glucose monitoring devices cleared by the Food and Drug Administration (FDA) specifically for home use; o Spun microhematocrit; and o Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout (e.g., HemaCue). HHAs holding a certificate for physician-performed microscopy procedures are limited to performing only those tests determined to be in the physician-performed microscopy procedure category listed below or in combination with waived tests: o Wet mounts, including preparations of vaginal, cervical or skin specimens; o All potassium hydroxide preparations; o Pinworm examinations; o Fern tests; o Post-coital direct, qualitative examinations of vaginal or cervical mucous; and o Urine sediment examinations. These tests must be performed by a physician on his or her own patients or the patients of the medical group practice of which the physician is a member. If performed by anyone else, the performance of these tests would require a registration certificate, certificate of accreditation or certificate. If the HHA performs any other testing procedures, it would require a registration certificate (which allows the performance of such testing until a determination of compliance is made), a certificate of accreditation, or a certificate (issued upon the determination of compliance after an on-site survey). Assisting individuals in administering their own tests, such as fingerstick blood glucose testing, is not considered testing subject to the CLIA regulations. However, if the HHA staff is actually responsible for measuring the blood glucose level of patients with an FDA approved blood glucose monitor, and no other tests are being performed, request to see the facility's certificate of waiver, since glucose testing with a blood glucose meter (approved by the FDA specifically for home use) is a waived test under the provisions at 42 CFR 493.15. If the facility does not possess the appropriate CLIA certificate, inform the facility that it is in violation of

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0151 GROUP OF PROFESSIONAL PERSONNEL 484.16		
0152 GROUP OF PROFESSIONAL PERSONNEL 484.16	A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other professional disciplines.	If an HHA has a branch(es), the annual review includes services delivered through the branch(es). The parent agency's group of professional personnel or a subcommittee of the group may also serve as the subunit's group of professional personnel or the subunit may establish its own group. If the HHA is part of a larger organization (e.g., a State, county, hospital) and the parent organization's policies are mostly applicable to the HHA, the HHA does not have to develop new policies. Rather, the HHA should review and revise patient policies to accommodate the conditions of participation, the patient care needs of the HHA and the quality of services to be provided.
0153 GROUP OF PROFESSIONAL PERSONNEL 484.16	The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.	If an HHA has a branch(es), the annual review includes services delivered through the branch(es). The parent agency's group of professional personnel or a subcommittee of the group may also serve as the subunit's group of professional personnel or the subunit may establish its own group. If the HHA is part of a larger organization (e.g., a State, county, hospital) and the parent organization's policies are mostly applicable to the HHA, the HHA does not have to develop new policies. Rather, the HHA should review and revise patient policies to accommodate the conditions of participation, the patient care needs of the HHA and the quality of services to be provided.
0154 ADVISORY AND EVALUATION FUNCTION 484.16(a)	The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program.	If an HHA has a branch(es), the annual review includes services delivered through the branch(es). The parent agency's group of professional personnel or a subcommittee of the group may also serve as the subunit's group of professional personnel or the subunit may establish its own group. If the HHA is part of a larger organization (e.g., a State, county, hospital) and the parent organization's policies are mostly applicable to the HHA, the HHA does not have to develop new policies. Rather, the HHA should review and revise patient policies to accommodate the conditions of participation, the patient care needs of the HHA and the quality of services to be provided. PROBE: What documentation is there of advice concerning professional issues, evaluation of the professional service program, or assistance in maintaining liaison with other community groups by the professional group?

TAGS	RULES	INTERPRETIVE GUIDELINES
0155 ADVISORY AND EVALUATION FUNCTION 484.16(a)	The group of professional personnel's meetings are documented by dated minutes.	If an HHA has a branch(es), the annual review includes services delivered through the branch(es). The parent agency's group of professional personnel or a subcommittee of the group may also serve as the subunit's group of professional personnel or the subunit may establish its own group. If the HHA is part of a larger organization (e.g., a State, county, hospital) and the parent organization's policies are mostly applicable to the HHA, the HHA does not have to develop new policies. Rather, the HHA should review and revise patient policies to accommodate the conditions of participation, the patient care needs of the HHA and the quality of services to be provided. PROBE: What documentation is there of advice concerning professional issues, evaluation of the professional service program, or assistance in maintaining liaison with other community groups by the professional group?
0156 ACCEPTANCE OF PATIENTS, POC, MED SUPER 484.18		
0157 ACCEPTANCE OF PATIENTS, POC, MED SUPER 484.18	Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.	It is CMS's policy to require that the HHA must have a plan of care for each patient, regardless of the patient's Medicare status or that nurse practice acts do not specifically require a physician's order. The CoPs do not require a physician's order for services furnished by the HHA that are not related to the patient's illness, injury, or treatment of the patient's medical, nursing, or social needs. Medical orders may authorize a specific range in the frequency of visits for each service (i.e., 2-4 visits per week) to ensure that the most appropriate level of service is provided to the patient. The regulation requires the HHA to alert the physician to any changes that suggest a need to alter the plan of care. If the HHA provides fewer visits than the physician orders, it has altered the plan of care and the physician must be notified. This can be accomplished by obtaining a physician's order to cover the missed visit or notifying the physician, and maintaining documentation in the clinical record indicating that the physician is aware of the missed visit. PROBE: What evidence (if any) demonstrates that patients are admitted or denied services for reasons contrary to the intent of this standard?

TAGS	RULES	INTERPRETIVE GUIDELINES
0158 ACCEPTANCE OF PATIENTS, POC, MED SUPER 484.18	Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.	It is CMS's policy to require that the HHA must have a plan of care for each patient, regardless of the patient's Medicare status or that nurse practice acts do not specifically require a physician's order. The CoPs do not require a physician's order for services furnished by the HHA that are not related to the patient's illness, injury, or treatment of the patient's medical, nursing, or social needs. Medical orders may authorize a specific range in the frequency of visits for each service (i.e., 2-4 visits per week) to ensure that the most appropriate level of service is provided to the patient. The regulation requires the HHA to alert the physician to any changes that suggest a need to alter the plan of care. If the HHA provides fewer visits than the physician orders, it has altered the plan of care and the physician must be notified. This can be accomplished by obtaining a physician's order to cover the missed visit or notifying the physician, and maintaining documentation in the clinical record indicating that the physician is aware of the missed visit. PROBE: What evidence (if any) demonstrates that patients are admitted or denied services for reasons contrary to the intent of this standard?

TAGS	RULES	INTERPRETIVE GUIDELINES
0159 PLAN OF CARE 484.18(a)	The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.	A statutory change renamed the "plan of treatment" to "the plan of care." These terms are synonymous. Neither is to be confused with a nursing care plan. The conditions do not require an HHA to either develop or maintain a nursing care plan as opposed to a medical plan of care. This does not preclude an HHA from using nursing care plans if it believes that such plans strengthen patient care management, the organization and delivery of services, and the ability to evaluate patient outcomes. Review a case-mix, stratified sample of clinical records (see §2200B) to determine if the requirements of this standard are met. Written HHA policies and procedures should specify that all clinical services are implemented only in accordance with a plan of care established by a physician's written orders. Policies should also specify if the HHA: o Accepts physician's orders on referral communicated verbally by an institution's discharge planner, nurse practitioner, physician's assistant, or other authorized staff member followed by written, signed and dated physician's orders, in order to begin HHA services as soon as possible. o Accepts signed physician certification and recertification of plans of care, as well as signed orders changing the plan of care, by telecommunication systems ("fax"), which are filed in the clinical record. The plan of care must be established and authorized in writing by the physician based on an evaluation of the patient's immediate and long term needs. The HHA staff, and if appropriate, other professional personnel, shall have a substantial role in assessing patient needs, consulting with the physician, and helping to develop the overall plan of care. The patient has the right, and should be encouraged, to participate in the development of the plan of care before care is started and when changes in the established plan of care are implemented. (See §484.10(c)(2).) Section 1861(r) of the Act defines the term, "physician", to permit a podiatrist to establish and recertify an HHA patient's plan of care. The podiatrist's functions must be consistent with the HHA's policies and procedures that pertain to therapeutic activities he/she is legally authorized by the State to perform. Form CMS-485, "Home Health Certification and Plan of Treatment", may be used as the plan of care. This form fulfills the regulatory requirements for a plan of care and may be used to evaluate compliance with this standard. PROBES: 1- How does an HHA evaluate whether the plan of care, and the coordination of services help the patient attain and maintain his or her highest practicable functional capacity based on medical, nursing and rehabilitative needs? 2- How does the HHA monitor the delivery of services, including those provided under arrangement or contract, to ensure compliance with the specificity and frequency of services ordered in the plan of care?

TAGS	RULES	INTERPRETIVE GUIDELINES
0160 PLAN OF CARE 484.18(a)	If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan.	A statutory change renamed the "plan of treatment" to "the plan of care." These terms are synonymous. Neither is to be confused with a nursing care plan. The conditions do not require an HHA to either develop or maintain a nursing care plan as opposed to a medical plan of care. This does not preclude an HHA from using nursing care plans if it believes that such plans strengthen patient care management, the organization and delivery of services, and the ability to evaluate patient outcomes. Review a case-mix, stratified sample of clinical records (see §2200B) to determine if the requirements of this standard are met. Written HHA policies and procedures should specify that all clinical services are implemented only in accordance with a plan of care established by a physician's written orders. Policies should also specify if the HHA: o Accepts physician's orders on referral communicated verbally by an institution's discharge planner, nurse practitioner, physician's assistant, or other authorized staff member followed by written, signed and dated physician's orders, in order to begin HHA services as soon as possible. o Accepts signed physician certification and recertification of plans of care, as well as signed orders changing the plan of care, by telecommunication systems ("fax"), which are filed in the clinical record. The plan of care must be established and authorized in writing by the physician based on an evaluation of the patient's immediate and long term needs. The HHA staff, and if appropriate, other professional personnel, shall have a substantial role in assessing patient needs, consulting with the physician, and helping to develop the overall plan of care. The patient has the right, and should be encouraged, to participate in the development of the plan of care before care is started and when changes in the established plan of care are implemented. (See §484.10(c)(2).) Section 1861(r) of the Act defines the term, "physician", to permit a podiatrist to establish and recertify an HHA patient's plan of care. The podiatrist's functions must be consistent with the HHA's policies and procedures that pertain to therapeutic activities he/she is legally authorized by the State to perform. Form CMS-485, "Home Health Certification and Plan of Treatment", may be used as the plan of care. This form fulfills the regulatory requirements for a plan of care and may be used to evaluate compliance with this standard. PROBES: 1- How does an HHA evaluate whether the plan of care, and the coordination of services help the patient attain and maintain his or her highest practicable functional capacity based on medical, nursing and rehabilitative needs? 2- How does the HHA monitor the delivery of services, including those provided under arrangement or contract, to ensure compliance with the specificity and frequency of services ordered in the plan of care?

TAGS	RULES	INTERPRETIVE GUIDELINES
0161 PLAN OF CARE 484.18(a)	Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration.	A statutory change renamed the "plan of treatment" to "the plan of care." These terms are synonymous. Neither is to be confused with a nursing care plan. The conditions do not require an HHA to either develop or maintain a nursing care plan as opposed to a medical plan of care. This does not preclude an HHA from using nursing care plans if it believes that such plans strengthen patient care management, the organization and delivery of services, and the ability to evaluate patient outcomes. Review a case-mix, stratified sample of clinical records (see §2200B) to determine if the requirements of this standard are met. Written HHA policies and procedures should specify that all clinical services are implemented only in accordance with a plan of care established by a physician's written orders. Policies should also specify if the HHA: o Accepts physician's orders on referral communicated verbally by an institution's discharge planner, nurse practitioner, physician's assistant, or other authorized staff member followed by written, signed and dated physician's orders, in order to begin HHA services as soon as possible. o Accepts signed physician certification and recertification of plans of care, as well as signed orders changing the plan of care, by telecommunication systems ("fax"), which are filed in the clinical record. The plan of care must be established and authorized in writing by the physician based on an evaluation of the patient's immediate and long term needs. The HHA staff, and if appropriate, other professional personnel, shall have a substantial role in assessing patient needs, consulting with the physician, and helping to develop the overall plan of care. he patient has the right, and should be encouraged, to participate in the development of the plan of care before care is started and when changes in the established plan of care are implemented. (See §484.10(c)(2).) Section 1861(r) of the Act defines the term, "physician", to permit a podiatrist to establish and recertify an HHA patient's plan of care. The podiatrist's functions must be consistent with the HHA's policies and procedures that pertain to therapeutic activities he/she is legally authorized by the State to perform. Form CMS-485, "Home Health Certification and Plan of Treatment", may be used as the plan of care. This form fulfills the regulatory requirements for a plan of care and may be used to evaluate compliance with this standard. PROBES: 1- How does an HHA evaluate whether the plan of care, and the coordination of services help the patient attain and maintain his or her highest practicable functional capacity based on medical, nursing and rehabilitative needs? 2- How does the HHA monitor the delivery of services, including those provided under arrangement or contract, to ensure compliance with the specificity and frequency of services ordered in the plan of care?

