MED PRO HOME HEALTH SERVICES

12905 SW 42 St.
Suite 109
Miami, FL 33175
Ph: (305) 303-4152
Fax: (305) 480-3995
License #: HHA299993999

Medicare Certified & Joint Commission Accredited

Thank you for allow us to serve your health care needs, we hope that your care was of a more than satisfactory nature. Please complete the “Patient Survey” that is included in this packet and return it to us with any suggestion that you may have to serve you better in the future. We wish you will continue with good health, please contact us should you need further or additional assistance.

Gracias por permitirnos cuidar de su salud, esperamos que el cuidado proveido halla sido en la forma más satisfactoria posible. Favor de completar la encuesta incluida en este paquete para que nos ayude con cualquier sugerencia para poder servirle mejor en el futuro. Deseamos que continue con buena salud, favor de contactarnos si necesita cualquier asistencia adicional.

www.pnsystem.com

DISCHARGE PACKAGE

Med Pro Home Health Services

Discharge Letter Notification To Patient/Family

Dear: _____

Please be advised that as of _____/_____/_____ you have been discharged from our Home Health Care Agency. We have sent the final discharge summary to your physician.

We hope that your care was of a more than satisfactory nature. Please complete the "Patient Survey" that is included in your patient package and return mail it to us at:

12905 SW 42 St. Suite 109
Miami, FL 33175

We wish you will continue with good health. Please remember to take your medications as prescribed by your physician and to follow-up visit your visit your physician per his/her request.

Please call us should you need further or additional assistance at: (305) 303-4152

Med Pro Home Health Services

Carta de Información de Alta al Paciente/Familía

Por la presente le informamos que en ____/____/____ usted ha sido dado de alta de nuestra Agencia de Cuidados de Salud en el Hogar. Sus documentos finales fueron enviados a su doctor.

Esperamos que su cuidado haya sido más que satisfactorio. Por favor complete la "Encuesta del Paciente" incluido en los papeles dejados en su casa y retornarlo por correo a nosotros.

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Nosotros deseamos que usted continúe con buena salud. Por favor, recuerde tomar sus medicamentos como han sido prescritos por su doctor y seguir todas las indicaciones de el/ella.

Por favor, llámenos si usted necesitara asistencia adicional al: (305) 303-4152

Med Pro Home Health Services

QUALITY ASSURANCE EVALUATION FORM
PATIENT / FAMILY QUESTIONNAIRE

DATE OF EVALUATION: _____

NAME OF STAFF RECORDING THE EVALUATION: _____

NAME OF PATIENT: _____

NAME OF PERSON MAKING RESPONSES: _____
(person being interviewed)

Rating from 1 "Disagree" - 5 "Strongly Agree"

QUESTIONS	ALWAYS/Good 4 - 5	SOMETIMES 2 - 3	NEVER 1
1. Did you like your nurse/aide/therapist?			
2. Was your nurse/aide/therapist always there when she was expected to be there?			
3. Did your nurse/aide/therapist always wear a clean uniform?			
4. Did your nurse/aide/therapist appear to know her job?			
5. Was your nurse/aide/therapist punctual?			
6. Would you say the nurse/aide/therapist took good care of you?			
7. Was your nurse/aide/therapist a good listener?			
8. Perception of effectiveness of Care Provided: Care Plan Management, Disease Management, Pain Management, Patient's Safety, Medication Management, Infection Prevention, Fall prevention.			
9. Your nurse/aide/therapist were always available to communicate with you?			
Other Comments			

_____ Signature of Staff

_____ Patient's Signature (optional)

Med Pro Home Health Services

C U E S T I O N A R I O *(Spanish version)*

Fecha de la evaluación: _____

Nombre del empleado haciendo la encuesta: _____

Nombre del Paciente: _____

Nombre de la persona dando respuesta: _____
(Persona intervenida)

Escala desde 1 “No estoy de acuerdo” - 5 “Estoy completamente de acuerdo”

Preguntas	Siempre/Bien 4 - 5	Algunas Veces 2 - 3	Nunca 1
1. Le gusto el empleado (enfermera(o), ayudante, therapista?)			
2. Estuvo nuestro empleado siempre con usted cuando era ersperado?			
3. Nuestros empleados siempre usaron uniformes limpios?			
4. Conocian nuestros empleados su trabajo?			
5. Nuestros empleados fueron puntuales?			
6. Diria que nuestros empleados le dieron un buen cuidado?			
7. Nuestros empleados oian sus opiniones?			
8. Evaluación del Cuidado recibido: Manejo del Plan de Cuidado, Manejo de la Enfermedad, Manejo del Dolor, Seguridad del Paciente, Manejo de los Medicamentos, Prevención de Infecciones, Prevención de Caidas.			
9. Nuestros empleados estuvieron siempre disponible para comunicarse con usted?			
Otros comentarios			

_____ _____

Firma de empleado Firma del paciente (opcional)

Med Pro Home Health Services
12905 SW 42 St. Suite 109
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(305) 303-4152

DISCHARGE ORDER

Physician Name: _____
Physician Address: _____
_____
_____
Physician Phone: _____

Patient Name: _____ MR #: _____
Patient Address: _____
Diagnosis: _____
Date Effective: _____

DISCHARGE PATIENT FROM HOME HEALTH SERVICES TODAY ☐

DISCHARGE THE FOLLOWING DISCIPLINE AND PATIENT WILL CONTINUE WITH HOME HEALTH SERVICES ☐

Skilled Nurse ☐ Aide ☐ Physical Therapy ☐ Occupational Therapy ☐
Speech Therapy ☐ Medical Social Worker ☐ Respiratory Therapy ☐

_____
_____
_____
_____

REASON FOR DISCHARGE

Goals Met ☐ Patient Refused Further Services ☐ Patient has moved out of geographical area ☐
Patient has expired ☐ Hospitalization ☐ Physician Cancelled Services ☐
Transferred to Another Agency ☐ Partial Discharge ☐ Other ☐

