Instructions:
Home Health Change of Care Notice (HHCCN)

Contents
When to Provide the HHCCN ........................................................................................................................ 2
When is HHCN NOT Required? ..................................................................................................................... 2
Sample HHCCN Form .................................................................................................................................... 3
Guidelines for Completing HHCCN Form ...................................................................................................... 4
Guidelines for Delivering HHCCN Form ........................................................................................................ 5
When to Provide the HHCCN

Reduction:
The HHCCN must be issued before care is decreased, such as frequency, amount, or level of care. The HHCCN must list the items/services that are listed on the POC that are being reduced and the reason for the reduction, regardless of who is responsible for paying for that service.

Note:
If a reduction occurs for an item or service that will no longer be provided but the beneficiary wants to continue to receive the care and assume the financial charges, an ABN must be issued to the beneficiary.

Termination:
The HHCCN must be issued before the discontinuation of all home health care. Reasons for ending home health care include:

- administrative decisions
- staff shortage
- closure of the home health agency
- failure to meet face-to-face encounter requirements
- due to physician’s orders to discontinue care
- lack of orders to continue care

Note:
When all Medicare covered services are ending based on the physician’s orders, the Notice of Medicare Provider Non-Coverage (NOMNC) must be issued to the beneficiary.

When the NOMNC is issued as required, the home health agency does not have to issue a separate HHCCN; however, when care ends because of physician’s orders, home health agencies have the option of issuing the NOMNC alone or the NOMNC and the HHCCN.

When is HHCN NOT Required?
The HHCCN is not required when changes in care involve:

- Increase in care;
- Changes in home health agency personnel;
- Changes in expected arrival or departure times;
- Change in the duration of services (reduction from an hour to 45 minutes);
- Lessening the number of items/services where a range of services is included in the POC (PT 3 – 5 x per week);
- Changes in the mix of services delivered in a specific discipline (skilled nurse discontinues blood draw, but continues other skilled services; same frequency/duration);
- Changes in the modality affecting supplies used as part of a specific treatment; or
- Changes in care decided by the beneficiary and documented in the medical record.
Sample HHCCN Form

<table>
<thead>
<tr>
<th>Home Health Agency:</th>
<th>Patient Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Patient Identification:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Items/services:</th>
<th>Reason for change:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Signature of the Patient or of the Authorized Representative*</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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.
## Guidelines for Completing HHCCN Form

| **Home Health Agency** | Full name of the home health agency  
*(may be pre printed on form)* |
|-----------------------|--------------------------------------------------------------------------------|
| **Address**           | Corresponding address of the home health agency  
*(may be pre printed on form)* |
| **Phone**             | Telephone number and, if necessary, a TTY number must be included  
*(may be pre printed on form)* |
| **Patient Name**      | Full name of the Medicare beneficiary. |
| **Patient identification** | This field is optional. Medical record number may be inserted.  
*Do not use the client’s Medicare number or Social Security number.* |
| **Date**              | Insert the date that the changes on the notice will begin. |
| **Items/services description** | Use language a lay person would understand. For example, on December 17, 2013 the frequency of your wound care will decrease to 3 times/wk. |
| **Reason for change** | A specific reason must be inserted in this section. For example, your doctor has changed your order for this care. |
| **First check box**   | The first check box is chosen when care will be reduced or stopped because of an order change or lack of an order to renew care. |
| **Second check box**  | The second check box is chosen when the home health agency decides to stop providing care for other reasons such as availability of staffing, failure to obtain a face-to-face encounter, or safety concerns. |
| **Additional Information** | This section is optional. It can be used to provide clarifying information to the client. |
| **Signature**         | The form must be signed by the beneficiary or their representative. If the representative signs the form it should be noted on the form.  
If the client refuses to sign the form it should be noted on the form. |
| **Date**              | The beneficiary or representative enters the date the form was signed. If they are physically unable to the home health agency staff may insert the date. |
Guidelines for Delivering HHCCN Form

When delivering HHCCNs, we are required to explain the entire notice and its content and answer all questions to the best of our ability. Make every effort to ensure beneficiaries understand the HHCCN prior to signing it. If common abbreviations are used, explain their meanings to the beneficiary. While in person delivery of the HHCCN is preferable, it is not required.

BAYADA keeps the original of the completed, signed and annotated HHCCN in the beneficiary’s record and the beneficiary receives a copy. Electronic retention of electronically issued or scanned HHCCNs is permitted.