

# Home Health Questionnaires



**Title**

**Presented to:**  
**Home Health Providers**

Presented By:

KEPRO

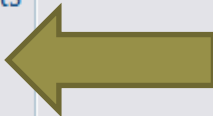


- Case Creation in Atrezzo Portal
  - Requires a questionnaire for:
    - Skilled Nurse Visits
    - Home Health Aide Visits.

At the end of your request, a there is a step for a questionnaire

### OUTPATIENT SERVICES REQUEST

<input checked="" type="checkbox"/> Patient Detail	<b>QUESTIONNAIRES</b>	
<input checked="" type="checkbox"/> Requesting Provider		
<input checked="" type="checkbox"/> Service Provider	Questionnaire Name	Status
<input checked="" type="checkbox"/> Attending Physician	Home Health Plan of Care: HHA and Skilled Nurse Visits	Not Completed
<input checked="" type="checkbox"/> Service Detail		
<input checked="" type="checkbox"/> Procedures		
<input checked="" type="checkbox"/> Diagnoses		
Clinical Information		
<input checked="" type="checkbox"/> Attached Documents		
<b>Questionnaires</b>		



If you try to submit your request without completing the questionnaire, you will receive an error message.



Error: Questionnaire must be completed before submission.

## OUTPATIENT SERVICES REQUEST

- Patient Detail
- Requesting Provider
- Service Provider
- Attending Physician
- Service Detail


### QUESTIONNAIRES

Questionnaire Name	Status
Home Health Plan of Care: HHA and Skilled Nurse Visits	Not Completed

Please click on the title of the questionnaire to begin.

Error: Questionnaire must be completed before submission.

## OUTPATIENT SERVICES REQUEST

<input checked="" type="checkbox"/> Patient Detail	<b>QUESTIONNAIRES</b>	
<input checked="" type="checkbox"/> Requesting Provider		
<input checked="" type="checkbox"/> Service Provider		
<input checked="" type="checkbox"/> Attending Physician		
<input checked="" type="checkbox"/> Service Detail		
Questionnaire Name		Status
Home Health Plan of Care: HHA and Skilled Nurse Visits		Not Completed

The questionnaire will open. You will need to answer all questions. You may save changes or return to the request if needed. **Edit Questionnaire**

Save Changes  Status: Incomplete [Return To Request](#)

---

## Home Health Plan of Care

1. *What type of request are you entering for this recipient?*

(Please select one.)

- Initial, short term, 45 days or less
- Initial, long term, 46 days or more
- Re certification, ongoing request
- Change of condition, change of plan, or change of types of authorized services (explain)

2. *Is the recipient on any of the following medications?*

(Please select between 1 and 4 items.)

- IV Medications
- Injectable Medications
- Oral Medications
- Other
- N/A; not on any medications

3. *Medication Management*

(Please select one.)

Some of the selections you make, will populate further questions for response.

2. *Is the recipient on any of the following medications?*

*(Please select between 1 and 4 items.)*

IV Medications  
 Injectable Medications  
 Oral Medications  
 Other  
 N/A; not on any medications

2.1.1. *Please list the name, does and frequency for each IV medication.*

2.1.2. *Have any been prescribed within 30 days of the start date of this CERT period?*

*(Please select one.)*

Yes  
 No

2.1.3. *Was there a dosage change for any of the medications?*

*(Please select one.)*

Yes  
 No

Some of the questions may allow multiple answers with additional questions that appear. This example wants you to describe the contracture (6.3.1) and the endurance (6.6.1). The second number corresponds to where the item is in the list.

6. Functional limitations, please describe each that is selected

(Please select between 1 and 11 items.)

- Amputation
- Bowel/bladder incontinence
- Contracture
- Hearing
- Paralysis
- Endurance
- Ambulation
- Speech
- Visual impairment (Glasses, poor vision)
- Legally blind
- Dyspnea with minimal exertion
- Other

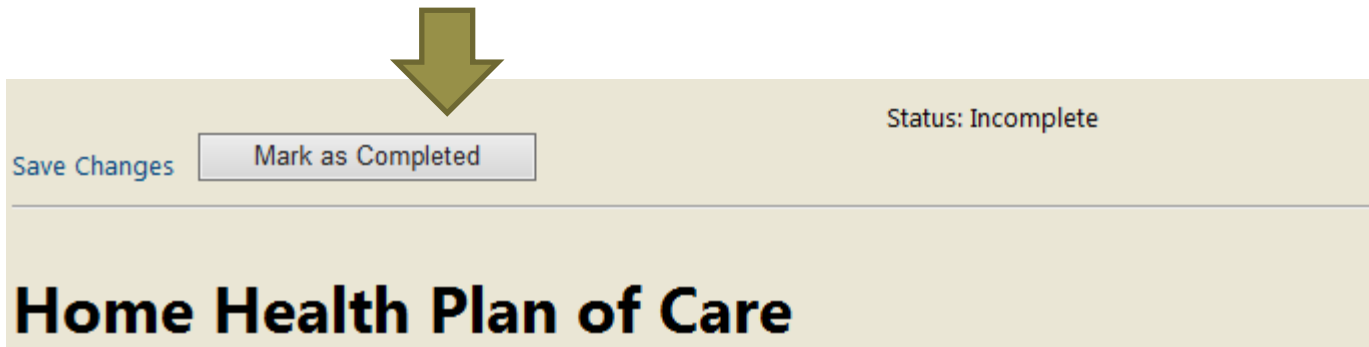
6.3.1. Please describe.

**Contracture** is item 3 in the list and  
Corresponds to this box.

6.6.1. Please describe.



- You may save your changes at any time and return to the request later to finish and submit.
- Once you have completed the questionnaire, click the “mark as completed” button. You will not be able to modify once you do this.

A screenshot of a web form interface. At the top, there is a light beige header bar. On the left side of this bar, there are two buttons: 'Save Changes' and 'Mark as Completed'. The 'Mark as Completed' button is highlighted with a green arrow pointing down to it. On the right side of the header bar, the text 'Status: Incomplete' is displayed. Below the header bar, the main content area is also light beige and contains the text 'Home Health Plan of Care' in a large, bold, black font.

Save Changes Mark as Completed Status: Incomplete

## Home Health Plan of Care

# Thank you!