TAGS	RULES	INTERPRETIVE GUIDELINES
0162 PLAN OF CARE 484.18(a)	The therapist and other agency personnel participate in developing the plan of care.	A statutory change renamed the "plan of treatment" to "the plan of care." These terms are synonymous. Neither is to be confused with a nursing care plan. The conditions do not require an HHA to either develop or maintain a nursing care plan as opposed to a medical plan of care. This does not preclude an HHA from using nursing care plans if it believes that such plans strengthen patient care management, the organization and delivery of services, and the ability to evaluate patient outcomes. Review a case-mix, stratified sample of clinical records (see §2200B) to determine if the requirements of this standard are met. Written HHA policies and procedures should specify that all clinical services are implemented only in accordance with a plan of care established by a physician's written orders. Policies should also specify if the HHA: o Accepts physician's orders on referral communicated verbally by an institution's discharge planner, nurse practitioner, physician's assistant, or other authorized staff member followed by written, signed and dated physician's orders, in order to begin HHA services as soon as possible. o Accepts signed physician certification and recertification of plans of care, as well as signed orders changing the plan of care, by telecommunication systems ("fax"), which are filed in the clinical record. The plan of care must be established and authorized in writing by the physician based on an evaluation of the patient's immediate and long term needs. The HHA staff, and if appropriate, other professional personnel, shall have a substantial role in assessing patient needs, consulting with the physician, and helping to develop the overall plan of care. The patient has the right, and should be encouraged, to participate in the development of the plan of care before care is started and when changes in the established plan of care are implemented. (See §484.10(c)(2).) Section 1861(r) of the Act defines the term, "physician", to permit a podiatrist to establish and recertify an HHA patient's plan of care. The podiatrist's functions must be consistent with the HHA's policies and procedures that pertain to therapeutic activities he/she is legally authorized by the State to perform. Form CMS-485, "Home Health Certification and Plan of Treatment", may be used as the plan of care. This form fulfills the regulatory requirements for a plan of care and may be used to evaluate compliance with this standard. PROBES: 1- How does an HHA evaluate whether the plan of care, and the coordination of services help the patient attain and maintain his or her highest practicable functional capacity based on medical, nursing and rehabilitative needs? 2- How does the HHA monitor the delivery of services, including those provided under arrangement or contract, to ensure compliance with the specificity and frequency of services ordered in the plan of care?

TAGS	RULES	INTERPRETIVE GUIDELINES
0163 PERIODIC REVIEW OF PLAN OF CARE 484.18(b)	The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode.	Changes in the patient's condition that require a change in the plan of care should be documented in the patient's clinical record.
0164 PERIODIC REVIEW OF PLAN OF CARE 484.18(b)	Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.	Changes in the patient's condition that require a change in the plan of care should be documented in the patient's clinical record.

TAGS	RULES	INTERPRETIVE GUIDELINES
0165 CONFORMANCE WITH PHYSICIAN ORDERS 484.18(c)	Drugs and treatments are administered by agency staff only as ordered by the physician.	Review HHA policies and procedures in regard to obtaining physician orders, changes in orders, and verbal orders. All physician orders must be included in the patient's clinical record. Plans of care must be signed and dated by the physician. Verbal orders must be countersigned by the physician as soon as possible. Ask HHAs, whose pattern of obtaining signed physicians' orders exceeds the HHA's policy or State law, to clarify or explain what circumstances created the time lapse and how they are approaching a resolution to the problem. Other designated HHA personnel who accept oral orders must be able to do so in accordance with State and Federal law and regulations and HHA policy. Oral orders must be signed and dated by the registered nurse or qualified therapist who is furnishing or supervising the ordered service and it is the RN's responsibility to make any necessary revisions to the plan of care based on that order. All drugs and treatments ordered by the patient's physician should be recorded in the clinical record. Over-the-counter drugs which the patient takes must be noted in the patient's record. Over-the-counter drugs should be reported to the physician only if an RN determines that they could detrimentally affect the prescribed drugs of the patient. The label on the bottle of a prescription medication constitutes the pharmacist's transcription or documentation of the order. Such medications should be noted in the clinical record and listed on the recertification plan of care (Form CMS-485). This is consistent with acceptable standards of practice, and Federal regulations do not have additional requirements. Aides may help patients take drugs ordinarily self-administered by the patient, unless the State restricts this practice. PROBES: 1- If HHA personnel identify patient sensitivity or other medication problems, what actions does the HHA require its personnel to take? 2- How does the HHA secure physicians' signatures on oral, change, or renewal orders? 3- How does the HHA ensure that oral orders are accepted, cosigned by the nurse ot therapist and countersigned by the physician appropriately?

TAGS	RULES	INTERPRETIVE GUIDELINES
0166 CONFORMANCE WITH PHYSICIAN ORDERS 484.18(c)	Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.	Review HHA policies and procedures in regard to obtaining physician orders, changes in orders, and verbal orders. All physician orders must be included in the patient's clinical record. Plans of care must be signed and dated by the physician. Verbal orders must be countersigned by the physician as soon as possible. Ask HHAs, whose pattern of obtaining signed physicians' orders exceeds the HHA's policy or State law, to clarify or explain what circumstances created the time lapse and how they are approaching a resolution to the problem. Other designated HHA personnel who accept oral orders must be able to do so in accordance with State and Federal law and regulations and HHA policy. Oral orders must be signed and dated by the registered nurse or qualified therapist who is furnishing or supervising the ordered service and it is the RN's responsibility to make any necessary revisions to the plan of care based on that order. All drugs and treatments ordered by the patient's physician should be recorded in the clinical record. Over-the-counter drugs which the patient takes must be noted in the patient's record. Over-the-counter drugs should be reported to the physician only if an RN determines that they could detrimentally affect the prescribed drugs of the patient. The label on the bottle of a prescription medication constitutes the pharmacist's transcription or documentation of the order. Such medications should be noted in the clinical record and listed on the recertification plan of care (Form CMS-485). This is consistent with acceptable standards of practice, and Federal regulations do not have additional requirements. Aides may help patients take drugs ordinarily self-administered by the patient, unless the State restricts this practice. PROBES: 1- If HHA personnel identify patient sensitivity or other medication problems, what actions does the HHA require its personnel to take? 2- How does the HHA secure physicians' signatures on oral, change, or renewal orders? 3- How does the HHA ensure that oral orders are accepted, cosigned by the nurse ot therapist and countersigned by the physician appropriately?
0168 SKILLED NURSING SERVICES 484.30		

TAGS	RULES	INTERPRETIVE GUIDELINES
0169 SKILLED NURSING SERVICES 484.30	The HHA furnishes skilled nursing services by or under the supervision of a registered nurse.	
0170 SKILLED NURSING SERVICES 484.30	The HHA furnishes skilled nursing services in accordance with the plan of care.	
0171 DUTIES OF THE REGISTERED NURSE 484.30(a)	The registered nurse makes the initial evaluation visit.	An RN is required to make the initial evaluation visit except in those circumstances where the physician has ordered only therapy services. If the physician orders only therapy services, it would be acceptable for the appropriate therapist (physical therapist or speech-language pathologist) to perform the initial evaluation visit. This does not mean that an HHA is precluded from having the RN perform all initial evaluation visits if the HHA believes that this promotes coordinated patient care, and/or if this is part of the HHA's own policies, procedures, and particular approach to patient care services. Review a case-mix, stratified sample of clinical records according to the HHA survey and certification process, and make home visits to determine if RNs perform their responsibilities within the State's nurse practice acts, and in compliance with the plan of care. (See §484.12(c).) See §§2200 and 2202 of the SOM. PROBE: How does the HHA confirm that services requiring specialized nursing skills are furnished by individuals with the appropriate qualifications?

TAGS	RULES	INTERPRETIVE GUIDELINES
0172 DUTIES OF THE REGISTERED NURSE 484.30(a)	The registered nurse regularly re-evaluates the patients nursing needs.	An RN is required to make the initial evaluation visit except in those circumstances where the physician has ordered only therapy services. If the physician orders only therapy services, it would be acceptable for the appropriate therapist (physical therapist or speech-language pathologist) to perform the initial evaluation visit. This does not mean that an HHA is precluded from having the RN perform all initial evaluation visits if the HHA believes that this promotes coordinated patient care, and/or if this is part of the HHA's own policies, procedures, and particular approach to patient care services. Review a case-mix, stratified sample of clinical records according to the HHA survey and certification process, and make home visits to determine if RNs perform their responsibilities within the State's nurse practice acts, and in compliance with the plan of care. (See §484.12(c).) See §§2200 and 2202 of the SOM. PROBE: How does the HHA confirm that services requiring specialized nursing skills are furnished by individuals with the appropriate qualifications?
0173 DUTIES OF THE REGISTERED NURSE 484.30(a)	The registered nurse initiates the plan of care and necessary revisions.	An RN is required to make the initial evaluation visit except in those circumstances where the physician has ordered only therapy services. If the physician orders only therapy services, it would be acceptable for the appropriate therapist (physical therapist or speech-language pathologist) to perform the initial evaluation visit. This does not mean that an HHA is precluded from having the RN perform all initial evaluation visits if the HHA believes that this promotes coordinated patient care, and/or if this is part of the HHA's own policies, procedures, and particular approach to patient care services. Review a case-mix, stratified sample of clinical records according to the HHA survey and certification process, and make home visits to determine if RNs perform their responsibilities within the State's nurse practice acts, and in compliance with the plan of care. (See §484.12(c).) See §§2200 and 2202 of the SOM. PROBE: How does the HHA confirm that services requiring specialized nursing skills are furnished by individuals with the appropriate qualifications?

TAGS	RULES	INTERPRETIVE GUIDELINES
0174 DUTIES OF THE REGISTERED NURSE 484.30(a)	The registered nurse furnishes those services requiring substantial and specialized nursing skill.	An RN is required to make the initial evaluation visit except in those circumstances where the physician has ordered only therapy services. If the physician orders only therapy services, it would be acceptable for the appropriate therapist (physical therapist or speech-language pathologist) to perform the initial evaluation visit. This does not mean that an HHA is precluded from having the RN perform all initial evaluation visits if the HHA believes that this promotes coordinated patient care, and/or if this is part of the HHA's own policies, procedures, and particular approach to patient care services. Review a case-mix, stratified sample of clinical records according to the HHA survey and certification process, and make home visits to determine if RNs perform their responsibilities within the State's nurse practice acts, and in compliance with the plan of care. (See §484.12(c).) See §§2200 and 2202 of the SOM. PROBE: How does the HHA confirm that services requiring specialized nursing skills are furnished by individuals with the appropriate qualifications?
0175 DUTIES OF THE REGISTERED NURSE 484.30(a)	The registered nurse initiates appropriate preventative and rehabilitative nursing procedures.	An RN is required to make the initial evaluation visit except in those circumstances where the physician has ordered only therapy services. If the physician orders only therapy services, it would be acceptable for the appropriate therapist (physical therapist or speech-language pathologist) to perform the initial evaluation visit. This does not mean that an HHA is precluded from having the RN perform all initial evaluation visits if the HHA believes that this promotes coordinated patient care, and/or if this is part of the HHA's own policies, procedures, and particular approach to patient care services. Review a case-mix, stratified sample of clinical records according to the HHA survey and certification process, and make home visits to determine if RNs perform their responsibilities within the State's nurse practice acts, and in compliance with the plan of care. (See §484.12(c).) See §§2200 and 2202 of the SOM. PROBE: How does the HHA confirm that services requiring specialized nursing skills are furnished by individuals with the appropriate qualifications?