_____
_____
_____
_____

_____ _____
Signature of Nurse Receiving Orders Date

_____ _____
Physician Signature Date

Date Received: _____

Med Pro Home Health Services

PATIENT DISCHARGE. NOTIFICATION/INSTRUCTIONS

ALTA DEL PACIENTE. NOTIFICACION/INTRUCCIONES

Discharge Date/*Fecha de Alta del Paciente* _____

Patient Name/*Nombre de el(la) Paciente* _____

Patient Record Number/*Número de Record del Paciente* _____

Dear Patient/*Estimado Paciente:*

It has been our pleasure to assist you during your recovery period from your recent illness, in accordance with your private physician's plan of treatment and in compliance with Medicare/Medicaid guidelines, you are being discharged from all home health services.
Ha sido un placer asistirlo durante su periodo de recuperación de su reciente enfermedad. De acuerdo con el plan de tratamiento de su médico y en cumplimiento de las regulaciones de Medicare/Medicaid, Ud. está siendo dado de alta de sus servicios de cuidado a la casa.

l.-Continue to follow any Diet instructions you received/*Continúe las Instrucciones de Dieta Recibidas.*
Current Diet/*Dieta Corriente* _____

2.-Take Only Medications Prescribed by Your Doctor, Discard all Out-Dated Medications/*Tome Solamente Medicamentos Recetados por su Doctor, Deseche Todos los Medicamentos Expirados.*
Current Medications Include/*MedicamentosActuales lncluyen:* ☐ **See current/updated medication schedule**/*Vea el listado de medicamentos actualizado*
Comment/*Comentarios:* _____

3.-Continue with the Following Treatments/*Continue con los Siguientes Tratamientos:*
Current Treatments Include/*Tratamientos Actuales Incluyen* _____

4.-Continue with the Following Activities/*Continue con las Siguientes Actividades:*
Current Activities Include/*Actividades Actuales Incluyen* _____

Special Precautions/*Precauciones Especiales* _____

Psychosocial Need Follow/*Necesidades Psycosociales a Seguir* _____

Community Resource to Contact-Referrals Made/*Recursos de la Comunidad para Contactar o Referir* _____

Keep Doctor's Name and Phone Number, and Your Address Clearly Printed Next to Your Phone or On Your Refrigerator.
Keep Name and Phone Number of Friend or Relative to Be Contacted in Case of Emergency, Next to Your Phone or On Your Refrigerator.
Mantenga Nombre y Teléfono de Su Médico, así como su dirección, claramente escritos Cerca de Su Teléfono o Refrigerador.
Mantenga Nombre y Teléfono de un Amigo o Familiar que Pueda Ser Contactado en Caso de Emergencia

Physician Name/*Nombre del Médico* _____

Phone Number/*Número de Teléfono* _____

Next Physician Appointment/*Próxima Cita* _____

Instructions given to/*Instrucciones dadas a* _____

Relationship to Patient/*Relación con el Paciente* _____

Patient signature / *Firma del Paciente* _____ Date/*Fecha* _____

Witness (Agency's Representative)/*Testigo(Representante de la Agencia.)* _____ Date/*Fecha* _____

FOR EMERGENCY CALL 911 - *EN CASO DE EMERGENCIA LLAME AL 911*

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NURSING DISCHARGE SUMMARY / NOTE

PATIENT _____

MED REC #_____ ADM DATE _____ DISCH DATE _____

DIAGNOSIS *(Primary)* _____

DR. _____

ADDRESS _____

CITY, ZIP _____ TEL _____

SERVICES RENDERED: *Frequency on ADM to Discharge*

SN _____ H H A _____

MSW _____ ☐ DIETICIAN_____

REASON FOR DISCHARGE: _____

☐ **PARTIAL** - STILL RECEIVING SERVICES OF:

☐ PT ☐ ST ☐ OT ☐ HHA _____

☐ **COMPLETE**

CONDITION ON DISCHARGE:

☐ STABLE ☐ IMPROVED

☐ UNSTABLE ☐ DECEASED

DISPOSITION OF THE PATIENT:

☐ ABLE TO CARE FOR SELF ☐ FAMILY TO ASSIST

☐ INSTITUTIONALIZED ☐ HOMEMAKER TO ASSIST ☐ DECEASED

LAST M.D. VISIT:_____

LAB REPORTS _____

CHANGE ORDERS / NEW DIAGNOSIS:

☐ YES ☐ NO

RN CONTACTED PHYSICIAN ON DATE: _____ AND DISCHARGE IS APPROVED.

SUMMARIZE:

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

☐ VERBALIZES KNOWLEDGE OF MEDICATIONS, SIDE EFFECTS, PRECAUTIONS, DIET. FLUIDS, DISEASE PROCESS, TREATMENT PROGRAM. S/S NECESSITATING MEDICAL ATTENTION.

☐ RETURN TO PREVIOUS LIFESTYLE WITH MODIFICATIONS WITHIN DISEASE LIMITATIONS.

☐ HOME FREE OF HAZARDS USING PROPER SAFETY MEASURES.

☐ PRESENTING SYMPTOMS ABSENT AND/OR CONTROLLED BY APPROPRIATE INTERVENTION.

☐ INDEPENDENCE IN SELF CARE WITHIN DISEASE LIMITATIONS.

☐ MAXIMUM POTENTIAL OF SKILLED SERVICES ATTAINED WITHIN HOME SETTING.

