Instructions for the JFS 07137 Home Care Certification Form

Consumer's Name - Enter the name of the patient needing increased home health or private duty nursing services.

Treating Physician's Name - Print the name of the treating physician who is ordering home health services.

Consumer's Medicaid Billing Number - Enter the 12 digit patient's Medicaid number as it appears on their Ohio Medicaid Card.

Treating Physician's Medicaid Provider Number - Enter the 7 digit Medicaid billing number of the treating physician ordering home health service(s.)

POST HOSPITAL SERVICE FOR HOME HEALTH

Check Box if consumer was discharged from a 3 day or more hospital stay and write in the date of discharge.

Check Box if consumer needs nursing or skilled therapy at least 1 time per week.

Check Box if consumer meets any one of the following requirements.

Note: all three boxes must be checked and date of discharge must be written on the line for the consumer to receive post hospital service for home health. The option to sign and date the form is available here or at the end of the next section.

POST HOSPITAL SERVICE FOR PRIVATE DUTY NURSING

Check Box if consumer was discharged from a 3 day or more hospital stay and write in the date of discharge.

Check Box if consumer has a comparable level of care to skilled level of care.

Note: both boxes must be checked and date of discharge must be written on the line for the consumer to receive post hospital service for private duty nursing.

Licensed Professional's Signature and Initials (i.e. MD, DO, RN, APN, LSW) - An original signature of the treating physician is required. A registered nurse or a discharge planner, with the consent of the attending practitioner, may print the physician's name on the signature line and sign his or her own first name, last name, and nursing skill level (if applicable) after the physician's name. In addition, the discharge planner must be a licensed social worker who is practicing within their scope of practice in accordance with chapter 4757 of the Administrative Code.

Date of signature - Enter the date the form was signed.

Disclaimer: This form is required as a certification of level of care for increased home health services or private duty nursing services in accordance with Chapters 5101:3-12, and 5101:3-3 of the Administrative Code. In no instance does this requirement constitute the determination of a level of care for waiver eligibility status, or admission into a Medicaid covered long term care institution.