CHOICEREHAB

A Division of Nathan Jackson, PLLC

Hard Copy of all Choice Rehab Forms

Time off Request

Weekly Timesheet

Home Health Timesheet

Mileage Log

Expense Report

Screening

Payer Verification

Discharge Notification

Incident/Accident

Formal Complaint

Patient Satisfaction Survey

End of Month Pre-Closing

Patient Admission Communication

IDT Meeting

Time Off Request

EMPLOYEE NAME:_____ DATE SUBMITTED: _____

- ❑ LWOP (Leave without Pay)
- ❑ PTO (Paid Time Off)

DATE(S) REQUESTING: _____ AMOUNT OF HOURS REQUESTING:_____

Building/Facility Lead Signature: _____ please fax to 800.503.4607

Operations Manager Approval: _____ turn into HR

HR Notified and entered into system:_____

*Employee accrues up to 144 hr of PTO per year. PTO requests need to be submitted at least 2 weeks prior to date given unless otherwise approved. Employee should keep up with accrual vs. used PTO hours as payroll system is manually adjusted as needed. PTO is accrued at .073 hr per hour worked.

WEEKLY TIMESHEET

EMPLOYEE:_____

WEEK OF:_____

LOCATION:_____

**Round time to nearest quarter hour.

DAY OF WEEK/DATE	TIME IN	LUNCH	TIME OUT	TRAVEL TIME	VACATION, PTO, SICK, HOLIDAY, OR OTHER	TOTAL HOURS WORKED
Sun __/__/__						
Mon __/__/__						
Tues __/__/__						
Wed __/__/__						
Thurs __/__/__						
Fri __/__/__						
Sat __/__/__						

TOTAL HOURS WORKED:_____

I CERTIFY THAT THE HOURS ON THIS TIMESHEET WERE WORKED AND ARE CORRECT. **FAX TO 800-503-4607 AT THE END OF EACH WORK WEEK.**

_____ _____

EMPLOYEE SIGNATURE DATE

_____ _____

SITE SUPERVISOR OR NJC SIGNATURE DATE

Home Health Time Sheet- **Please use this form if seeing patients for agency other than Choice Homecare.**

Date:_____

Time In	Time Out	Mileage Start	Mileage End	Mileage Total	Patient 1st initial and last name	Agency, Patient location (City, State)	Date Documentation Complete and Turned In

***Mileage starts after first visit or place of employment. Do not count mileage from home to first patient or from last patient back to home.**

Total Mileage: _____

Number of billable visits: _____

Number of missed visits: _____

My signature below indicates that the above visits have been completed and all documentation has been turned in to appropriate location.

_____

Therapist Signature

Fax to (800)503-4607 by Monday no later than 9:00am for payment on current payroll cycle.

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Mileage Log

Date	Start Destination	End Destination	Start Mileage	End Mileage	Total Mileage

Calculation for hours worked begins at the time of initial daily visit or arrival at agency office, and concludes at the end of the last visit or 5pm which ever is later.

Therapist Signature & Date: _____ **Total Mileage:** _____

Expense Report

Employee:

To:

Purpose:

Department:

Date Submitted:

Date	Expense Type	Establishment	Location	Cost	Notes

Total Due:

Employee Signature:

Date:

Approved:

Date:

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Patient Name: _____ **Date:** _____

Check all that apply: ◯ Incident requiring screen ◯ Quarterly screen

◯ New Admission ◯ Change in functional status

Request orders for:

◯ Physical Therapy

- ☐ Balance during ambulation or transfers
- ☐ Complaints of pain
- ☐ Bed Mobility
- ☐ Decreased ROM
- ☐ Potential for contracture
- ☐ Refusal to bear weight
- ☐ Increased/decreased motivation to walk, sit up, etc.
- ☐ Transfers
- ☐ Poor posture/body mechanics
- ☐ Risk for fall/Recent fall
- ☐ Decreased safety awareness
- ☐ Decreased w/c mobility
- ☐ Decreased strength
- ☐ Edema/swelling in LE
- ☐ Decreased sensation in LE
- ☐ Activity tolerance/Fatigue