SKILLED OBSERVATION / ASSESSMENT ON DISCHARGE

DISCHARGED V/S _____

VITAL SIGNS RANGE:

BP _____ TO _____

AP _____ TO _____

RR _____ TO _____

TEMP _____ TO _____

GU/GI:

VOIDING: INCONTINENT, NORMAL, FOLEY CATHETER

BOWELS: REGULATED, NOT REGULATED, OSTOMY, CATHARTIC REQUIRED

_____

_____

MENTAL STATUS:

☐ ALERT ☐ DISORIENTED

☐ FORGETFUL ☐ CONFUSED

ANXIOUS

DERMA:

TURGOR ☐ GOOD ☐ FAIR ☐ POOR

WOUND/DECUBITUS: ☐ HEALED ☐ NOT HEALED-PT/FAMILY DEMONSTRATES PROPER WOUND CARE

CARDIAC/CIRCULATORY:

☐ FREQUENCY OF CHEST PAIN

☐ FREE OF CHEST PAIN

☐ CONTROLLED ON MEDICATION

EDEMA: ☐ NONE ☐ TRACE ☐ MODE RATE ☐ PITTING ☐ NON-PITTING

NUTRITION:

DIET _____

☐ TUBE FEEDING ☐ TPN

APPETITE:

☐ GOOD ☐ FAIR ☐ POOR

PULMONARY:

LUNGS: ☐ CLEAR ☐ RONCHI ☐ IBS ☐ RALES ☐ WHEEZING

O2 ☐ REQUIRED ☐ NOT REQUIRED

ENDOCRINE:

DIABETES

☐ DIET CONTROLLED

☐ ORAL HYPOGLYCEMIC

☐ INSULIN DEPENDENT

EENT:

HEARING ☐ GOOD ☐ POOR

VISION ☐ GOOD ☐ POOR

PATIENT / FAMILY INSTRUCTED IN:

☐ POST CATARACT CARE
☐ INJECTION ADMINISTRATION
☐ DISEASE PROCESS
☐ S/S OF COMPLICATIONS
☐ ACTION/SIDE EFFECTS OF MEDS
☐ FOLEY CARE
☐ WOUND/DECUBITUS CARE
☐ CARE OF TERMINALLY ILL
☐ DIABETIC MANAGEMENT
☐ DIET/FLUID INTAKE
☐ OSTOMY/CONDUIT CARE
☐ SAFETY FACTORS
☐ ACTIVITY RESTRICTIONS
☐ ADMINISTRATION OF TUBE FEEDINGS
☐ ADMINISTRATION OF INHALATION RX
☐ IV THERAPY
☐ FIT. INDWELLING CATHETER CARE/PRECAUT.
☐ S/S COMPLICATIONS/INFECTION

PT/FAMILY RESPONSE AND ADHERENCE TO TEACHINGS: ☐ GOOD ☐ FAIR ☐ POOR ☐ REPETITIVE TEACHING REQUIRED

NURSING GOALS MET: ☐ YES ☐ NO .... IF NO, EXPLAIN _____

PATIENT/FAMILY GOALS MET: ☐ YES ☐ NO ... IF NO, EXPLAIN _____

ADDITIONAL COMMENTS AND INSTRUCTIONS: _____

RN SIGNATURE _____ DATE _____

MED PRO HOME HEALTH SERVICES

A. Notifier: 12905 SW 42 ST. SUITE 109 MIAMI, FL 33175 (305) 303-4152

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

A. Notificante:

B. Nombre del paciente: **C. Número de identificación:**

Notificación previa de NO-cobertura al beneficiario (ABN)

NOTA: Si Medicare no paga **D.** _____ a continuación, usted deberá pagar. Medicare no paga todo, incluso ciertos servicios que, según usted o su médico, están justificados. Prevemos que Medicare no pagará **D.** _____ a continuación.

D.	E. Razón por la que no está cubierto por Medicare:	F. Costo estimado

Lo que usted necesita hacer ahora:

- Lea la presente notificación, de manera que pueda tomar una decisión fundamentada sobre la atención que recibe.
- Háganos toda pregunta que pueda tener después de que termine de leer.
- Escoja una opción a continuación sobre si desea recibir D. _____ mencionado anteriormente.

  Nota: Si escoge la opción 1 ó 2, podemos ayudarlo a usar cualquier otro seguro que tal vez tenga, pero Medicare no puede exigirnos que lo hagamos.

G. OPCIONES: Sírvase marcar un recuadro solamente. No podemos escoger un recuadro por usted.

☐ **OPCIÓN 1.** Quiero **D.** _____ mencionado anteriormente. Puede cobrarme ahora, pero también deseo que se cobre a Medicare a fin de que se expida una decisión oficial sobre el pago, la cual se me enviará en el Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable por el pago, pero **puedo apelar a Medicare** según las instrucciones en el MSN. Si Medicare paga, se me reembolsarán los pagos que he realizado, menos los copagos o deducibles.

☐ **OPCIÓN 2.** Quiero **D.** _____ mencionado anteriormente, pero que no se cobre a Medicare. Puede solicitar que se le pague ahora dado que soy responsable por el pago. **No tengo derecho a apelar si no se le cobra a Medicare.**

☐ **OPCIÓN 3.** No quiero **D.** _____ mencionado anteriormente. Entiendo que con esta opción no soy responsable por el pago y **no puedo apelar para determinar si pagaría Medicare.**

H. Información adicional:

En esta notificación se da a conocer nuestra opinión, no la de Medicare. Si tiene otras preguntas sobre la presente notificación o el cobro a Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Al firmar abajo usted indica que ha recibido y comprende la presente notificación. También se le entrega una copia.

I. Firma:	J. Fecha:

Med Pro Home Health Services

Chart Audit *(Discharge)*

Date of Review:_____	Client MR#:_____
Episode Dates:	Principal Dx:
Current Disciplines/Frequency: (circle) SN:_____ PT:_____ OT:_____ ST:_____ MSW:_____ HHA:_____	Primary Physician:_____ Discipline/frequency change in last 60 days? ☐ Yes ☐ No If Yes, is there an order for the change? ☐ Yes ☐ No Supporting documentation for change? ☐ Yes ☐ No Explain:_____

Admission	YES	NO	COMMENTS
Client admitted to service within 48 hrs of referral?			
Assessment of client's needs appropriate, including appropriate initial referral and diagnosis?			
Consents (Client Rights, Admission Agreement, Ins. Determination) present and signed?			
Plan of Care reflects client's needs?			
If applicable, is there a predictable end point of daily visits specified?			
Each 485 locater complete and accurate?			
Plan of Care signed/dated by physician?			
Physician's Orders (all disciplines)			
If missed visits occurred (as compared with orders), is there documentation that the physician was notified?			
Services delivered, as ordered (freq/duration)?			
Lab results, as ordered, are present and it is noted that physician notified?			
Telephone/verbal orders obtained/signed for all changes (treatment, frequency, etc.)?			
Physician has been informed of changes in client needs or status?			

