Home Health Check Off List
Required for all Home Health requests for Continued Service

Home Health Agency Contact Information

Contact Person: ______________________________

Contact Number: ______________________________

CHECK ALL THAT APPLY:

Requested Service	Required Documentation
☐ Nursing	
☐ Medication Management	▪ Clinical notes demonstrating medical necessity.
☐ IV Medication	▪ MD orders. Expected IV therapy end date.
☐ Wound Care	▪ Wound notes. Wound measurements.
☐ Other Skilled Need	▪ Clinical notes demonstrating medical necessity.
☐ Shift Care/Private Duty Nursing	▪ Clinical notes demonstrating medical necessity. ▪ Include hours/day, days/week, total units. ▪ Include detail on referral request form.
☐ Physical Therapy	▪ PT Notes: Prior level of function. Current level of function. Goal level of function.
☐ Occupational Therapy	▪ OT Notes: Prior level of function. Current level of function. Goal level of function.
☐ Speech Therapy	▪ ST Notes: Prior level of function. Current level of function. Goal level of function.
☐ Social Worker	▪ Clinical notes demonstrating medical necessity.
☐ Home Health Aide	▪ Clinical notes demonstrating medical necessity.

**** ALL REQUESTS SHOULD BE SUBMITTED WITH SIGNED MD ORDERS ****

Please return this form along with a **completed referral request and clinical documentation** to the IEHP UM Department at **(909) 890-5751**.

Initial document data: 04/05/2019
Revised: 04/18/2019