◯ Occupational Therapy

- ☐ Feeding
- ☐ Dressing
- ☐ Toileting
- ☐ Bathing
- ☐ Grooming
- ☐ Weakness in UE
- ☐ Fine/gross motor coordination
- ☐ Poor sitting balance
- ☐ Decreased w/c mobility
- ☐ Poor positioning
  - o Risk for wound development
  - o Risk for contracture development
  - o Poor ventilation
- ☐ Cognitive deficits
  - o Problem solving
  - o Sequencing
  - o Attention
- ☐ Activity tolerance/Fatigue
- ☐ Functional mobility

◯ Speech Therapy

- ☐ Speech clarity
- ☐ Confused/disoriented
- ☐ Increased difficulty in hearing
- ☐ Impaired safety awareness
- ☐ Difficulty expressing self
- ☐ Communication needs
- ☐ Word recall impairment
- ☐ 10% weight loss in past month
- ☐ Pocketing food
- ☐ Consuming 50% or less of meal
- ☐ Coughing, choking, reddening of face at mealtime
- ☐ Drooling or spillage of food
- ☐ Difficulty swallowing oral medications
- ☐ Difficulty chewing
- ☐ Eating slowly
- ☐ Change in medication delivery method
- ☐ Change in diet

Comments: _____

_____

Nursing Documentation Needed in the Areas Above

Return to Therapy Dept. by: ___/___/___

Therapy Payer Verification Form

Date of Request: _____ **Time:** _____

Resident Name: _____

SS#: _____

☐ **Physical Therapy** $_____ **PT/ST Part B Cap Used**
☐ **Occupational Therapy**
☐ **Speech Therapy** $_____ **OT Part B Cap Used**

MR#: _____

Please Identify Payor Status Below:

☐ Medicare Part A # of days remaining _____

☐ Medicare Part B with Private Insurance for 20% copay

Please specify insurer/authorization # _____

☐ Medicare Part B with Private (non-insurance) 20% copay

Please specify responsible party:

Name: _____ Phone: _____

☐ Medicare Part B with Medicaid 20% copay

☐ Private Insurance

Please specify coverage and/or attach insurance verification

☐ Other; specify (e.g. private pay, no funding, etc.)

_____

_____

_____

_____ _____ _____

BOM Signature **Date** **Time**

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Discharge Notice

TODAY'S DATE: _____

PATIENT NAME: _____

PHYSICIAN NAME: _____

Circle one:

MEDICARE – A MEDICARE – B OTHER: _____

Effective Date of Discharge:

PHYSICAL THERAPY: _____

OCCUPATIONAL THERAPY: _____

SPEECH THERAPY: _____

LAST TREATMENT DAY: _____

THERAPY SIGNATURE: _____

BILLING OFFICE SIGNATURE: _____

MDS COORDINATOR SIGNATURE: _____

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Incident/Accident Form

Date_____ Location_____

Employee Name_____ Title_____

Department_____ Supervisor Name_____

Type of Incident/Accident_____

Resident's Name_____

Reported Incident/Accident to_____

Statement of Incidnet/Accident:_____

_____

_____

_____

_____

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_____

Employee Signature_____

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Formal Complaint

Date_____Location_____

Employee Name_____Title_____

Department_____Supervisor Name_____

Please describe in as much detail the nature of your complaint.

_____

_____

_____

Please provide or identify all known persons, documents and witnesses to your concerns.

_____

_____

_____

Please describe how the actions of your complaint affect your ability to perform your job.

_____

_____

_____

Please describe any positive solutions you believe can help resolve your complaint.

_____

_____

_____

Please provide any additional comments you wish the company to consider when investigating your complaint.

_____

_____

_____

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Patient Satisfaction Survey

Please indicate your level of agreement or disagreement with the following statements.

Therapy staff members:	Do not agree					Agree
were kind and courteous.	0	1	2	3	4	5
answered questions I had about treatment.	0	1	2	3	4	5
were respectful of my time.	0	1	2	3	4	5
Therapy helped me reach my goals.	0	1	2	3	4	5
I enjoyed therapy!	0	1	2	3	4	5

Comments:

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End of Month Pre-Closing

Before using the closeout wizard on Optima please complete this check-off. The reports listed below should enable a more thorough end of month process. Our goal is to decrease the amount of errors and changes made after the closeout is complete. Close out must be completed by noon on the 1st of each month or first Monday if it falls on weekend.