Service Delivery	YES	NO	COMMENTS
Medication profile is present and reflects any changes that took place?			
Progress notes/documentation reflect involvement of client and/or family in planning process and care?			
Documentation reflects coordination among services?			
Supervisory visits completed per policy/regulation?			

Med Pro Home Health Services

Does documentation identify supplies used during each visit?			
Does documentation support that all medical supplies have a diagnostic or therapeutic use and have been ordered by physician?			
Evaluation/measurement of client's progress toward anticipated goals documented?			
If outcomes were not met by client, is reason documented?			
Care plans updated as interventions completed/goals met?			
Frequency/duration for each discipline appropriate per client's condition?			
Are visit notes for each discipline signed/dated and within ordered frequency?			
Is homebound status documented at least once twice monthly?			
For each visit, is skill documented and personal care performed?			
Oasis Assessment(s)			
Were all OASIS assessments completed within specified time frames per regulation and policy?			
Are diagnoses listed on the OASIS assessment(s) consistent with diagnoses listed on 485?			
Are therapy visits consistent with answer to MO825?			

Follow up action required: _____

Signature of
Reviewer/Title:_____

Corrections completed

by:_____Date:_____

Med Pro Home Health Services

QUALITY ASSURANCE FORM
PHYSICIAN QUESTIONNAIRE

Dear Dr. _____

We are conducting a survey on our Quality Assurance Standard. Please check the appropriate box in the questionnaire form below:

Thanks.

ITEMS PHYSICIAN	RESPONSE			
	EXCELLENT	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
1. Did agency staff display adequate knowledge and professionalism in maintaining patient records?				
2. Did agency staff make themselves accessible to physician when applicable?				
3. Were agency staff members able to communicate adequately with patient's family and to the physician?				
4. How would you rate overall quality of nursing care toward patients as performed by the staff of this agency?				
5. Other				

Date: _____

Physician's signature (optional if is by phone): _____

Med Pro Home Health Services

PHYSICAL THERAPY
DISCHARGE SUMMARY ADDENDUM

PHYSICAL THERAPY GOALS REACHED

POC (485) GOALS REACHED:

- ❑ PATIENT DEMONSTRATED CORRECT BODY MECHANICS
- ❑ PATIENT AND/OR CG COMPREHEND AND DEMONSTRATED HOME EXERCISE PROGRAM
- ❑ ABLE TO COMPLY WITH EXERCISES: BOTH PASSIVE AND ACTIVE EXERCISE REGIMEN
- ❑ DEMONSTRATED EFFECTIVE FALL PREVENTION PROGRAM
- ❑ IMPROVED THE USE OF ASSISTIVE DEVICE: _____
- ❑ MAINTAIN/COMPLY WITH HOME SAFETY PROGRAM
- ❑ PATIENT AMBULATED WITH _____ (device) FOR _____ FT WITH _____ ASSIST
- ❑ INCREASED STRENGTH OF ❑ RUE ❑ LUE ❑ RLE ❑ LLE TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITIES: _____.
- ❑ INCREASED RANGE OF MOTION (ROM) OF _____ JOINT TO _____ DEGREE FLEXION AND _____ DEGREE EXTENSION IN ____ WEEKS TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITY: _____.

CARE PLAN SHORT/LONG TERM GOALS REACHED:

GENERAL

- ❑ Gait increased tinetti gait score to _____ / 12
- ❑ Improved gait requiring ____ to _____ from _____ to _____

BED MOBILITY

- ❑ Pt. able to turn side (facing up) to lateral (left/right)
- ❑ Pt. able to lie back down
- ❑ Pt. able to sit up independently _____
- ❑ Pt. able to self reposition
- ❑ IMPROVED BED MOBILITY (INDEPENDENT)

BALANCE

- ❑ Increased tinetti balance score to _____/16
- ❑ Pt. able to reach steady static/dynamic sitting/standing balance with/without assistance

TRANSFER

- ❑ Pt. able to transfer from _____ to _____ with/without assistance
- ❑ INDEPENDENT WITH TRANSFER SKILLS

STAIR/UNEVEN SURFACE

- ❑ Pt. able to climb stair/uneven surface with/without assistance _____ steps # _____

MUSCLE STRENGTH

- ❑ Pt. able to hold weigh _____ lb
- ❑ Pt. able to oppose flexion or extension force over _____

PAIN

- ❑ Pain decreased from _____/10 to _____ /10
- ❑ DEMONSTRATED EFFECTIVE PAIN MANAGEMENT
- ❑ PATIENT EXPERIENCED A DECREASE IN PAIN

ROM

- ❑ Pt. increased ROM of _____ by _____ degrees flexion/extension

SAFETY

- ❑ Pt. able to use _____ independently to _____ feet
- ❑ Pt. able to self propel wheel chair _____ feet
- ❑ Pt able to finalize and demonstrated to follow up HEP.

OTHER:

_____

_____

_____

_____

_____

ADDITIONAL SPECIFIC THERAPY GOALS REACHED

Patient Expectation	SHORT TERM	LONG TERM

DISCHARGE INSTRUCTIONS DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) _____

CARE WAS COORDINATED: ❑ Physician ❑ OT ❑ SN ❑ ST ❑ MSW ❑ Aide ❑ PTA ❑ Other (specify) _____

- ❑ DISCHARGED: PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE KNOWLEDGE OF DISEASE MANAGEMENT, S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.
- ❑ RETURNED TO INDEPENDENT LEVEL OF SELF CARE.
- ❑ ABLE TO REMAIN SAFELY IN RESIDENCE WITH ASSISTANT OF _____

REHAB STATUS: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

- ❑ DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED
- ❑ ABLE TO UNDERSTAND MEDICATION REGIME AND CARE RELATED TO DISEASE
- ❑ ABLE TO REMAIN IN HOME/RESIDENCE/ALF WITH ASSISTANCE OF PRIMARY CAEGIVER/SUPPORT AT HOME ABLE TO UNDERSTAND MEDICATION REGIMEN, AND CARE RELATED TO HIS/HER DISEASE. DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED.

