Premium Select Home Care, Inc. – Patient Information Verification Sheet
5513 Illinois Avenue, NW Washington, DC 20011 (O) 202-882-9310 (F) 202-882-9374

DOCUMENTATION CHECKLIST

Nursing/Therapy Staff. Please complete this checklist to ensure that the documentation that you are submitted is complete & accounted for. Please utilize the following checklist and *place your forms in an envelope to ensure the documents submitted remain together.*

I. PAPER FORMS THAT NEED TO BE SUBMITTED:	QTY SUBMITTED:	RECEIVED in OFFICE:
• **Patient Consent Form** *(for Start Of Care)*	□ QTY: _____	□ QTY: _____
• **HHA/PCA Plan of Care** ****Copy to be left in patient's home*	□ QTY: _____	□ QTY: _____
• **Medication Sheet (Paper Copy)** ****Copy to be left in patient's home*	□ QTY: _____	□ QTY: _____
• **Physician Add Orders** *(e.g., for wound care, SOC, ROC, RC, PCA hour changes, etc.)* ***to be entered into ALLEGHENY***	□ QTY: _____	□ QTY: _____
• **Patient Signature Page** *(verifying visit, for Visits digitally entered into Alleghany)*	□ QTY: _____	□ QTY: _____
• **Patient Information Verification Sheet** ****Please use to identify any changes to the physician's name &/or phone #, patient's address &/or phone #, etc., if applicable*	□ QTY: _____	□ QTY: _____
• **Patient Individualized Emergency Plan Form** ****Please complete this form at SOC and when any patient information/needs/instructions change*	□ QTY: _____	□ QTY: _____
• **Beneficiary Rights and Responsibilities** *(for Start Of Care)*	□ QTY: _____	□ QTY: _____
• **Signed Abuse/Neglect/Exploitation Form** *(for Start Of Care)*	□ QTY: _____	□ QTY: _____

II. MISCELLANEOUS FORMS:

- **Copy of Advance Directive, if applicable**
  Legal Guardian/Power of Attorney □ QTY: _____ □ QTY: _____

  ***Name of Patient & Date Received: _____/_____

- **Other:** _____ □ QTY: _____ □ QTY: _____

Submitted by: _____/_____ **Date:** _____
Printed Name & Signature of Clinician

Received by: _____/_____ **Date:** _____
Printed Name & Signature of PSHC Staff