TAGS	RULES	INTERPRETIVE GUIDELINES
0176 DUTIES OF THE REGISTERED NURSE 484.30(a)	The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.	An RN is required to make the initial evaluation visit except in those circumstances where the physician has ordered only therapy services. If the physician orders only therapy services, it would be acceptable for the appropriate therapist (physical therapist or speech-language pathologist) to perform the initial evaluation visit. This does not mean that an HHA is precluded from having the RN perform all initial evaluation visits if the HHA believes that this promotes coordinated patient care, and/or if this is part of the HHA's own policies, procedures, and particular approach to patient care services. Review a case-mix, stratified sample of clinical records according to the HHA survey and certification process, and make home visits to determine if RNs perform their responsibilities within the State's nurse practice acts, and in compliance with the plan of care. (See §484.12(c).) See §§2200 and 2202 of the SOM. PROBE: How does the HHA confirm that services requiring specialized nursing skills are furnished by individuals with the appropriate qualifications?
0177 DUTIES OF THE REGISTERED NURSE 484.30(a)	The registered nurse counsels the patient and family in meeting nursing and related needs.	An RN is required to make the initial evaluation visit except in those circumstances where the physician has ordered only therapy services. If the physician orders only therapy services, it would be acceptable for the appropriate therapist (physical therapist or speech-language pathologist) to perform the initial evaluation visit. This does not mean that an HHA is precluded from having the RN perform all initial evaluation visits if the HHA believes that this promotes coordinated patient care, and/or if this is part of the HHA's own policies, procedures, and particular approach to patient care services. Review a case-mix, stratified sample of clinical records according to the HHA survey and certification process, and make home visits to determine if RNs perform their responsibilities within the State's nurse practice acts, and in compliance with the plan of care. (See §484.12(c).) See §§2200 and 2202 of the SOM. PROBE: How does the HHA confirm that services requiring specialized nursing skills are furnished by individuals with the appropriate qualifications?

TAGS	RULES	INTERPRETIVE GUIDELINES
0178 DUTIES OF THE REGISTERED NURSE 484.30(a)	The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel.	An RN is required to make the initial evaluation visit except in those circumstances where the physician has ordered only therapy services. If the physician orders only therapy services, it would be acceptable for the appropriate therapist (physical therapist or speech-language pathologist) to perform the initial evaluation visit. This does not mean that an HHA is precluded from having the RN perform all initial evaluation visits if the HHA believes that this promotes coordinated patient care, and/or if this is part of the HHA's own policies, procedures, and particular approach to patient care services. Review a case-mix, stratified sample of clinical records according to the HHA survey and certification process, and make home visits to determine if RNs perform their responsibilities within the State's nurse practice acts, and in compliance with the plan of care. (See §484.12(c).) See §§2200 and 2202 of the SOM. PROBE: How does the HHA confirm that services requiring specialized nursing skills are furnished by individuals with the appropriate qualifications?
0179 DUTIES OF THE LICENSED PRACTICAL NURSE 484.30(b)	The licensed practical nurse furnishes services in accordance with agency policy.	Determine if services are provided in accordance with the HHA's professional practice standards and with guidance and supervision from RNs. Make the same comparisons set forth in the §484.30(a) probe when reviewing duties of the LPN.
0180 DUTIES OF THE LICENSED PRACTICAL NURSE 484.30(b)	The licensed practical nurse prepares clinical and progress notes.	Determine if services are provided in accordance with the HHA's professional practice standards and with guidance and supervision from RNs. Make the same comparisons set forth in the §484.30(a) probe when reviewing duties of the LPN.
0181 DUTIES OF THE LICENSED PRACTICAL NURSE 484.30(b)	The licensed practical nurse assists the physician and registered nurse in performing specialized procedures.	Determine if services are provided in accordance with the HHA's professional practice standards and with guidance and supervision from RNs. Make the same comparisons set forth in the §484.30(a) probe when reviewing duties of the LPN.
0182 DUTIES OF THE LICENSED PRACTICAL NURSE 484.30(b)	The licensed practical nurse prepares equipment and materials for treatments, observing aseptic technique as required.	Determine if services are provided in accordance with the HHA's professional practice standards and with guidance and supervision from RNs. Make the same comparisons set forth in the §484.30(a) probe when reviewing duties of the LPN.

TAGS	RULES	INTERPRETIVE GUIDELINES
0183 DUTIES OF THE LICENSED PRACTICAL NURSE 484.30(b)	The licensed practical nurse assists the patient in learning appropriate self-care techniques.	Determine if services are provided in accordance with the HHA's professional practice standards and with guidance and supervision from RNs. Make the same comparisons set forth in the §484.30(a) probe when reviewing duties of the LPN.
0184 THERAPY SERVICES 484.32		
0185 THERAPY SERVICES 484.32	Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care.	PROBES: 1- How does the HHA ensure that therapy services furnished by staff under arrangement or contract meet the requirements of this condition? 2- Are patient recordings in the clinical record current, describing responses to therapy? 3- How does the HHA coordinate therapy services with other skilled services to complete the plan of care and promote positive therapeutic outcomes?
0186 THERAPY SERVICES 484.32	The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.)	PROBES: 1- How does the HHA ensure that therapy services furnished by staff under arrangement or contract meet the requirements of this condition? 2- Are patient recordings in the clinical record current, describing responses to therapy? 3- How does the HHA coordinate therapy services with other skilled services to complete the plan of care and promote positive therapeutic outcomes?
0187 THERAPY SERVICES 484.32	The qualified therapist prepares clinical and progress notes.	PROBES: 1- How does the HHA ensure that therapy services furnished by staff under arrangement or contract meet the requirements of this condition? 2- Are patient recordings in the clinical record current, describing responses to therapy? 3- How does the HHA coordinate therapy services with other skilled services to complete the plan of care and promote positive therapeutic outcomes?

TAGS	RULES	INTERPRETIVE GUIDELINES
0188 THERAPY SERVICES 484.32	The qualified therapist advises and consults with the family and other agency personnel.	PROBES: 1- How does the HHA ensure that therapy services furnished by staff under arrangement or contract meet the requirements of this condition? 2- Are patient recordings in the clinical record current, describing responses to therapy? 3- How does the HHA coordinate therapy services with other skilled services to complete the plan of care and promote positive therapeutic outcomes?
0189 THERAPY SERVICES 484.32	The qualified therapist participates in in-service programs.	PROBES: 1- How does the HHA ensure that therapy services furnished by staff under arrangement or contract meet the requirements of this condition? 2- Are patient recordings in the clinical record current, describing responses to therapy? 3- How does the HHA coordinate therapy services with other skilled services to complete the plan of care and promote positive therapeutic outcomes?
0190 SUPERVISION OF PHYSICAL & OCCUPATIONAL 484.32(a)	Services furnished by a qualified physical therapy assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist. A physical therapy assistant or occupational therapy assistant performs services planned, delegated, and supervised by the therapist.	Specific instructions for assistants must be based on treatments prescribed in the plan of care, patient evaluations by the therapist, and accepted standards of professional practice. The therapist evaluates the effectiveness of the services furnished by the assistant. Documentation in the clinical record should show that communication and supervision exist between the assistant and therapist about the patient's condition, the patient's response to services furnished by the assistant, and the need to change the plan of care. PROBES: 1- How does the therapist evaluate the patient's needs and responses to services furnished by the assistant to measure the patient's progress in achieving the anticipated outcomes? 2- How does the HHA ensure that plans of care are initiated by the assistant only with appropriate supervision by the therapist when therapy services are provided under arrangement or contract? 3- What kinds of in-service programs have the therapist and assistant participated in during the past year? Who provides them?

TAGS	RULES	INTERPRETIVE GUIDELINES
0191 SUPERVISION OF PHYSICAL & OCCUPATIONAL 484.32(a)	A physical therapy assistant or occupational therapy assistant assists in preparing clinical notes and progress reports.	Specific instructions for assistants must be based on treatments prescribed in the plan of care, patient evaluations by the therapist, and accepted standards of professional practice. The therapist evaluates the effectiveness of the services furnished by the assistant. Documentation in the clinical record should show that communication and supervision exist between the assistant and therapist about the patient's condition, the patient's response to services furnished by the assistant, and the need to change the plan of care. PROBES: 1- How does the therapist evaluate the patient's needs and responses to services furnished by the assistant to measure the patient's progress in achieving the anticipated outcomes? 2- How does the HHA ensure that plans of care are initiated by the assistant only with appropriate supervision by the therapist when therapy services are provided under arrangement or contract? 3- What kinds of in-service programs have the therapist and assistant participated in during the past year? Who provides them?
0192 SUPERVISION OF PHYSICAL & OCCUPATIONAL 484.32(a)	A physical therapy assistant or occupational therapy assistant participates in educating the patient and family, and in in-service programs.	Specific instructions for assistants must be based on treatments prescribed in the plan of care, patient evaluations by the therapist, and accepted standards of professional practice. The therapist evaluates the effectiveness of the services furnished by the assistant. Documentation in the clinical record should show that communication and supervision exist between the assistant and therapist about the patient's condition, the patient's response to services furnished by the assistant, and the need to change the plan of care. PROBES: 1- How does the therapist evaluate the patient's needs and responses to services furnished by the assistant to measure the patient's progress in achieving the anticipated outcomes? 2- How does the HHA ensure that plans of care are initiated by the assistant only with appropriate supervision by the therapist when therapy services are provided under arrangement or contract? 3- What kinds of in-service programs have the therapist and assistant participated in during the past year? Who provides them?

TAGS	RULES	INTERPRETIVE GUIDELINES
0193 SUPERVISION OF SPEECH THERAPY SERVICES 484.32(b)	Speech therapy services are furnished only by or under the supervision of a qualified speech-language pathologist or audiologist.	PROBE: How does the HHA confirm that speech therapy services provided under arrangement or contract, meet the requirements of this condition?
0194 MEDICAL SOCIAL SERVICES 484.34		Medical social services, when required by the plan of care, must be available on a visiting, not consultative, basis in a patient's place of residence. Either the social worker or a social work assistant may make the initial visit to the HHA patient. Information gathered during the home visit is reviewed by the social worker who makes suggestions to the physician for additions to the plan of care. The social worker may provide the patient with approved professional services or assign the care to the assistant, providing supervision as required. (See §484.2.) PROBE: How does the HHA confirm that patients' social service needs are adequately met, including those services provided under arrangement or contract?
0195 MEDICAL SOCIAL SERVICES 484.34	If the agency furnishes medical social services, those services are given by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker, and in accordance with the plan of care. The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems.	Medical social services, when required by the plan of care, must be available on a visiting, not consultative, basis in a patient's place of residence. Either the social worker or a social work assistant may make the initial visit to the HHA patient. Information gathered during the home visit is reviewed by the social worker who makes suggestions to the physician for additions to the plan of care. The social worker may provide the patient with approved professional services or assign the care to the assistant, providing supervision as required. (See §484.2.) PROBE: How does the HHA confirm that patients' social service needs are adequately met, including those services provided under arrangement or contract?

TAGS	RULES	INTERPRETIVE GUIDELINES
0196 MEDICAL SOCIAL SERVICES 484.34	The social worker participates in the development of the plan of care.	Medical social services, when required by the plan of care, must be available on a visiting, not consultative, basis in a patient's place of residence. Either the social worker or a social work assistant may make the initial visit to the HHA patient. Information gathered during the home visit is reviewed by the social worker who makes suggestions to the physician for additions to the plan of care. The social worker may provide the patient with approved professional services or assign the care to the assistant, providing supervision as required. (See §484.2.) PROBE: How does the HHA confirm that patients' social service needs are adequately met, including those services provided under arrangement or contract?
0197 MEDICAL SOCIAL SERVICES 484.34	The social worker prepares clinical and progress notes.	Medical social services, when required by the plan of care, must be available on a visiting, not consultative, basis in a patient's place of residence. Either the social worker or a social work assistant may make the initial visit to the HHA patient. Information gathered during the home visit is reviewed by the social worker who makes suggestions to the physician for additions to the plan of care. The social worker may provide the patient with approved professional services or assign the care to the assistant, providing supervision as required. (See §484.2.) PROBE: How does the HHA confirm that patients' social service needs are adequately met, including those services provided under arrangement or contract?