Goals documented by: _____ Date _____

Therapist Name/Signature/title

PATIENT NAME - Last, First, Middle Initial	ID#

Med Pro Home Health Services

OCCUPATIONAL THERAPY DISCHARGE SUMMARY ADDENDUM

OCCUPATIONAL THERAPY GOALS REACHED

POC (485) GOALS REACHED:

- ❑ DEMONSTRATED PROPER USE OF PROSTHESIS/BRACE/SPLINT DEMONSTRATED PROPER USE OF DME/HME.
- ❑ PATIENT AND/OR CG COMPREHEND AND DEMONSTRATED HOME EXERCISE PROGRAM
- ❑ PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN ADL'S, IADL'S.
- ❑ DEMONSTRATED EFFECTIVE FALL PREVENTION PROGRAM
- ❑ IMPROVED THE USE OF ORTHOTIC, SPLINTING AND/OR EQUIPMENT, ASSISTIVE DEVICE: _____
- ❑ MAINTAIN/COMPLY WITH HOME SAFETY PROGRAM
- ❑ PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN MUSCLE USE, MOTOR COORDINATION
- ❑ INCREASED STRENGTH OF ❑ RUE ❑ LUE ❑ RLE ❑ LLE TO ALLOW PATIENT TO PERFORM THE FOLLOWING ACTIVITIES: _____.
- ❑ PATIENT DEMONSTRATED IMPROVEMENT IN COPING IN NEURO RESPONSE
- ❑ DISCHARGE PLANNED DISCUSSED WITH PATIENT / FAMILY

CARE PLAN SHORT/LONG TERM GOALS REACHED:

- ❑ Patient able to finalize and demonstrate to follow up HEP.
- ❑ Pain level decreased from ____/10 to ____/10
- ❑ Pt. able to stand in kitchen to prepare meal for _____ min
- ❑ Patient able to reach _____ on _____
- ❑ Patient able to lift _____ # pounds from _____ to _____
- ❑ Patient able to wash _____
- ❑ Patient able to reach a Cup from _____ and taked to _____
- ❑ Patient able to integrate orthotic/prosthetic _____ to _____
- ❑ Patient independent with safety issues in _____
- ❑ Improved bathing skills, use to _____
- ❑ Patient retraining of cognitive, feeding, and perceptual skills
- ❑ Patient able to improve body image with _____
- ❑ Independent with muscle re-education

OTHER:

_____

_____

_____

- ❑ Increased strength ❑ R ❑ L Hands
- ❑ Increased coordination ❑ R ❑ L Hands
- ❑ Increased sensation ❑ R ❑ L Hands
- ❑ Increase Neuro response by _____
- ❑ Use of SPLINTING AND/OR EQUIPMENT independent
- ❑ Demonstrate Hands motion to WNL within

OTHER:

_____

_____

_____

_____

_____

_____

_____

_____

_____

ADDITIONAL SPECIFIC OT GOALS REACHED

Patient Expectation	SHORT TERM	LONG TERM

DISCHARGE INSTRUCTIONS DISCUSSED WITH: ❑ Patient/Family ❑ Care Manager ❑ Physician ❑ Other (specify) _____

CARE WAS COORDINATED: ❑ Physician ❑ PT ❑ SN ❑ ST ❑ MSW ❑ Aide ❑ OTA ❑ Other (specify) _____

- ❑ DISCHARGED: PATIENT AND/OR CAREGIVER IS/ARE ABLE TO DEMONSTRATE KNOWLEDGE OF DISEASE MANAGEMENT, S/S COMPLICATIONS. PATIENT IS ABLE TO FUNCTION INDEPENDENTLY WITHIN HIS/HER CURRENT LIMITATION AT HOME.
- ❑ RETURNED TO INDEPENDENT LEVEL OF SELF CARE.
- ❑ ABLE TO REMAIN SAFELY IN RESIDENCE WITH ASSISTANT OF _____

REHAB STATUS: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

- ❑ DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED
- ❑ ABLE TO UNDERSTAND MEDICATION REGIME AND CARE RELATED TO DISEASE
- ❑ ABLE TO REMAIN IN HOME/RESIDENCE/ALF WITH ASSISTANCE OF PRIMARY CAEGIVER/SUPPORT AT HOME ABLE TO UNDERSTAND MEDICATION REGIMEN, AND CARE RELATED TO HIS/HER DISEASE. DISCHARGED: MAXIMUM FUNCTIONAL POTENTIAL REACHED.

Goals documented by: _____ Date _____

Therapist Name/Signature/title

PATIENT NAME - Last, First, Middle Initial	ID#

Home Health Agency: MED PRO HOME HEALTH SERVICES **Patient Name:**_____

Address: 12905 SW 42 ST. SUITE 109
MIAMI, FL 33175

Phone: (305) 303-4152

Patient Identification: _____

Home Health Change of Care Notice (HHCCN)

Your home health care is going to change. Starting on _____ , your home health agency will change the following items and/or services for the reasons listed below.

Items/services:	Reason for change:

Read the information next to the checked box below. Your home health agency is giving you this information because:

Your doctor's orders for your home care have changed.

☐ The home health agency must follow physician orders to give you care.
The home health agency can't give you home care without a physician's order.
If you don't agree with this change, discuss it with your home health agency or the doctor who orders your home care.

Your home health agency has decided to stop giving you the home care listed above.

☐ You can look for care from a different home health agency if you have a valid order for home care and still think you need home care.
If you need help finding a different home health agency to give you this care, contact the doctor who ordered your home care.
If you get care from a different home health agency, you can ask it to bill Medicare.