- ☐ **Employee Labor Log** - Verify that everyone has their time in and out logged correctly for facility.
- ☐ **Trailblazer Unit Cap Management** - Verify no more than 60 units have been delivered per discipline for each patient.
- ☐ **Patient Detail** - Verify with MDS coordinator that ICD-9 codes and demographic data match.
- ☐ **Part B Cap** - Verify that all KX modifiers, if needed, are entered and being billed correctly.
- ☐ **PPS Billing** - Verify admission (start) dates and RUG levels match with facility.
- ☐ **Documentation Due Dates** - Verify that all documentation has been completed and signed.
- ☐ Look through **projections** for all MCR A patients and inform the facility of any anticipated COT OMRAs that would affect the close out month's billing.

_____ _____

Signature Date

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www.choicerehab.com

Patient Admit Communication Form

1) Patient Name: _____

2) SS#:_____

3) Intake/Most Recent Admit Date: _____

4) Gender: _____

5) D.O.B.:_____

6) Medical Record #:_____

7) Admitted from: Acute Hospital
_____/_____/20____ to _____/_____/20____ @ _____

This SNF _____ other:_____

8) Primary Care Physician:_____

9) Room #:_____

10) Reason for referral: recent fall _____
documented decline _____
hospitalization _____
other:_____

11) Payer source? Med A _____ Med B _____ Medicaid _____ other:_____

12) Medical DX needed. Please attach copy of the facility's **face sheet** & **H&P** with this form.

Patient: ______________________

Weekly Interdisciplinary Team Meeting

Key: Dep = Dependent, Ext = Assist Required, Lim = CGA, S = Sup/SBA, MI = Modified Ind, Ind = Independent, Sev = Severely Impaired, Mod = Moderately Impaired

	SOC	Freq	D/C	Date:	Planned D/C Location:		
OT				UB Drsg: Dep Ext Lim S Ind	Feeding: Dep Ext Lim S Ind	Bathing: Dep Ext Lim S Ind	ADL Xfer: Dep Ext Lim S Ind
				LB Drsg: Dep Ext Lim S Ind	Grooming: Dep Ext Lim S Ind	Toileting: Dep Ext Lim S Ind	Other:
PT				Bed Mob: Dep Ext Lim S Ind	Gait: Dep Ext Lim S Ind	Sit Bal: Dep Ext Lim S Ind	Xfer: Dep Ext Lim S Ind
				W/c Mob: Dep Ext Lim S Ind	AD: Dist:	Stand Bal: Dep Ext Lim S Ind	Modalities:
ST				Orientation: Sev Mod MI I	Problem Solving: Sev Mod MI I	Receptive Lang: Sev Mod MI I	Swallow: Sev Mod MI I
				Memory: Sev Mod MI I	Speech Clarity: Sev Mod MI I	Expressive Lang: Sev Mod MI I	Diet (Liquid/Food):

	SOC	Freq	D/C	Date:	Planned D/C Location:		
OT				UB Drsg: Dep Ext Lim S Ind	Feeding: Dep Ext Lim S Ind	Bathing: Dep Ext Lim S Ind	ADL Xfer: Dep Ext Lim S Ind
				LB Drsg: Dep Ext Lim S Ind	Grooming: Dep Ext Lim S Ind	Toileting: Dep Ext Lim S Ind	Other:
PT				Bed Mob: Dep Ext Lim S Ind	Gait: Dep Ext Lim S Ind	Sit Bal: Dep Ext Lim S Ind	Xfer: Dep Ext Lim S Ind
				W/c Mob: Dep Ext Lim S Ind	AD: Dist:	Stand Bal: Dep Ext Lim S Ind	Modalities:
ST				Orientation: Sev Mod MI I	Problem Solving: Sev Mod MI I	Receptive Lang: Sev Mod MI I	Swallow: Sev Mod MI I
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OT				UB Drsg: Dep Ext Lim S Ind	Feeding: Dep Ext Lim S Ind	Bathing: Dep Ext Lim S Ind	ADL Xfer: Dep Ext Lim S Ind
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				W/c Mob: Dep Ext Lim S Ind	AD: Dist:	Stand Bal: Dep Ext Lim S Ind	Modalities:
ST				Orientation: Sev Mod MI I	Problem Solving: Sev Mod MI I	Receptive Lang: Sev Mod MI I	Swallow: Sev Mod MI I
				Memory: Sev Mod MI I	Speech Clarity: Sev Mod MI I	Expressive Lang: Sev Mod MI I	Diet (Liquid/Food):