TAGS	RULES	INTERPRETIVE GUIDELINES
0198 MEDICAL SOCIAL SERVICES 484.34	The social worker works with the family.	Medical social services, when required by the plan of care, must be available on a visiting, not consultative, basis in a patient's place of residence. Either the social worker or a social work assistant may make the initial visit to the HHA patient. Information gathered during the home visit is reviewed by the social worker who makes suggestions to the physician for additions to the plan of care. The social worker may provide the patient with approved professional services or assign the care to the assistant, providing supervision as required. (See §484.2.) PROBE: How does the HHA confirm that patients' social service needs are adequately met, including those services provided under arrangement or contract?
0199 MEDICAL SOCIAL SERVICES 484.34	The social worker uses appropriate community resources.	Medical social services, when required by the plan of care, must be available on a visiting, not consultative, basis in a patient's place of residence. Either the social worker or a social work assistant may make the initial visit to the HHA patient. Information gathered during the home visit is reviewed by the social worker who makes suggestions to the physician for additions to the plan of care. The social worker may provide the patient with approved professional services or assign the care to the assistant, providing supervision as required. (See §484.2.) PROBE: How does the HHA confirm that patients' social service needs are adequately met, including those services provided under arrangement or contract?

TAGS	RULES	INTERPRETIVE GUIDELINES
0200 MEDICAL SOCIAL SERVICES 484.34	The social worker participates in discharge planning and in in-service programs.	Medical social services, when required by the plan of care, must be available on a visiting, not consultative, basis in a patient's place of residence. Either the social worker or a social work assistant may make the initial visit to the HHA patient. Information gathered during the home visit is reviewed by the social worker who makes suggestions to the physician for additions to the plan of care. The social worker may provide the patient with approved professional services or assign the care to the assistant, providing supervision as required. (See §484.2.) PROBE: How does the HHA confirm that patients' social service needs are adequately met, including those services provided under arrangement or contract?
0201 MEDICAL SOCIAL SERVICES 484.34	The social worker acts as a consultant to other agency personnel.	

TAGS	RULES	INTERPRETIVE GUIDELINES
0202 HOME HEALTH AIDE SERVICES 484.36		CMS has identified the requirements that a home health aide training program and competency evaluation program or competency evaluation program must have for individuals to qualify as home health aides in a Medicare participating HHA. CMS does not intend to provide any additional procedures or further elaboration concerning skills in which aides must become proficient beyond the subject areas identified. It is the responsibility of the HHA to ensure that aides are proficient to carry out the patient care they are assigned, in a safe, effective, and efficient manner. The HHA is responsible for ensuring that home health aides used by the HHA meet the provisions of §484.4 and §484.36. This includes home health aides trained and evaluated by other HHAs or other organizations, and those hired by the HHA under an arrangement as well as those who are employed by the HHA. While CMS will not establish a national program to approve each home health aide training and competency evaluation program, a sample of home health aides used by a particular HHA will have their files reviewed for documentation of compliance with the training and competency evaluation or competency evaluation requirements during a standard and/or partial extended or extended survey of the HHA. If the HHA has been out of compliance with a Condition of Participation, it may not provide its own 75 hour training program, its initial training and competency evaluation, or the competency evaluation for its aides to meet the requirements of §§484.36(a) and (b). With the exception of licensed health professionals and volunteers, home health aide training and competency evaluation or competency evaluation requirements apply to all individuals who are employed by or work under contract with a Medicare-certified HHA and who provide "hands-on" patient care services regardless of the title of the individual. It is the FUNCTION of the aide that determines the need for training and competency evaluation or competency evaluation. As discussed in general guidelines, all Conditions of Participation apply to a Medicare certified HHA as an entity and to all individuals or patients under the HHA's care. (See §§1861(m), 1861(o)(3) and 1891(a)(1) of the Social Security Act.)

TAGS	RULES	INTERPRETIVE GUIDELINES
0203 HOME HEALTH AIDE SERVICES 484.36(a)	Home health aides are selected on the basis of such factors as a sympathetic attitude toward the care of the sick, ability to read, write, and carry out directions, and maturity and ability to deal effectively with the demands of the job. They are closely supervised to ensure their competence in providing care. For home health services furnished (either directly or through arrangements with other organizations) after August 14, 1990, the HHA must use individuals who meet the personnel qualifications specified in §484.4 for "home health aide".	Classroom and supervised practical training should be based on an instruction plan that includes learning objectives, clinical content, and minimum, acceptable performance standards that meet the requirements of the regulation. A mannequin may be used for training purposes only.
0204 HHA TRAINING - CONTENT & DURATION 484.36(a)(1)	The aide training program must address each of the following subject areas through classroom and supervised practical training totalling at least 75 hours, with at least 16 hours devoted to supervised practical training.	Classroom and supervised practical training should be based on an instruction plan that includes learning objectives, clinical content, and minimum, acceptable performance standards that meet the requirements of the regulation. A mannequin may be used for training purposes only.
0205 HHA TRAINING - CONTENT & DURATION 484.36(a)(1)	The individual aide being trained must complete at least 16 hours of classroom training before beginning the supervised practical training.	Classroom and supervised practical training should be based on an instruction plan that includes learning objectives, clinical content, and minimum, acceptable performance standards that meet the requirements of the regulation. A mannequin may be used for training purposes only.

TAGS	RULES	INTERPRETIVE GUIDELINES
0206 HHA TRAINING - CONTENT AND DURATION 484.36(a)(1)	The home health aide must complete training in: - Communications skills. - Observation, reporting and documentation of patient status and the care or service furnished. - Reading and recording temperature, pulse, and respiration. - Basic infection control procedures. - Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. - Maintenance of a clean, safe, and healthy environment. - Recognizing emergencies and knowledge of emergency procedures. - The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy and his or her property. Appropriate and safe techniques in personal hygiene and grooming that include-- - Bed bath. - Sponge, tub, or shower bath. - Shampoo, sink, tub, or bed. - Nail and skin care. - Oral hygiene. - Toileting and elimination. - Safe transfer techniques and ambulation. - Normal range of motion and positioning. - Adequate nutrition and fluid intake. Any other task that the HHA may choose to have the home health aide perform. "Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse.	"Requirement" means non-compliance with a condition level deficiency. Effective February 14, 1990, an HHA must not have had any Condition of Participation out of compliance within 24 months before it begins a training and competency evaluation or competency evaluation program. Correction of a condition level deficiency does not relieve the 2-year restriction identified in this standard. Nothing in this standard precludes an HHA that has a condition out of compliance from hiring or contracting for aides who have already completed a training and competency evaluation or competency evaluation program, or arranging for aides to attend a training and competency evaluation or competency evaluation program provided by another entity. If a partial extended or extended survey is conducted, but substandard care (a condition out of compliance) is not found, the HHA would not be precluded from offering its own aide training and/or competency evaluation program. If an HHA, while conducting its own training and competency evaluation program or competency evaluation program, has either a standard, partial extended or extended survey in which it is found to be out of compliance with a Condition of Participation, it may complete that training and competency evaluation program or competency evaluation program for aides currently enrolled, but it may not accept new candidates into the program or begin a new program, for 2 years after receiving written notice from the RO that the HHA was out of compliance with one or more Conditions of Participation.

TAGS	RULES	INTERPRETIVE GUIDELINES
0207 HHA TRAINING - CONDUCT 484.36(a)(2)	A home health aide training program may be offered by any organization except an HHA that, within the previous two years, has been found: - Out of compliance with requirements of this paragraph (a) or paragraph (b) of this section - To permit an individual that does not meet the definition of "home health aide" as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers) - Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State) - Has been assessed a civil monetary penalty of not less than $5,000 as an intermediate sanction - Has been found to have compliance deficiencies that endanger the health and safety of the HHA's patients and has had a temporary management appointed to oversee the management of the HHA - Has had all or part of its Medicare payments suspended Further, under any Federal or State law within the 2-year period beginning on October 1, 1988: - Has had its participation in the Medicare program terminated - Has been assessed a penalty of not less than $5,000 for deficiencies in Federal or State standards for HHAs - Was subject to a suspension of Medicare payments to which it otherwise would have been entitled; - Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients - Was closed or had its residents transferred by the State.	The required 2 years of nursing experience for the instructor should be "hands on" clinical experience such as providing care and/or supervising nursing services or teaching nursing skills in an organized curriculum or in-service program. "Other individuals" who may help with aide training would include health care professionals such as physical therapists, occupational therapists, medical social workers, and speech-language pathologists. Experienced aides, nutritionists, pharmacists, lawyers and consumers might also be teaching resources.
0208 HHA TRAINING - CONDUCT 484.36(a)(2)	The training of home health aides and the supervision of home health aides during the supervised practical portion of the training must be performed by or under the general supervision of a registered nurse who possesses a minimum of two years nursing experience, at least 1 year of which must be in the the provision of home health care.	The required 2 years of nursing experience for the instructor should be "hands on" clinical experience such as providing care and/or supervising nursing services or teaching nursing skills in an organized curriculum or in-service program. "Other individuals" who may help with aide training would include health care professionals such as physical therapists, occupational therapists, medical social workers, and speech-language pathologists. Experienced aides, nutritionists, pharmacists, lawyers and consumers might also be teaching resources.

TAGS	RULES	INTERPRETIVE GUIDELINES
0209 HHA TRAINING - CONDUCT 484.36(a)(2)	Other individuals may be used to provide instruction under the supervision of a qualified registered nurse.	It is the responsibility of the HHA to maintain adequate documentation of compliance with the regulation for home health aides employed by or under contract with the HHA. A home health aide may receive training from different organizations if the amount of training totals 75 hours, the content of training addresses all subjects listed at §484.36(a) and the organization, training, instructors, and documentation meet the requirements of the regulation. Documentation of training should include: o A description of the training/competency evaluation program, including the qualifications of the instructors; o A record that distinguishes between skills taught at a patient's bedside, with supervision, and those taught in a laboratory using a volunteer or "pseudo-patient," (not a mannequin) and indicators of which skills each aide was judged to be competent; and o How additional skills (beyond the basic skills listed in the regulation) are taught and tested if the admission policies and case-mix of HHA patients require aides to perform more complex procedures.
0210 HHA TRAINING - DOCUMENTATION 484.36(a)(3)	The HHA must maintain sufficient documentation to demonstrate that the requirements of this standard are met.	The HHA must ensure that skills learned or tested elsewhere can be transferred successfully to the care of the patient in his/her place of residence. The HHA should give careful attention to evaluating both employees and aides who provide services under arrangement or contract. This review of skills could be done when the nurse installs an aide into a new patient care situation, during a supervisory visit, or as part of the annual performance review. A mannequin may not be used for this evaluation. If the HHA's admission policies and the case-mix of HHA patients demand that the aide care for individuals whose personal care and basic nursing or therapy needs require more complex training than the minimum required in the regulation, the HHA must document how these additional skills are taught and tested. PROBE: If aide services are provided under arrangement or contract, how does the HHA ensure that aides providing patient care have the appropriate competency skills?

TAGS	RULES	INTERPRETIVE GUIDELINES
0211 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(1)	An individual may furnish home health aide services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this paragraph.	The HHA must ensure that skills learned or tested elsewhere can be transferred successfully to the care of the patient in his/her place of residence. The HHA should give careful attention to evaluating both employees and aides who provide services under arrangement or contract. This review of skills could be done when the nurse installs an aide into a new patient care situation, during a supervisory visit, or as part of the annual performance review. A mannequin may not be used for this evaluation. If the HHA's admission policies and the case-mix of HHA patients demand that the aide care for individuals whose personal care and basic nursing or therapy needs require more complex training than the minimum required in the regulation, the HHA must document how these additional skills are taught and tested. PROBE: If aide services are provided under arrangement or contract, how does the HHA ensure that aides providing patient care have the appropriate competency skills?