If you have questions about these changes, you can contact your home health agency and/or the doctor who orders your home care.

You cannot appeal to Medicare about payment for the items/services listed above unless you both receive them and a Medicare claim is filed.

Additional Information:

Please sign and date below to show that you received and understand this notice. Return this signed notice to your home health agency in person or by mailing it to them at the address listed at the top of this notice.

Signature of the Patient or of the Authorized Representative*	Date

*If a representative signs for the beneficiary, write "(rep)" or "(representative)" next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed.

Agencia: **Nombre del paciente:**

Dirección postal: **Número de identificación (paciente):**

Teléfono:

Aviso de Cambio del Cuidado de la Salud en el Hogar (HHCCN)

El cuidado de su salud en el hogar cambiará. A partir del *[fecha]*, su agencia de cuidado de la salud en el hogar cambiará los siguientes artículos y/o servicios por las razones mencionadas a continuación.

Artículos y/o servicios:	**Razón del cambio:**

Lea la información a continuación. Su agencia de cuidado de la salud en el hogar le está dando a esta información porque:

☐	**Las órdenes de su médico o proveedor sobre su plan de cuidado han cambiado.** La agencia para el cuidado de la salud en el hogar debe seguir las órdenes de su médico al ofrecerle los servicios. La agencia para el cuidado de la salud en el hogar no puede ofrecerle servicios sin una orden del médico/proveedor de la salud. Si está en desacuerdo con el cambio, háblelo con su agencia, su médico o proveedor.
☐	**La agencia para el cuidado de la salud en el hogar decidió dejar de brindarle los servicios mencionados.** Usted puede obtener estos servicios de otra agencia para el cuidado de la salud en el hogar si tiene una orden válida para los servicios y su médico piensa que todavía necesita los servicios. Si necesita ayuda para buscar otra agencia que le pueda ofrecer estos servicios, hable con el médico o proveedor que ordenó los servicios. Si obtiene los servicios de otra agencia, puede pedirles que le envíen la factura a Medicare.

Si tiene preguntas sobre estos cambios, llame a su agencia de cuidado de la salud en el hogar y/o el médico o proveedor que ordenó los servicios.

Usted no puede apelar a Medicare el pago del servicio o artículo mencionado arriba a menos que lo haya recibido, y se haya presentado el reclamo a Medicare.

Más información:

Firme abajo y ponga la fecha como prueba de que ha recibido y entendido el contenido de este aviso. Entréguele la copia firmada a su agencia de cuidado de la salud en el hogar, en persona o por correo a la dirección que aparece en la parte superior de este aviso.

Firma del paciente o representante legal*	Fecha

* Si el representante firma en vez del paciente, escriba "(rep)" o "(representante)" al lado de la firma. Si la firma del representante no es legible, debe escribir su nombre en letra de molde.

Med Pro Home Health Services

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Miami, FL 33175 (305) 303-4152

Notice of Medicare Non-Coverage

Patient name: _____ **Patient number:** _____

The Effective Date Coverage of Your Current _____
_____ Services Will End: _____

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current _____ services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: FMQAI (1-866-800-8768) to appeal, or if you have questions. Hearing/Speech impaired TDD/TTY 1-866-800-8753.

See page 2 of this notice for more information.

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Miami, FL 33175 (305) 303-4152

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information _____

_____

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____ _____

Signature of Patient or Representative Date

Notificación de Medicare de No-Cobertura

Nombre del Paciente: _____ **Número de ID del Paciente:** _____

La fecha en que comenzó la cobertura de los servicios de _____ _____ Los servicios terminarán el _____

- Su plan de Medicare o su proveedor ha determinado que Medicare probablemente no pagará por los servicios de _____ que usted está recibiendo, a partir de la fecha indicada arriba.
- Después de esa fecha, usted quizás tendrá que pagar por cualquier servicio que reciba.

Su derecho a apelar esta decisión

- Usted tiene derecho a una revisión médica (apelación) inmediata e independiente de la decisión de terminar la cobertura de Medicare por estos servicios. Usted continuará recibiendo los servicios hasta que se tome una decisión.
- Si apela la decisión, el revisor independiente le pedirá su opinión, también analizará su historial médico y otra información relevante. Usted no tendrá que preparar un informe escrito, pero si lo desea puede hacerlo.
- Si decide apelar, tanto usted como el revisor independiente recibirán una copia de la explicación detallada sobre el motivo por el cual la cobertura de los servicios no debe continuar. Usted recibirá esta explicación después de que haya presentado su pedido de apelación.
- Si decide apelar, y el revisor independiente coincide en que la cobertura de los servicios no debe continuar después de la fecha indicada arriba, ni Medicare ni su plan pagarán por dichos servicios a partir de esa fecha.
- Si usted deja de recibir los servicios a partir de la fecha indicada arriba, podrá evitarse cualquier responsabilidad económica.

Cómo solicitar una apelación inmediata

- Debe presentar su solicitud a la Organización para Mejoras de la Calidad (QIO por sus siglas en inglés). La QIO es el revisor independiente autorizado por Medicare para evaluar la decisión de terminar estos servicios.
- Su solicitud de apelación inmediata debe hacerse tan pronto sea posible, pero a más tardar para el mediodía del día antes de la fecha de efectividad indicada arriba.
- La QIO le notificará su decisión tan pronto como sea posible. Si usted está inscrito en el Medicare Original por lo general será a los dos días de la fecha de vigencia de este aviso. Si está inscrito en un plan de salud de Medicare, la QIO le informará su decisión para la fecha de vigencia de este aviso.
- Llame a su QIO al: FMQAI (1-866-800-8768) para apelar la decisión o si tiene preguntas. Problemas Habla/Oido TDD/TTY 1-866-800-8753.

Si desea más información sobre este aviso, consulte la página 2.

