

HOUSTON HSDA – HOME HEALTH CARE
CLIENT RECORD EVALUATION FORM

AGENCY: _____

FILE #: _____

CRITERIA	SATISFIED?	NOTES
CONSENTS		
Consent for service in the record.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Consent for exchange/release of information in record.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Proof of Client Rights and Responsibilities.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Proof of receipt of Grievance Procedure.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Proof of receipt by client of client confidentiality policy.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Proof that client feedback is regularly obtained about quality of services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
ELIGIBILITY		
HIV Diagnosis is documented.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Residency in the Houston HSDA is documented.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Income no greater than 300% of the Federal poverty level is documented.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Proof of identification.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
INITIAL CONTACT		
Contact attempted/made w/in 24 hours of case assignment.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
If contact not made, noted in record.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Subsequent attempts are noted.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
INTAKE		
Intake form is completed w/in acceptable timeframe of obtaining client's written consent for services.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Proof that client is provided alternatives to office visits such as home visits	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
SERVICE COORDINATION		
Documentation of physician's order.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Documentation that skilled nursing visits are initiated with 48 hours of receipt of physician's order.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	

SERVICE COORDINATION		
Documentation that skilled rehabilitation visits are initiated with 48 hours of receipt of physician's order.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Documentation that intravenous therapy visits are initiated with 48 hours of receipt of physician's order.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Documentation that home health aid care makes phone contact within 24 hours of the date of the referral with client by the agency	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Documentation that the Registered Nurse makes a home visit with the patient within 72 hours of the referral	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Documentation that the home health aid care are re-evaluated a minimum of 60 days by the RN	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
FILE FORMAT		
One record/file per client.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Record is legible and in a consistent format.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Client name is on all records.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Staff sign name on all entries in the client record.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
DOCUMENTATION OF SERVICE		
TYPE OF SERVICE	DOCUMENTED?	NOTES
	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA

Comments: _____