TAGS	RULES	INTERPRETIVE GUIDELINES
0212 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(1)	The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section.	HHAs are not required to conduct a yearly competency evaluation of its aides, but are required to do a performance review of each aide at least every 12 months. HHAs that are precluded from conducting their own training and/or competency evaluation programs must still complete their aides' annual performance reviews and in-service training as part of their administrative, personnel and patient care responsibilities. An annual performance review may be completed and documented over a period of time during an aide's two-week supervisory visits in a patient's home or during the installation of an aide in a new patient care situation. Any reasonable performance review method that is logical and consistent with the HHA's policies and procedures would meet the intent of this standard. Home health aide in-service training, that occurs with a patient in a place of residence, supervised by an RN, can occur as part of the two-week supervisory visit, but must be documented as to the exact new skill or theory taught. In-service training taught in the patient's environment should not be a repetition of a basic skill or part of the annual performance review of the aide's competency in basic skills. HHAs may fulfill the annual 12-hour in-service training requirement on either a calendar year basis or an employment anniversary basis. PROBE: If aide services are provided under arrangement or contract, how does the HHA ensure that aides providing patient care have the appropriate competency skills?

TAGS	RULES	INTERPRETIVE GUIDELINES
0213 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(2)(i)	The competency evaluation must address each of the subjects listed in paragraphs (a)(1)(ii) through (xiii) of this section.	HHAs are not required to conduct a yearly competency evaluation of its aides, but are required to do a performance review of each aide at least every 12 months. HHAs that are precluded from conducting their own training and/or competency evaluation programs must still complete their aides' annual performance reviews and in-service training as part of their administrative, personnel and patient care responsibilities. An annual performance review may be completed and documented over a period of time during an aide's two-week supervisory visits in a patient's home or during the installation of an aide in a new patient care situation. Any reasonable performance review method that is logical and consistent with the HHA's policies and procedures would meet the intent of this standard. Home health aide in-service training, that occurs with a patient in a place of residence, supervised by an RN, can occur as part of the two-week supervisory visit, but must be documented as to the exact new skill or theory taught. In-service training taught in the patient's environment should not be a repetition of a basic skill or part of the annual performance review of the aide's competency in basic skills. HHAs may fulfill the annual 12-hour in-service training requirement on either a calendar year basis or an employment anniversary basis. PROBE: If aide services are provided under arrangement or contract, how does the HHA ensure that aides providing patient care have the appropriate competency skills?

TAGS	RULES	INTERPRETIVE GUIDELINES
0214 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(2)(ii)	The HHA must complete a performance review of each home health aide no less frequently than every 12 months.	HHAs are not required to conduct a yearly competency evaluation of its aides, but are required to do a performance review of each aide at least every 12 months. HHAs that are precluded from conducting their own training and/or competency evaluation programs must still complete their aides' annual performance reviews and in-service training as part of their administrative, personnel and patient care responsibilities. An annual performance review may be completed and documented over a period of time during an aide's two-week supervisory visits in a patient's home or during the installation of an aide in a new patient care situation. Any reasonable performance review method that is logical and consistent with the HHA's policies and procedures would meet the intent of this standard. Home health aide in-service training, that occurs with a patient in a place of residence, supervised by an RN, can occur as part of the two-week supervisory visit, but must be documented as to the exact new skill or theory taught. In-service training taught in the patient's environment should not be a repetition of a basic skill or part of the annual performance review of the aide's competency in basic skills. HHAs may fulfill the annual 12-hour in-service training requirement on either a calendar year basis or an employment anniversary basis. PROBE: If aide services are provided under arrangement or contract, how does the HHA ensure that aides providing patient care have the appropriate competency skills?

TAGS	RULES	INTERPRETIVE GUIDELINES
0215 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(2)(iii)	The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient.	HHAs are not required to conduct a yearly competency evaluation of its aides, but are required to do a performance review of each aide at least every 12 months. HHAs that are precluded from conducting their own training and/or competency evaluation programs must still complete their aides' annual performance reviews and in-service training as part of their administrative, personnel and patient care responsibilities. An annual performance review may be completed and documented over a period of time during an aide's two-week supervisory visits in a patient's home or during the installation of an aide in a new patient care situation. Any reasonable performance review method that is logical and consistent with the HHA's policies and procedures would meet the intent of this standard. Home health aide in-service training, that occurs with a patient in a place of residence, supervised by an RN, can occur as part of the two-week supervisory visit, but must be documented as to the exact new skill or theory taught. In-service training taught in the patient's environment should not be a repetition of a basic skill or part of the annual performance review of the aide's competency in basic skills. HHAs may fulfill the annual 12-hour in-service training requirement on either a calendar year basis or an employment anniversary basis. PROBE: If aide services are provided under arrangement or contract, how does the HHA ensure that aides providing patient care have the appropriate competency skills?

TAGS	RULES	INTERPRETIVE GUIDELINES
0216 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(3)(i)	A home health aide competency evaluation program may be offered by an organization except as specified in paragraph (a)(2)(i) of this section. The in-service training may be offered by any organization.	Subject areas (a)(1)(iii), (ix), (x), and (xi) may be evaluated with the tasks being performed on a "pseudo-patient" such as another aide or volunteer in a laboratory setting. The tasks must not be simulated in any manner and the use of a mannequin is not an acceptable substitute. PROBES: 1- How does the HHA ensure that aides perform only tasks for which they received satisfactory ratings in the competency evaluation? 2- If the aide performs skills which exceed the basic skills included in this standard, how does the HHA train and test aides for competency? 3- How does the HHA plan for extended training if it is unable to train its own aides? 4- How does the HHA monitor the assignment of aides to match the skills needed for individual patients?
0217 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(3)(ii)	The competency evaluation must be performed by a registered nurse. The in-service training generally must be supervised by a registered nurse who possesses a minimum of 2 years of nursing experience at least 1 year of which must be in the provision of home health care.	Subject areas (a)(1)(iii), (ix), (x), and (xi) may be evaluated with the tasks being performed on a "pseudo-patient" such as another aide or volunteer in a laboratory setting. The tasks must not be simulated in any manner and the use of a mannequin is not an acceptable substitute. PROBES: 1- How does the HHA ensure that aides perform only tasks for which they received satisfactory ratings in the competency evaluation? 2- If the aide performs skills which exceed the basic skills included in this standard, how does the HHA train and test aides for competency? 3- How does the HHA plan for extended training if it is unable to train its own aides? 4- How does the HHA monitor the assignment of aides to match the skills needed for individual patients?

TAGS	RULES	INTERPRETIVE GUIDELINES
0218 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(3)(iii)	The subject areas listed at paragraphs (a)(1)(iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aides performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient.	Subject areas (a)(1)(iii), (ix), (x), and (xi) may be evaluated with the tasks being performed on a "pseudo-patient" such as another aide or volunteer in a laboratory setting. Use of a mannequin is not an acceptable substitute. PROBES: 1- How does the HHA ensure that aides perform only tasks for which they received satisfactory ratings in the competency evaluation? 2- If the aide performs skills which exceed the basic skills included in this standard, how does the HHA train and test aides for competency? 3- How does the HHA plan for extended training if it is unable to train its own aides? 4- How does the HHA monitor the assignment of aides to match the skills needed for individual patients?

TAGS	RULES	INTERPRETIVE GUIDELINES
0219 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(4)(i)	A home health aide is not considered competent in any task for which he or she is evaluated as "unsatisfactory". The aide must not perform that task without direct supervision by a licensed nurse until after he or she receives training in the task for which he or she was evaluated as "unsatisfactory" and passes a subsequent evaluation with "satisfactory".	A home health aide who is evaluated as "satisfactory" in all subject areas except one would be considered "competent". However, this aide would not be allowed to perform the task in which he or she was evaluated as "unsatisfactory" except under direct supervision. If a home health aide receives an "unsatisfactory" evaluation in more than one subject area, the aide would not be considered to have successfully passed a competency evaluation program and would be precluded from performing as a home health aide in any subject area. The regulations place no restrictions on the number of times or the period of time an aide can be tested in a deficient area. A home health aide may have different skills evaluated by different organizations as long as the organizations, the training and competency evaluation program(s), the evaluators, and the documentation meet the requirements of the regulation. The aide must have had ALL of the required skills evaluated. Aides that have undergone a "sampling methodology" for the evaluation of aide skills must have the additional required skills evaluated before the aide is determined to be competent. Aides required to provide items or services which exceed the basic skills must demonstrate competency before they are assigned to care for patients who require these skills. It is not intended that all home health aides be required to deliver all types of home health services. However, each individual aide should be qualified to perform each individual task for which he or she is responsible. PROBES: 1- How does the HHA confirm aide skills on an ongoing basis for its employees including new hires and personnel under arrangement or contract? 2- If aides are performing tasks that are an extension of home health services other than nursing, how does the HHA document that these aides have proven competency in these tasks to the appropriate health professional?

TAGS	RULES	INTERPRETIVE GUIDELINES
0220 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(4)(ii)	A home health aide is not considered to have successfully passed a competency evaluation if the aide has an "unsatisfactory" rating in more than one of the required areas.	A home health aide who is evaluated as "satisfactory" in all subject areas except one would be considered "competent". However, this aide would not be allowed to perform the task in which he or she was evaluated as "unsatisfactory" except under direct supervision. If a home health aide receives an "unsatisfactory" evaluation in more than one subject area, the aide would not be considered to have successfully passed a competency evaluation program and would be precluded from performing as a home health aide in any subject area. The regulations place no restrictions on the number of times or the period of time an aide can be tested in a deficient area. A home health aide may have different skills evaluated by different organizations as long as the organizations, the training and competency evaluation program(s), the evaluators, and the documentation meet the requirements of the regulation. The aide must have had ALL of the required skills evaluated. Aides that have undergone a "sampling methodology" for the evaluation of aide skills must have the additional required skills evaluated before the aide is determined to be competent. Aides required to provide items or services which exceed the basic skills must demonstrate competency before they are assigned to care for patients who require these skills. It is not intended that all home health aides be required to deliver all types of home health services. However, each individual aide should be qualified to perform each individual task for which he or she is responsible. PROBES: 1- How does the HHA confirm aide skills on an ongoing basis for its employees including new hires and personnel under arrangement or contract? 2- If aides are performing tasks that are an extension of home health services other than nursing, how does the HHA document that these aides have proven competency in these tasks to the appropriate health professional?
0221 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(5)	The HHA must maintain documentation which demonstrates that the requirements of this standard are met.	
0222 COMPETENCY EVALUATION & IN-SERVICE TRAI 484.36(b)(6)	The HHA must implement a competency evaluation program that meets the requirements of this paragraph before February 14, 1990. The HHA must provide the preparation necessary for the individual to successfully complete the competency evaluation program. After August 14, 1990, the HHA may use only those aides that have been found to be competent in accordance with §484.36(b).	

TAGS	RULES	INTERPRETIVE GUIDELINES
0223 ASSIGNMENT & DUTIES OF HOME HEALTH AIDE 484.36(c)(1)	The home health aide is assigned to a specific patient by the registered nurse.	The aide assignments must consider the skills of the aide, the amount and kind of supervision needed, specific nursing or therapy needs of the patient, and the capabilities of the patient's family. During the standard survey, when possible, schedule at least one home visit when a home health aide is present. Informal questions to the aide(s) or a review of the aide's assignment sheets will offer information about HHA compliance with this standard. To evaluate coordination of home health aide services according to the requirements of §484.14(g), look for documentation by the aide in the clinical records that describes significant information or changes to his or her patient's conditions, and to whom he or she reported the information. Notes should be dated and signed by the aide. If the aide is performing simple procedures as an extension of therapy services, review documentation of how the aide was evaluated for competency to perform these tasks. Also, review the plan of care and therapy notes to insure that the services performed by the aide are not services ordered by the physician to be performed by a qualified therapist or therapy assistant.
0224 ASSIGNMENT & DUTIES OF HOME HEALTH AIDE 484.36(c)(1)	Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.	The aide assignments must consider the skills of the aide, the amount and kind of supervision needed, specific nursing or therapy needs of the patient, and the capabilities of the patient's family. During the standard survey, when possible, schedule at least one home visit when a home health aide is present. Informal questions to the aide(s) or a review of the aide's assignment sheets will offer information about HHA compliance with this standard. To evaluate coordination of home health aide services according to the requirements of §484.14(g), look for documentation by the aide in the clinical records that describes significant information or changes to his or her patient's conditions, and to whom he or she reported the information. Notes should be dated and signed by the aide. If the aide is performing simple procedures as an extension of therapy services, review documentation of how the aide was evaluated for competency to perform these tasks. Also, review the plan of care and therapy notes to insure that the services performed by the aide are not services ordered by the physician to be performed by a qualified therapist or therapy assistant.