Si se le ha pasado la fecha para solicitar una apelación inmediata. Podría tener otros derechos de apelación:

- Si tiene el Medicare Original: llame a la QIO mencionada en la página 1.
- Si tiene otro plan de salud de Medicare: llame al plan al número mencionado abajo.

Información para comunicarse con el plan: _____

_____

Información adicional (Opcional):

Por favor firme abajo para indicar que ha recibido esta notificación.

Se me ha informado que la cobertura de mis servicios terminará en la fecha indicada en este aviso, y que puedo ponerme en contacto con mi QIO para apelar la decisión.

_____ _____

Firma del paciente o del representante Fecha

Med Pro Home Health Services

THERAPY DISCHARGE SUMMARY

PATIENT LAST NAME | FIRST NAME | PATIENT #

TYPE OF DISCHARGE: ☐ COMPLETE ☐ PARTIAL - STILL RECEIVING SERVICES OF: ☐ PT ☐ ST ☐ OT ☐ HHA ☐ SN

ADM DATE _____ **DISCH DATE** _____ DR _____

DIAGNOSIS (PRIMARY) _____ ADDRESS _____

_____ CITY, ST _____ ZIP _____

VISITS RENDERED BY: _____ RN _____ HHA _____ PT _____ OT _____ ST _____ MSW

REASON FOR DISCHARGE:
☐ GOALS MET ☐ MOVED OUT OF AREA ☐ OTHER
☐ HOSPITALIZATION ☐ PATIENT EXPIRED
☐ SKILLED NURSING FACILITY ☐ CARE REFUSED
☐ TRANSFER TO ANOTHER AGENCY ☐ SKILLED CARE NO LONGER NEEDED

DISPOSITION ☐ SELF CARE ☐ NH ☐ ACLF ☐ FAMILY CARE ☐ OTHER

CONDITION ☐ IMPROVED ☐ STABLE ☐ UNSTABLE ☐ DECEASED ☐ REGRESSED

DEPENDENCY ☐ DEPENDENT ☐ INDEPENDENT ☐ REQUIRES SUPERVISION/ASSIST

EXERCISES ☐ PASSIVE ☐ ACTIVE ☐ ACTIVE ASSISTIVE ☐ RESISTIVE

PERFORMED WITH: ☐ R.U.E. ☐ R.L.E. ☐ L.U.E. ☐ L.L.E. ☐ TRUNK ☐ NECK

TRANSFER ACTIVITIES: ☐ HOYER LIFT ☐ CRUTCHES ☐ WALKER ☐ W/C ☐ CANE ☐ QUAD CANE ☐ OTHER _____

GAIT TRAINING: ☐ N.W.B. ☐ P.W.B. ☐ F.W.B. ☐ EVEN SURFACES ☐ STAIRS ☐ UNEVEN SURFACES

ASSISTANCE REQUIRED: ☐ MAXIMUM ☐ MINIMUM ☐ MODERATE ☐ GUARDING ☐ OTHER _____

DISTANCE AMBULATED: ☐ 20 ft. ☐ 40 ft. ☐ 60 ft. ☐ 80 ft. ☐ 100 ft. ☐ 120 ft.

INSTRUCTED ON HOME PROGRAM: ☐ PATIENT ☐ SIGNIFICANT OTHER ☐ FAMILY

NARRATIVE: _____

SUMMATION OF SERVICES RENDERED AND GOALS ACHIEVED

Physical Therapy

_____ PATIENT HAS ACHIEVED ANTICIPATED GOALS
_____ PATIENT IS SAFELY INDEPENDENT WITHIN DISEASE LIMITATIONS
_____ ABSENCE OF PAIN
_____ FREE OF CONTRACTURES
_____ RANGE OF MOTION OF ALL JOINTS IS WITHIN NORMAL RANGE
_____ DEMONSTRATES RANGE OF MOTION EXERCISES
_____ DEMONSTRATES MUSCLE STRENGTHENING EXERCISES
_____ DEMONSTRATES TURNING AND POSITIONING SCHEDULE
_____ AMBULATES SAFELY WITH ASSISTIVE DEVICE
_____ AMBULATES SAFELY WITHOUT ASSISTIVE DEVICE

Speech Therapy

_____ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
_____ PATIENT HAS ATTAINED MAXIMUM BENEFIT FROM THERAPEUTIC PROGRAM
_____ VERBAL AND SENTENCE FORMULATION AND COMPREHENSION IMPROVED TO MAXIMUM ATTAINMENT WITHIN DISEASE LIMITATIONS

_____ DEMONSTRATES TRANSFER TECHNIQUE AND USE OF SPECIAL DEVICES
_____ DEMONSTRATES ABILITY TO DO SPECIAL TREATMENTS
_____ HEALED INCISION
_____ DEMONSTRATES STUMP WRAPPING AND HYGIENE
_____ DEMONSTRATES TECHNIQUE TO CARE FOR AND PROTECT FUNCTIONING EXTREMITY
_____ DESCRIBES PHANTOM LIMB SENSATION
_____ PATIENT DEMONSTRATES STABILIZATION OF AMBULATION

Occupational Therapy

_____ PATIENT HAS REACHED ALL REALISTIC ACHIEVABLE GOALS
_____ DEMONSTRATES KNOWLEDGE OF OPERATION & CARE OF ADAPTIVE EQUIPMENT
_____ DEMONSTRATES ENERGY CONSERVATION/WORK SIMPLIFICATION TECHNIQUES
_____ DEMONSTRATIONS COMPENSATORY & SAFETY TECHNIQUES

PATIENT/S.O. RESPONSE AND ADHERENCE TO TEACHING: ☐ GOOD ☐ FAIR ☐ POOR

THERAPY GOALS MET: ☐ YES ☐ NO ☐ IF NO, EXPLAIN _____

PATIENT/S.O.GOALS MET: ☐ YES ☐ NO ☐ IF NO, EXPLAIN _____

COMMENTS: _____

☐ PATIENTS/So. INSTRUCTED ON IMPORTANCE OF ADHERENCE OF EXERCISE PROGRAM, M.D. FOLLOW-UP AND NOTIFY M.D. IF COMPLICATIONS OCCUR. ☐ M.D. NOTIFIED OF DISCHARGE

