HAWAII
LIFE AND DISABILITY INSURANCE
GUARANTY ASSOCIATION

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HOME HEALTH CARE RECERTIFICATION

BY FURNISHING THIS BLANK AND INVESTIGATING THE CLAIM, THE COMPANY SHALL NOT BE HELD TO ADMIT VALIDITY OF ANY CLAIM OR TO WAIVE ANY OF ITS RIGHTS OR ANY OF THE CONDITIONS OF THE POLICY

POLICYHOLDER NAME **POLICY #:** _____

NAME ADDRESS

CITY STATE ZIP PHONE#

1. What is the nature of your condition? _____
2. Has there been a change in your health condition?

3. State between what dates, if any, you were	Confined to a hospital……..……From	_____	To
	Confined to a rehabilitation facility……..……..…. From	_____	To
	Confined to a skilled nursing unit or facility……..……..…. From	_____	To

If confined, please provide details regarding the facility:

NAME _____ ADDRESS _____ PHONE _____

NAME _____ ADDRESS _____ PHONE _____

NAME _____ ADDRESS _____ PHONE _____

DATE **SIGNED**

PHYSICIAN'S SUPPLEMENTARY REPORT

1. Past Medical History including diagnosis with date of onset: _____
   What complications, if any, have arisen? (Describe fully) _____
2. Diagnosis for Home Health Care: _____
3. Please tell us why this patient would require Home Health Care for the above diagnosis: _____

CHECK the level of assistance you patient requires with the following activities:

Standby- Must have verbal guidance and partial or intermittent hands- assistance from another person.
Hands On- Must have assistance from another person with all or most of the activity.
Total- Does not participate in the activity and must be totally continuously cared for by another person.

Activities of Daily Living

Eating	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Toileting	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Dressing	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Bathing	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Ambulation	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Transfer	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Mobility	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance

Instrumental Activities of Daily Living

Housekeeping	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance
Meal preparation	☐	No Assistance	☐	Standby Assistance	☐	Hands On Assistance	☐ Total Assistance

Shopping	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Transportation	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Managing Medicines	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance
Laundry	☐ No Assistance	☐ Standby Assistance	☐ Hands On Assistance	☐ Total Assistance

Bowel/Bladder	☐ Continent	☐ Incontinent	☐ Foley Catheter	☐ Ostomy	☐ Other
Vision	☐ Normal/Corrected	☐ Impaired	☐ Blind	☐ Glasses/Contacts	
Hearing	☐ Normal/Corrected	☐ Impaired	☐ Deaf	☐ Hearing Aids:	☐ R ☐ L
Mental Status	☐ Alert & Oriented	☐ Forgetful*	☐ Confused*		

*PLEASE SPECIFY TEST RESULTS USED IN DIAGNOSING COGNITIVE IMPAIRMENT: _____

4. What equipment does this patient use?: ☐ Cane ☐ Walker ☐ Bedside Commode ☐ Wheel Chair ☐ Hospital Bed ☐ Seat Lift Chair ☐ Hoyer Lift ☐ Raised Toilet Seat

5.What level of care does this patient require:

Provider Level of Care	*Number of Hours/Day*	*Number of Hours/Week*
Skilled Care of RN, LPN, PT, OT, ST, MSW		
Home Health Aide/C.N.A		
Homemaker		
Sitter/Companion		

6. How long do you anticipate this level of care will last? _____

7. Is this care medically necessary? ☐ YES ☐ NO

8. Is this care in lieu of a hospital or nursing confinement? ☐ YES ☐ NO

9. Is this care to provide personal or medical care to patient? ☐ YES ☐ NO

10. Date care started or should start: _____ Date care should end: _____

11. Do you know whether or not your patient is still driving? ☐ YES ☐ NO ☐ UNK

12. If your patient is driving, do you agree that he/she should be driving? ☐ YES ☐ NO

PHYSICIAN RECERTIFICATION STATEMENT

I, recertify that the above service are required and authorized by myself with a written plan for treatment which will be periodically reviewed by myself. This patient is under my care and is in need of intermittent skilled nursing care and/or physical or speech therapy or has been furnished home health services based on such a need.

Signature **Date**

Print Physician/Practice Name Phone

Street City State Zip