TAGS	RULES	INTERPRETIVE GUIDELINES
0225 ASSIGNMENT & DUTIES OF HOME HEALTH AIDE 484.36(c)(2)	The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.	See §484.4 for the definition of a home health aide.
0226 ASSIGNMENT & DUTIES OF HOME HEALTH AIDE 484.36(c)(2)	The duties of a home health aide include the provision of hands on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self administered.	See §484.4 for the definition of a home health aide.
0227 ASSIGNMENT & DUTIES OF HOME HEALTH AIDE 484.36(c)(2)	Any home health aide services offered by an HHA must be provided by a qualified home health aide.	
0228 SUPERVISION 484.36(d)(1)	If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist.	Supervision visits may be made in conjunction with a professional visit to provide services. In any patient care situation where an HHA is providing care for an individual who has a condition which requires non-skilled, supportive home health aide services to help the patient with personal care or activities of daily living, the 2 week supervisory visit is not applicable. The RN must make a supervisory visit at least every 62 days. This must be made while the aide is furnishing patient care. PROBE: How does the HHA schedule supervisory visits so that aide skills can be evaluated?
0229 SUPERVISION 484.36(d)(2)	The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.	Supervision visits may be made in conjunction with a professional visit to provide services. In any patient care situation where an HHA is providing care for an individual who has a condition which requires non-skilled, supportive home health aide services to help the patient with personal care or activities of daily living, the 2 week supervisory visit is not applicable. The RN must make a supervisory visit at least every 62 days. This must be made while the aide is furnishing patient care. PROBE: How does the HHA schedule supervisory visits so that aide skills can be evaluated?

TAGS	RULES	INTERPRETIVE GUIDELINES
0230 SUPERVISION 484.36(d)(3)	If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 62 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care.	Supervision visits may be made in conjunction with a professional visit to provide services. In any patient care situation where an HHA is providing care for an individual who has a condition which requires non-skilled, supportive home health aide services to help the patient with personal care or activities of daily living, the 2 week supervisory visit is not applicable. The RN must make a supervisory visit at least every 62 days. This must be made while the aide is furnishing patient care. PROBE: How does the HHA schedule supervisory visits so that aide skills can be evaluated?
0231 SUPERVISION 484.36(d)(4)	If home health aide services are provided by an individual who is not employed directly by the HHA (or hospice), the services of the home health aide must be provided under arrangements, as defined in section 1861(w)(1) of the Act.	An individual providing services under an arrangement can qualify as a home health aide by completing a training and competency evaluation program or a competency evaluation program. PROBE: How does the HHA ensure that home health aides providing services under arrangements are supervised according to the requirements of §484.36(d)(1) and (d)(2) and meet the training and or competency evaluation requirements of §484.36(a) or (b)?
0232 SUPERVISION 484.36(d)(4)(i)	If the HHA (or hospice) chooses to provide home health aide services under arrangements with another organization, the HHA's (or hospice's) responsibilities include, but are not limited to, ensuring the overall quality of the care provided by the aide.	
0233 PERSONAL CARE ATTENDANT EVALUATION REQU 484.36(e)	This paragraph applies to individuals who are employed by HHAs exclusively to furnish personal care attendant services under a Medicaid personal care benefit. An individual may furnish personal care services, as defined in §440.170 of this chapter, on behalf of an HHA after the individual has been found competent by the State to furnish those services for which a competency evaluation is required by paragraph (b) of this section and which the individual is required to perform. The individual need not be determined competent in those services listed in paragraph (a) of this section that the individual is not required to furnish.	Personal care services also include those services defined at §440.180. PCAs who are employed by HHAs to furnish services under a Medicaid personal care benefit must abide by all other requirements for home health aides listed at 42 CFR 484.36 with the explicit exception of 42 CFR 484.36(e).

TAGS	RULES	INTERPRETIVE GUIDELINES
0234 QUALIFYING TO FURNISH OPT OR SPS 484.38	An HHA that wishes to furnish outpatient physical therapy or speech pathology services must meet all the pertinent conditions of this part and also meet the additional health and safety requirements set forth in sections 485.711-485.715, 485.719, 485.723 and 485.727 of this chapter to implement section 1861(p) of the Act.	An HHA that furnishes outpatient therapy services on its own premises, including its branches, must comply with the listed citations as well as meet all other Conditions of Participation. §§485.723 and 485.727 are not applicable when patients are served in their own homes. §§485.723 and 485.727 are applicable, and may be surveyed at the SA's or RO's discretion, when specialized rehabilitation space and equipment is owned, leased, operated, contracted for, or arranged for at sites under the HHA's control and when the HHA bills the Medicare/Medicaid programs for services rendered at these sites. Complete the corresponding section of the Outpatient Physical Therapy or Speech Pathology Survey Report, CMS-1893, and attach it to the Home Health Agency Survey and Deficiencies Report, Form CMS-1572 when surveying these sites. Indicate the agency's certification to provide outpatient therapy services via special remarks on the Certification and Transmittal, CMS-1539. (See §2764 Item 16.) The plan of care for outpatient physical and speech pathology therapy services may be developed by the individual therapist. For Medicare patients receiving outpatient physical and/or speech pathology therapy services, the plan of care and results of treatment must be reviewed by a physician. Non-Medicare patients are not required to be under the care of a physician, and therefore do not need a plan of care established by and reviewed by a physician. For non-Medicare patients, the plan of care may be reviewed by the therapist who established it or by a physician. (See Appendix E, Interpretive Guidelines, Outpatient Physical or Speech Pathology Service - Physicians' Directions and Plan of Care.)
0235 CLINICAL RECORDS 484.48		

TAGS	RULES	INTERPRETIVE GUIDELINES
0236 CLINICAL RECORDS 484.48	A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.	The clinical record must provide a current, organized, and clearly written synopsis of the patient's course of treatment, including services provided for the HHA by arrangement or contract. The clinical record should facilitate effective, efficient and coordinated care. Questionable patterns, rather then isolated instances, in clinical records are an indicator that the quality of care provided by the HHA needs to be carefully assessed for compliance with the plan of care, coordination of services, concurrence with the HHA's stated policies and procedures, and evaluations of patient outcomes. However, isolated instances depending on their nature and severity, can serve as the basis of a deficiency and enforcement action. (e.g. immediate and serious threat as outlined in appendix Q.) While the regulations specify that the documents must be signed, they do not prohibit the use of electronic signatures. HHAs which have created the option for an individuals record to be maintained by computer, rather than hard copy, may use electronic signatures as long as there is a process for reconstruction of the information, and there are safeguards to prevent unauthorized access to the records. Clinical progress notes, and summary reports as defined in §484.2 must be maintained on all patients. Forms CMS-486 (and CMS-487) may be used as a progress note and /or a summary report. Notations should be appropriately labeled and should provide an overall comprehensive view of the patient's total progress and /or current summary report including social, emotional, or behavioral adjustments relative to the diagnosis, treatment, rehabilitation potential, and anticipated outcomes toward recovery or further debilitation. The regulation does not dictate the frequency with which progress notes must be written. If necessary, review the HHA's policies and procedures concerning the frequency of preparing progress notes. The discharge summary need not be a separate piece of paper and may be incorporated into the routine summary reports already furnished to the physician. PROBES: 1- Are there patterns in the clinical records that are of concern? 2- Do clinical records document patient progress and outcomes of care based on changes in the patient's condition? 3- How does the HHA inform the attending physician of the availability of a discharge summary? 4- How does the HHA ensure that the discharge summary is sent to the attending physician upon his /her request?

TAGS	RULES	INTERPRETIVE GUIDELINES
0237 RETENTION OF RECORDS 484.48(a)	Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies provide for retention even if the HHA discontinues operations.	An HHA may store clinical and health insurance records on microfilm or optical disk imaging systems. All material must be available for review by CMS, the intermediary, Department of Health and Human Services, or other specially designated components for bill review, audit, or other examination during the retention period. With respect to a State agency or Federal survey to ensure compliance with the Conditions of Participation, clinical records requested by the surveyor along with the equipment necessary to read them, must be made available during the course of the unannounced survey.
0238 RETENTION OF RECORDS 484.48(a)	If a patient is transferred to another health facility, a copy of the record or abstract is sent with the patient.	An HHA may store clinical and health insurance records on microfilm or optical disk imaging systems. All material must be available for review by CMS, the intermediary, Department of Health and Human Services, or other specially designated components for bill review, audit, or other examination during the retention period. With respect to a State agency or Federal survey to ensure compliance with the Conditions of Participation, clinical records requested by the surveyor along with the equipment necessary to read them, must be made available during the course of the unannounced survey.
0239 PROTECTION OF RECORDS 484.48(b)	Clinical record information is safeguarded against loss or unauthorized use.	PROBES: 1- How are clinical records stored to protect them from physical destruction and unauthorized use? 2- What written policies and procedures govern the use, removal, and release of clinical records? 3- How does the HHA make the records available for all personnel furnishing services on behalf of the HHA?
0240 PROTECTION OF RECORDS 484.48(b)	Written procedures govern the use and removal of records and the conditions for release of information.	PROBES: 1- How are clinical records stored to protect them from physical destruction and unauthorized use? 2- What written policies and procedures govern the use, removal, and release of clinical records? 3- How does the HHA make the records available for all personnel furnishing services on behalf of the HHA?
0241 PROTECTION OF RECORDS 484.48(b)	The patient's written consent is required for the release of information not authorized by law.	PROBES: 1- How are clinical records stored to protect them from physical destruction and unauthorized use? 2- What written policies and procedures govern the use, removal, and release of clinical records? 3- How does the HHA make the records available for all personnel furnishing services on behalf of the HHA?

TAGS	RULES	INTERPRETIVE GUIDELINES
0242 EVALUATION OF THE AGENCY'S PROGRAM 484.52		All aspects of the HHA's evaluation are not required to have been done at the same time or by the same evaluators. For example, fiscal, patient care, and administrative policies may be evaluated by different members or committees of the group responsible for performing the evaluation at different times of the year. Patient care services should have been evaluated by providers and consumers. A "consumer" may be any individual in the community outside the agency, regardless of whether he or she has been a recipient of, or is eligible to receive, home health services. The evaluation should address the total program including services furnished directly to patients, and the administration and management of the HHA, including, but not limited to, policies and procedures, contract management, personnel management, clinical record review, patient care, and the extent to which the goals and objectives of the HHA are met. Results of the HHA's overall annual evaluation must be available for surveyor review, upon request.
0243 EVALUATION OF THE AGENCY'S PROGRAM 484.52	The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by the group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers.	All aspects of the HHA's evaluation are not required to have been done at the same time or by the same evaluators. For example, fiscal, patient care, and administrative policies may be evaluated by different members or committees of the group responsible for performing the evaluation at different times of the year. Patient care services should have been evaluated by providers and consumers. A "consumer" may be any individual in the community outside the agency, regardless of whether he or she has been a recipient of, or is eligible to receive, home health services. The evaluation should address the total program including services furnished directly to patients, and the administration and management of the HHA, including, but not limited to, policies and procedures, contract management, personnel management, clinical record review, patient care, and the extent to which the goals and objectives of the HHA are met. Results of the HHA's overall annual evaluation must be available for surveyor review, upon request.