THERAPIST SIGNATURE _____ DATE _____

Med Pro Home Health Services

NOTES: (For your records)

HOSPITALIZATIONS:

Admitted: ____/ ___/ _____ Discharge: ___/ ___/ _____
Admitido *Alta*
Hospital: _____
Reason / Razón: _____

- -

Admitted: ____/ ___/ _____ Discharge: ___/ ___/ _____
Admitido *Alta*
Hospital: _____
Reason / Razón: _____

- -

MD VISITS / *VISITAS AL DOCTOR*

Date	Physician/Doctor Name/Phone	Reason

Med Pro Home Health Services

NOTES: (For your records)

HOSPITALIZATIONS:

Admitted: ____/ ___/ _____ Discharge: ___/ ___/ _____
Admitido *Alta*
Hospital: _____
Reason / Razón: _____

- -

Admitted: ____/ ___/ _____ Discharge: ___/ ___/ _____
Admitido *Alta*
Hospital: _____
Reason / Razón: _____

- -

MD VISITS / *VISITAS AL DOCTOR*

Date	Physician/Doctor Name/Phone	Reason

Med Pro Home Health Services

Remember report ABUSE, NEGLECT or EXPLOITATION AT ANY TIME:

AHCA HOME HEALTH HOTLINE
Monday - Friday *(Lunes- Viernes)* **8:00 am - 6:00 pm**
To Report a Complaint regarding the services you receive, Report suspected Medicaid fraud, Information for local Agencies, or implemenation of the Advanced Directives, call toll free number:
Para reportar una Queja del Servicio que recibe, reportar sospecha de fraude al Medicaid, información sobre Agencias locales, o en la implementación de las Directivas Anticipadas, llame gratis a:
1 (888) 419-3456 *(Toll free/gratis)*

TO REPORT ABUSE, NEGLECT OR EXPLOITATION, PLEASE CALL THIS TOLL FREE
(para reportar ABUSOS, explotación, negligencia, por favor llame gratis a):
ABUSE REGISTRY *(Abusos)*
Toll free number *(llame gratis)*
1 (800) 96ABUSE ** 1 (800) 962-2873
(24 hrs/day, 7 days/week -- 24 hrs/día, 7 días/semana)
Emergency/Emergencia: 911

REMEMBER/RECUERDE:

As a recipient of Federal financial assistance, our Agency does not exclude, deny benefits to or otherwise discriminate against any person on the grounds of race, color, national origin, disability or age in admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by our Agency directly or through a contractor or any other entity with which our Agency arranges to carry out its programs and activities.
This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations Part 80, 84, and 91. (Other Federal Laws and Regulations provide similar protection against discrimination on grounds of sex and creed.)
In case of question please contact the Agency Section 504 Coordinator, (Agency's information in the cover of the book).

Como recipiente de asistencia federal financiera, nuestra Agencia no excluye, deniega beneficios o descrimina contra cualquier persona basado en la raza, origen nacional, discapacidad o edad en admisiones, participación o recibo de servicios y beneficios en cualquiera de nuestros programas, actividades o empleo cuando es desarrollado por nuestra agencia directamente o a travez de contraltos con otra entidad en el cual nuestra Agencia dirige esos programas y actividades.
Esta declaración es de acuerdo con las provisiones del Título VI del Acta de Derechos Civiles de 1964, la Sección 504 del Acta de Rehabilitación de 1973, el Acta de Discriminación por Edad de 1975, y las Regulaciones del Departamento de Salud y Servicios Humanos respect al Afta del Título 45 del Codigo Federal de Regulaciones Parte 80, 84 y 91. (Otras leyes y Regulaciones Federales que proven similar protección en contra de la discriminación de acuerdo al sexo y credo.)
En caso de preguntas favor de contactaral coordinador de la Sección 504 de la Agencia, información en el cover del libro.

Med Pro Home Health Services

We wish that you continue in good health, but if you need our services again do not hesitate to contact us at:

12905 SW 42 St. Suite 109
Miami, FL 33175 (305) 303-4152

When working with patients, insurers, or physician, our Agency believes that the optimal home care requires the use and availability of a multi-disciplinary team of professional and competent Administrative staff.

Our Agency strives to maintain a qualified staff, willing to help meet the goals of each Patient's Plan of Care. Thus, in selecting our staff we look not only for professionalism and technical abilities, but also, we seek nurses who interact with kindness and compassion, and demonstrate a willingness to achieve the goals of each patient.

Our team of professional staff, including Licensed and Registered Nurses, Therapists and Social Workers have been thoroughly trained to meet the challenges of their field and are required to attend continuing educational classes to stay up-to-date with the latest changes, discoveries, and treatments in the medical field.

* * * * * * * * * * *

Deseamos que mantenga buena salud, pero si necesita nuestro servicios de nuevo, no dude en llamarnos en cualquier momento:

12905 SW 42 St. Suite 109
Miami, FL 33175 (305) 303-4152

Cuando trabajamos con pacientes, Aseguradoras, o Doctores, nuestra Agencia cree que el cuidado óptimo en el Hogar requiere del uso de un equipo de profesionales de múltiples disciplinas y profesionales administrativos.

Nuestra Agencia se esfuerza por mantener un personal calificado que estén dispuestos a lograr los objectivos del plan de tratamiento de cada paciente. Así que cuando escogemos nuestro personal no solo buscamos enfermeros que muestren bondad y compasión, sino además que estén dispuestos a alcanzar el programa de cuidados de cada paciente.

Nuestro equipo professional incluyendo Enfermeros Licenciados y Registrados, terapistas, trabajadores sociales, han sido completamente entrenados para vencer los metodos en sus campos de trabajos y se les requiere que se mantengan entrenados para estar al día en los últimos cambios, descubrimientos y tratamientos nuevos en el campo de la Medicina.