TAGS	RULES	INTERPRETIVE GUIDELINES
0244 EVALUATION OF THE AGENCY'S PROGRAM 484.52	The evaluation consists of an overall policy and administrative review and a clinical record review.	All aspects of the HHA's evaluation are not required to have been done at the same time or by the same evaluators. For example, fiscal, patient care, and administrative policies may be evaluated by different members or committees of the group responsible for performing the evaluation at different times of the year. Patient care services should have been evaluated by providers and consumers. A "consumer" may be any individual in the community outside the agency, regardless of whether he or she has been a recipient of, or is eligible to receive, home health services. The evaluation should address the total program including services furnished directly to patients, and the administration and management of the HHA, including, but not limited to, policies and procedures, contract management, personnel management, clinical record review, patient care, and the extent to which the goals and objectives of the HHA are met. Results of the HHA's overall annual evaluation must be available for surveyor review, upon request.
0245 EVALUATION OF THE AGENCY'S PROGRAM 484.52	The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.	All aspects of the HHA's evaluation are not required to have been done at the same time or by the same evaluators. For example, fiscal, patient care, and administrative policies may be evaluated by different members or committees of the group responsible for performing the evaluation at different times of the year. Patient care services should have been evaluated by providers and consumers. A "consumer" may be any individual in the community outside the agency, regardless of whether he or she has been a recipient of, or is eligible to receive, home health services. The evaluation should address the total program including services furnished directly to patients, and the administration and management of the HHA, including, but not limited to, policies and procedures, contract management, personnel management, clinical record review, patient care, and the extent to which the goals and objectives of the HHA are met. Results of the HHA's overall annual evaluation must be available for surveyor review, upon request.

TAGS	RULES	INTERPRETIVE GUIDELINES
0246 EVALUATION OF THE AGENCY'S PROGRAM 484.52	Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency.	All aspects of the HHA's evaluation are not required to have been done at the same time or by the same evaluators. For example, fiscal, patient care, and administrative policies may be evaluated by different members or committees of the group responsible for performing the evaluation at different times of the year. Patient care services should have been evaluated by providers and consumers. A "consumer" may be any individual in the community outside the agency, regardless of whether he or she has been a recipient of, or is eligible to receive, home health services. The evaluation should address the total program including services furnished directly to patients, and the administration and management of the HHA, including, but not limited to, policies and procedures, contract management, personnel management, clinical record review, patient care, and the extent to which the goals and objectives of the HHA are met. Results of the HHA's overall annual evaluation must be available for surveyor review, upon request.
0247 EVALUATION OF THE AGENCY'S PROGRAM 484.52	Results of the evaluation are maintained separately as administrative records.	All aspects of the HHA's evaluation are not required to have been done at the same time or by the same evaluators. For example, fiscal, patient care, and administrative policies may be evaluated by different members or committees of the group responsible for performing the evaluation at different times of the year. Patient care services should have been evaluated by providers and consumers. A "consumer" may be any individual in the community outside the agency, regardless of whether he or she has been a recipient of, or is eligible to receive, home health services. The evaluation should address the total program including services furnished directly to patients, and the administration and management of the HHA, including, but not limited to, policies and procedures, contract management, personnel management, clinical record review, patient care, and the extent to which the goals and objectives of the HHA are met. Results of the HHA's overall annual evaluation must be available for surveyor review, upon request.

TAGS	RULES	INTERPRETIVE GUIDELINES
0248 POLICY AND ADMINISTRATIVE REVIEW 484.52(a)	As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient.	In evaluating each aspect of its total program, the HHA should have considered four main criteria: Appropriateness - Assurance that the area being evaluated addresses existing or potential problems. Adequacy - A determination as to whether the HHA has the capacity to overcome or minimize existing or potential problems. Effectiveness - The services offered accomplish the objectives of the HHA and anticipated patient outcomes. Efficiency - Whether there is a minimal expenditure of resources by the HHA to achieve desired goals and anticipated patient outcomes. PROBES: 1- How is consumer involvement in the evaluation process ensured? 2- How has the HHA responded to recommendations made by the professional group in relation to the most recent annual evaluation? 3- What areas does the HHA view as requiring change based on the most recent annual evaluation? 4- How does the program evaluation highlight the agency's efforts to resolve patients' grievances and complaints, if any?
0249 POLICY AND ADMINISTRATIVE REVIEW 484.52(a)	Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.	In evaluating each aspect of its total program, the HHA should have considered four main criteria: Appropriateness - Assurance that the area being evaluated addresses existing or potential problems. Adequacy - A determination as to whether the HHA has the capacity to overcome or minimize existing or potential problems. Effectiveness - The services offered accomplish the objectives of the HHA and anticipated patient outcomes. Efficiency - Whether there is a minimal expenditure of resources by the HHA to achieve desired goals and anticipated patient outcomes. PROBES: 1- How is consumer involvement in the evaluation process ensured? 2- How has the HHA responded to recommendations made by the professional group in relation to the most recent annual evaluation? 3- What areas does the HHA view as requiring change based on the most recent annual evaluation? 4- How does the program evaluation highlight the agency's efforts to resolve patients' grievances and complaints, if any?

TAGS	RULES	INTERPRETIVE GUIDELINES
0250 CLINICAL RECORD REVIEW 484.52(b)	At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.	Quarterly reviews need not be performed at a joint, sit-down meeting of the professionals performing the review. Each professional may review the records separately, at different times. The HHA should evaluate all services provided for consistency with professional practice standards for HHAs and the HHA's policies and procedures, compliance with the plan of care, the appropriateness, adequacy, and effectiveness of the services offered, and evaluations of anticipated patient outcomes. Evaluations should be based on specific record review criteria that are consistent with the HHA's admission policies and other HHA specific patient care policies and procedures. The review by "appropriate health professionals" should include those professionals representing the scope of services provided in that quarter. Therefore, for example, if no speech therapy services were performed, the speech therapist need not be part of that quarterly review. If the survey reveals that one (or more) approved services are never, or rarely, provided either for Medicare/Medicaid patients or non-Medicare/Medicaid patients, undertake the following actions to determine whether the HHA is complying with the patients' plans of care (§484.18): o Review the HHA's policies relevant to the evaluation of patient care needs. o Review HHA contracts for unserved or underserved services, if they are provided under contract or arrangement. o Review plans of care to determine if the services were ordered by a physician but not delivered. o Ask the HHA under what circumstances it would contact the patient's physician to request modification of a patient's plan of care. PROBES: 1- What patterns or problems does the summary report of the clinical record reviews identify? 2- What is the HHA's plan of correction? Are time frames for implementation and another evaluation review planned? 3- How does the HHA select the clinical records to be reviewed? 4- How do the procedures for review ensure that the review will ascertain whether: o HHA policies and procedures are followed? o Patients are being helped to attain and maintain their highest practicable functional capacity? o Goals or anticipated patient outcomes are appropriate to the diagnosis(es), plan of care, services provided, and patient potential?

TAGS	RULES	INTERPRETIVE GUIDELINES
0251 CLINICAL RECORD REVIEW 484.52(b)	There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.	Quarterly reviews need not be performed at a joint, sit-down meeting of the professionals performing the review. Each professional may review the records separately, at different times. The HHA should evaluate all services provided for consistency with professional practice standards for HHAs and the HHA's policies and procedures, compliance with the plan of care, the appropriateness, adequacy, and effectiveness of the services offered, and evaluations of anticipated patient outcomes. Evaluations should be based on specific record review criteria that are consistent with the HHA's admission policies and other HHA specific patient care policies and procedures. The review by "appropriate health professionals" should include those professionals representing the scope of services provided in that quarter. Therefore, for example, if no speech therapy services were performed, the speech therapist need not be part of that quarterly review. If the survey reveals that one (or more) approved services are never, or rarely, provided either for Medicare/Medicaid patients or non-Medicare/Medicaid patients, undertake the following actions to determine whether the HHA is complying with the patients' plans of care (§484.18): o Review the HHA's policies relevant to the evaluation of patient care needs. o Review HHA contracts for unserved or underserved services, if they are provided under contract or arrangement. o Review plans of care to determine if the services were ordered by a physician but not delivered. o Ask the HHA under what circumstances it would contact the patient's physician to request modification of a patient's plan of care. PROBES: 1- What patterns or problems does the summary report of the clinical record reviews identify? 2- What is the HHA's plan of correction? Are time frames for implementation and another evaluation review planned? 3- How does the HHA select the clinical records to be reviewed? 4- How do the procedures for review ensure that the review will ascertain whether: o HHA policies and procedures are followed? o Patients are being helped to attain and maintain their highest practicable functional capacity? o Goals or anticipated patient outcomes are appropriate to the diagnosis(es), plan of care, services provided, and patient potential?

TAGS	RULES	INTERPRETIVE GUIDELINES
0300 CONFORMANCE WITH PHYSICIANS ORDERS 484.18(c)	Verbal orders are only accepted by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies.	Review HHA policies and procedures in regard to obtaining physician orders, changes in orders, and verbal orders. All physician orders must be included in the patient's clinical record. Plans of care must be signed and dated by the physician. Verbal orders must be countersigned by the physician as soon as possible. Ask HHAs, whose pattern of obtaining signed physicians' orders exceeds the HHA's policy or State law, to clarify or explain what circumstances created the time lapse and how they are approaching a resolution to the problem. Other designated HHA personnel who accept oral orders must be able to do so in accordance with State and Federal law and regulations and HHA policy. Oral orders must be signed and dated by the registered nurse or qualified therapist who is furnishing or supervising the ordered service and it is the RN's responsibility to make any necessary revisions to the plan of care based on that order. All drugs and treatments ordered by the patient's physician should be recorded in the clinical record. Over-the-counter drugs which the patient takes must be noted in the patient's record. Over-the-counter drugs should be reported to the physician only if an RN determines that they could detrimentally affect the prescribed drugs of the patient. The label on the bottle of a prescription medication constitutes the pharmacist's transcription or documentation of the order. Such medications should be noted in the clinical record and listed on the recertification plan of care (Form CMS-485). This is consistent with acceptable standards of practice, and Federal regulations do not have additional requirements. Aides may help patients take drugs ordinarily self-administered by the patient, unless the State restricts this practice. PROBES: 1- If HHA personnel identify patient sensitivity or other medication problems, what actions does the HHA require its personnel to take? 2- How does the HHA secure physicians' signatures on oral, change, or renewal orders? 3- How does the HHA ensure that oral orders are accepted, cosigned by the nurse ot therapist and countersigned by the physician appropriately?

TAGS	RULES	INTERPRETIVE GUIDELINES
0301 SUPERVISION 484.36(d)(4)(ii)	If the HHA (or hospice) chooses to provide home health aide services under arrangements with another organization, the HHA's (or hospice's) responsibilities include, but are not limited to, supervision of the aide's services as described in paragraphs (d)(1) and (d)(2) of this section.	An individual providing services under an arrangement can qualify as a home health aide by completing a training and competency evaluation program or a competency evaluation program. PROBE: How does the HHA ensure that home health aides providing services under arrangements are supervised according to the requirements of §§484.36(d)(1) and (d)(2) and meet the training and or competency evaluation requirements of §484.36(a) or (b)?
0302 SUPERVISION 484.36(d)(4)(iii)	If the HHA (or hospice) chooses to provide home health aide services under arrangements with another organization, the HHA's (or hospice's) responsibilities include, but are not limited to, ensuring that home health aides providing services under arrangements have met the training requirements of paragraph (a) and/or (b) of this section	An individual providing services under an arrangement can qualify as a home health aide by completing a training and competency evaluation program or a competency evaluation program. PROBE: How does the HHA ensure that home health aides providing services under arrangements are supervised according to the requirements of §484.36(d)(1) and (d)(2) and meet the training and or competency evaluation requirements of §484.36(a) or (b)?

TAGS	RULES	INTERPRETIVE GUIDELINES
0303 CLINICAL RECORDS 484.48	The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge.	The clinical record must provide a current, organized, and clearly written synopsis of the patient's course of treatment, including services provided for the HHA by arrangement or contract. The clinical record should facilitate effective, efficient and coordinated care. Questionable patterns, rather than isolated instances, in clinical records are an indicator that the quality of care provided by the HHA needs to be carefully assessed for compliance with the plan of care, coordination of services, concurrence with the HHA's stated policies and procedures, and evaluations of patients outcomes. However, isolated instances depending on their nature and severity, can serve as the basis of a deficiency and enforcement action. (e.g. immediate and serious threat as outlined in appendix Q.) While the regulations specify that the documents must be signed, they do not prohibit the use of electronic signatures. HHAs which have created the option for an individuals record to be maintained by computer, rather than hard copy, may use electronic signatures as long as there is a process for reconstruction of the information, and there are safeguards to prevent unauthorized access to the records. Clinical progress notes, and summary reports as defined in §484.2 must be maintained on all patients. Forms CMS-486 and CMS-487 may be used as a progress note and / or a summary report. Notations should be appropriately labeled and should provide an overall comprehensive view of the patient's total progress and /or current summary report including social, emotional, or behavioral adjustments relative to the diagnosis, treatment, rehabilitation potential, and anticipated outcomes toward recovery or further debilitation. The regulation does not dictate the frequency with which progress notes must be written. If necessary, review the HHA's policies and procedures concerning the frequency of preparing progress notes. The discharge summary need not be a separate piece of paper and may be incorporated into the routine summary reports already furnished to the physician. PROBES: 1- Are there patterns in the clinical records that are of concern? 2- Do clinical records document patient progress and outcomes of care based on changes in the patient's condition? 3- How does the HHA inform the attending physician of the availability of a discharge summary? 4- How does the HHA ensure that the discharge summary is sent to the attending physician upon his /her request?

TAGS	RULES	INTERPRETIVE GUIDELINES
0310 RELEASE OF PATIENT IDENTIFIABLE OASIS INFO 484.11	The HHA and agent acting on behalf of the HHA in accordance with a written contract must ensure the confidentiality of all patient identifiable information contained in the clinical record, including OASIS data, and may not release patient identifiable information to the public.	
0320 REPORTING OASIS INFORMATION 484.20	HHAs must electronically report all OASIS data collected in accordance with §484.55	
0321 ENCODING OASIS DATA 484.20(a)	The HHA must encode and be capable of transmitting OASIS data for each agency patient within 7 days of completing an OASIS data set.	
0322 ACCURACY OF ENCODED OASIS DATA 484.20(b)	The encoded OASIS data must accurately reflect the patient's status at the time of assessment.	
0323 TRANSMITTAL OF OASIS DATA 484.20(c)(1)	The HHA must electronically transmit accurate, completed, encoded and locked OASIS data for each patient to the State agency or CMS OASIS contractor at least monthly.	
0324 TRANSMITTAL OF OASIS DATA 484.20(c)(2)	The HHA must, for all assessments completed in the previous month, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section.	
0325 TRANSMITTAL OF OASIS DATA 484.20(c)(3)	The HHA must successfully transmit test data to the State agency or CMS OASIS contractor.	
0326 TRANSMITTAL OF OASIS DATA 484.20(c)(4)	The HHA must transmit data using electronic communications software that provides a direct telephone connection from the HHA to the State agency or CMS OASIS contractor.	
0327 DATA FORMAT 484.20(d)	The HHA must encode and transmit data using the software available from CMS or software that Conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and that includes the required OASIS data set.	

TAGS	RULES	INTERPRETIVE GUIDELINES
0330 COMPREHENSIVE ASSESSMENT OF PATIENTS 484.55	Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary	
0331 INITIAL ASSESSMENT VISIT 484.55(a)(1)	A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.	
0332 INITIAL ASSESSMENT VISIT 484.55(a)(1)	The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.	
0333 INITIAL ASSESSMENT VISIT 484.55(a)(2)	When rehabilitation therapy service (speech-language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.	
0334 COMPLETION OF THE COMPREHENSIVE ASSESSMENT 484.55(b)(1)	The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.	
0335 COMPLETION OF THE COMPREHENSIVE ASSESSMENT 484.55(b)(2)	Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status.	
0336 COMPLETION OF THE COMPREHENSIVE ASSESSMENT 484.55(b)(3)	When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility.	

TAGS	RULES	INTERPRETIVE GUIDELINES
0337 DRUG REGIMEN REVIEW 484.55(c)	The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.	
0338 UPDATE OF THE COMPREHENSIVE ASSESSMENT 484.55(d)	The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status.	
0339 UPDATE OF THE COMPREHENSIVE ASSESSMENT 484.55(d)(1)	The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode.	
0340 UPDATE OF THE COMPREHENSIVE ASSESSMENT 484.55(d)(2)	The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.	
0341 UPDATE OF THE COMPREHENSIVE ASSESSMENT 484.55(d)(3)	The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge.	
0342 INCORPORATION OF OASIS DATA ITEMS 484.55(e)	The OASIS data items determined by the Secretary must be incorporated into the HHA's own assessment and must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.	
9999 FINAL OBSERVATIONS		

HOME HEALTH AGENCY APPLICATION REVIEW CHECKLIST

The following checklist is provided to ensure you include all the documents required for ORS to review your application for a Home Health Agency license. Please use the Applicant Use column for your own review to be sure all necessary documents are included. Under each rule listed, you will see the documents request and the content that must be acceptable in order to be reviewed. **Be aware that your application packet may be considered incomplete and ineligible for review if all documents are not included. It must be clear to the reviewer the identity of each document, therefore it is advised to have them clearly marked.**

Be advised that these are the minimum documents necessary for review for your license, but it is not intended to be a complete list of all policies, procedures, forms, etc., that you will need to operate your Home Health Agency effectively.

Applicant Use		***J HTF 'Office Use Onl{ '''''''''''T**eview Date:______________* *Acceptable*	*Not Accept.*	*Notes*
_______	**290-5-38-.02 Applications and Licenses** 1. A *completed* Application for a license to operate a Home Health Agency, signed and dated.	_________	_________	__________________________________
_______	2. Copy of Business License, or if not required, evidence of such communication with local government.	_________	_________	__________________________________
_______	3. Copy of Certificate of Incorporation, if incorporated; or if not incorporated, listing of IRS Tax ID number.	_________	_________	__________________________________
_______	**290-5-38-.03 Certificate of Need and 1122 Review** 4. Certificate of Need approval and 1122 Review.	_________	_________	__________________________________

	290-5-38-.07 Administrative Standards			
________	5. Copy of organization chart and policies and procedures regarding administrative control, lines of authority, and scope of services provided.	________	________	________
________	6. Policies that define the scope of services provided by the agency.	________	________	________
________	7. Policy regarding the role of the Governing Body/Board of Directors.	________	________	________
	Name and address for each board member and owner(s).	________	________	________
________	8. Copy of bylaws and written procedure for periodic review of bylaws.	________	________	________
________	9. Policy regarding the Professional Advisory Committee.	________	________	________
________	10. Policy regarding the fiscal affairs of the agency.	________	________	________
	Copy of budget plan for 1st year.	________	________	________
________	11. Description of composition and responsibilities of a group of professional personnel (may be policy or procedure).	________	________	________
	Contains all minimally required members.	________	________	________

	Responsibilities include establish and annually review policies, quarterly meetings with documentation of meeting minutes, participation in evaluation of agency's program, and assist in maintaining liaison with community.	______	______	______
______	12. Name, qualifications, and job description, (including professional license, if applicable) of administrator.	______	______	______
	Meets qualification requirements of either (check): Licensed physician; or Licensed registered nurse; or Has training and experience in health service administration and at least one (1) year of supervisor or administrative experience in home health care or related health programs.	______	______	______
	Job duties/responsibilities include:	______	______	______
	Ensures responsibility and accountability for organizing and directing the agency's ongoing functions.	______	______	
	Maintains ongoing liaison among the Governing Body, group of professional personnel, and the staff.	______	______	
	Ensures employment of qualified staff.	______	______	
	Ensures adequate staff education and evaluations.	______	______	
	Ensures the accuracy of public information, materials and activities.	______	______	
	Ensures the implementation of an effective budgeting and accounting system.	______	______	
______	13. Policy regarding budget and accounting system.	______	______	______

________	14. Policy regarding delegation of authority in the absence of the administrator.	________	________	________
________	15. Policy/procedure regarding supervision of skilled nursing and other therapeutic services provided.	________	________	________
________	16. Policies regarding personnel practices, including contract personnel.	________	________	________
	Names, qualifications/resumes, signed job descriptions, copies of current licenses where applicable, and health examinations for all staff members.	________	________	________
________	17. Copies of any contracts for hourly or per visit personnel.	________	________	________
________	18. Policy and procedure for the overall evaluation of the agency's total program.	________	________	________
	Requires annual evaluation of policies, administrative review and clinical record review.	________	________	________
	Defines mechanisms for the collection of data.	________	________	________
	Includes collection of at least the following data:	________	________	________
	Number of patients receiving each service offered	________	________	
	Number of patient visits	________	________	
	Reason for discharge	________	________	
	Breakdown by diagnosis	________	________	

	Sources of referral Number of patients not accepted with reasons Total staff days for each service	______ ______ ______	______ ______ ______	
______	19. Policy for sample review of both active and closed clinical records.	______	______	______
	290-5-38-.08 Scope of Services			
______	20. Name, qualifications/resume, job description, and evidence of current license for the supervisor/director of nursing services.	______	______	______
______	21. Policies and procedures for nursing services, including the scope of nursing services provided.	______	______	______
	Supervision of provision of nursing services by a RN.	______	______	______
______	22. Policy and procedure for the delivery of therapy services to include physical therapy, occupational therapy, speech therapy, and audiology.	______	______	______
______	23. Policy and procedure for the provision of medical social services.	______	______	______
______	24. Policy and procedure for the of provision of home health aide services.	______	______	______
	Requires competency evaluations for the home health aide before providing services to patients.	______	______	______

	Requires written instructions for each task prepared by the RN.	________	________	________
	Requires supervisory visits by a RN every two weeks at the patient's place of residence to evaluate the aide's performance.	________	________	________
________	25. Policy and procedure for coordination of patient services.	________	________	________
	Requires dated minutes of case conferences that reflect effective interchanges, reporting, and coordinated patient evaluation.	________	________	________
	Requires a written summary report for each patient is sent to the attending physician at least every 60 days.	________	________	________
________	Policy and procedure for services provided under arrangement.	________	________	________
	290-5-38-.09 Standards for Patient Care			
________	26. Written criteria and procedures for admission into home health care services.	________	________	________
	Requires that patient care follow a written plan of treatment established and periodically reviewed by a physician, and shall continue under the supervision of a physician.	________	________	________

________	27. Policy and procedure for development of the patient's treatment plan and sample form for a patient's plan of care.	________	________	________
	Requires that the treatment plan cover all pertinent diagnoses; types of services and equipment required; frequency of visits; prognosis; rehabilitation potential; functional limitations; permitted activities; nutritional requirements; medications and treatments; safety measures; instructions for discharge or referral; and other appropriate items.	________	________	________
________	28. Policy and procedure for review of the treatment plan.	________	________	________
	Provides for review of the treatment plan as needed, but no longer than 60 days.	________	________	________
________	29. Policy and procedures for conformance with physician's orders.	________	________	________
	Requires that staff administer drugs and treatments only as ordered by the physician.	________	________	________
	Addresses procedure for verbal orders.	________	________	________
	Requires that staff review all medications taken by the patient and promptly report any identified problems to the physician.	________	________	________

_______	30. Description of system for creating and maintaining clinical records.	_________	_________	_________________________________
	Requires each record contain pertinent past and current findings; plan of treatment; appropriate identifying data; name of physician; drug, dietary, treatment and activity orders; signed and dated progress notes; copies of case conferences; copies of summary reports sent to the physician; and discharge summary.	_________	_________	_________________________________
	Requires that clinical notes are written, signed and dated on the day service is rendered by the service provider and incorporated into the clinical record at least weekly.	_________	_________	_________________________________
_______	31. Procedure for furnishing the patient's clinical record to the receiving facility when the patient transfers to another Home Health Agency or health facility.	_________	_________	_________________________________
_______	32. Policies and procedures for organization and continuous maintenance of the clinical record, including retention of records and safeguards for storage and confidentiality of the records.	_________	_________	_________________________________

Reviewed by: ____

Date: ____