



# Clinician NOA Process

## Notice of Acceptance In HCHB

# Notice of Acceptance

The NOA is a signature form used to acknowledge receipt of the Patient Admission Handbook and confirms the patients understanding and is in agreement with its contents.

The signature image in our electronic health record indicates the patient **accepts this notice as valid, enforceable and admissible for care.**

**Without a signed NOA you should not be treating the patient, this can put your license in danger.**

# General Guidelines

**You do not legally have permission to treat the patient until the form is signed**

- You must complete **the electronic version** of the NOA in the tablet
- The NOA must be reviewed and signed **prior** to providing any treatment to the patient and **not** at the end of the visit
- The NOA is a onetime submission that establishes the Home Health POC and covers continuous 30-day POCs until you discharge the patient
- Visit frequency, including HHA visits, must be entered into the form.
- Each discipline should have their own NOA signed by the patient
- **Without a signed NOA we should not be treating the patient**
- **Without a signed NOA we cannot bill for services**

# Electronic Forms In HCHB

Once a legal form is signed, it cannot be edited. **Do not** under any circumstances click into the “Electronic Forms” sections after you have obtained patient signature, just clicking on the “Electronic Forms” section will erase the patient signatures on all forms.

- If there are other forms in this section, those signatures will be erased as well
- The NOA/consent **cannot** be added to a visit after it has been **paused or incomplete** as it needs to be done in the home

# Instructions for the Completion of the NOA

1. Complete the electronic version of the NOA on the tablet
2. Also provide the patient with a paper copy of the NOA to be left in the home. Paper copy **must** be filled out completely and signed and dated by patient and clinician.
3. There will be a paper copy in the admission folder, but you should obtain extra copies from the office to have at all times in your car.
4. The goal is to have 100% completion electronically, but should you have any difficulties with the electronic version, complete the paper forms. Return one copy to the office and provide an additional copy to the patient.
5. Please make sure to check the UR coordination note, if needed, titled “Insurance Benefit Details “ to obtain patient co-pay and deductible information required to complete the form
6. It is always best practice to return any paper copies of the NOA **asap** to the office: same day or next day.
7. Please take a moment to search your work bags and folders for any signed NOA forms you may have and return them to the office

## When signing the NOA the patient is also signing for receipt and understanding of the following:

- **CONSENT FOR CARE AND SERVICES**
- **PATIENT RIGHTS AND RESPONSIBILITIES**
- **GREIVANCE AND COMPLAINT PROCEDURE**
- **ACKNOWLEDGEMENT OF PRIVACY NOTICE**
- **RECEIPT OF OASIS PRIVACY ACT STATEMENT**
- **ADVANCE DIRECTIVES**
- **ACKNOWLEDGEMENT OF ADDITIONAL POLICIES, ADMISSION AND PLAN OF CARE**
- **AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT**
- **GUARANTEE OF PAYMENT**
- **PAYMENT FOR SERVICES RENDERED**

## CONSENT FOR MEDICARE

I have provided the agency with information for the Medicare Secondary Payer Questionnaire. Only applies to Medicare patients

YES  No  N/A

Medicare will pay in full for home care services.

Medicaid will pay in full for home care services.

Medicaid will pay for the home care services with a co-payment from me of

\$ This information will be found in the UR –Insurance Benefit Details coordination note if needed \_\_\_\_\_  
\_\_\_\_\_

Private Medical Insurance, Managed Care Company, or the Third Party Payer will pay agency for the care services provided, with a co-payment or deductible from me estimated to be

\$ \_\_\_\_\_ Contact your insurer for Home Health Care Benefits, Copayments, and/or deductible.

Patient Name \_\_\_\_\_

## I. INITIAL FREQUENCY AND SERVICE

- I have been informed of the nature and frequency of visits I will receive, and I have participated in the planning of my care.

Service (mark "X" service and enter frequency and duration):

{X} Skilled Nursing frequency and duration

{ } Physical Therapy frequency and duration

{ } Occupational Therapy frequency and duration

{ } Speech Therapy frequency and duration

{ } Medical Social Worker frequency and duration

{X} Home Health Aide frequency and duration

{ } Dietician frequency and duration



{ } Other sources of payment:

\_\_\_\_\_

Contact your insurer for Home Health Care Benefits, Copayments, and/or deductibles

{ } Private Pay: I am responsible for the total amount of the bill. Charges are

\$ \_\_\_\_\_

—

Charges will be rounded up or down to the nearest 1/4 hour. (i.e. 10:01 AM-10:07 AM would be billed as 10: 00 AM. 10:08 Am to 10:14 AM would be billed as 10:15 AM).

Print Patient

Name \_\_\_\_\_

Medical Record

Number \_\_\_\_\_

Signature of

Patient \_\_\_\_\_

If pt is able to sign

Signature of

Representative \_\_\_\_\_

If pt is unable to sign their representative will sign here and print their name below

Print Name of

Representative \_\_\_\_\_

# ATTENTION

Once you complete the “Electronic Forms” Section and have the patient sign all forms that apply, **DO NOT** click back into the “Electronic Forms”. If you even **just click** on the Electronic Forms section **the signatures will be erased** because the system will think you have made a change.

- **When the Forms are complete you will get a green checkmark in the Electronic Forms section.**
- **If you go back into electronic forms after you have left the patient’s home, for any reason it will clear out the patients signature and will not generate the NOA, so do not go back in.**

**If you do not obtain the patients signature or the signature gets erase, then we would need to go back to the patients home the next day.**

If a copy of the NOA was left in the patients home, and was completely filled out, signed, and dated then we can use that as a compliant NOA.

- Bring the compliant NOA back to the office
- Make a copy to return to the patient on the next visit
- The compliant NOA should be delivered to the manager

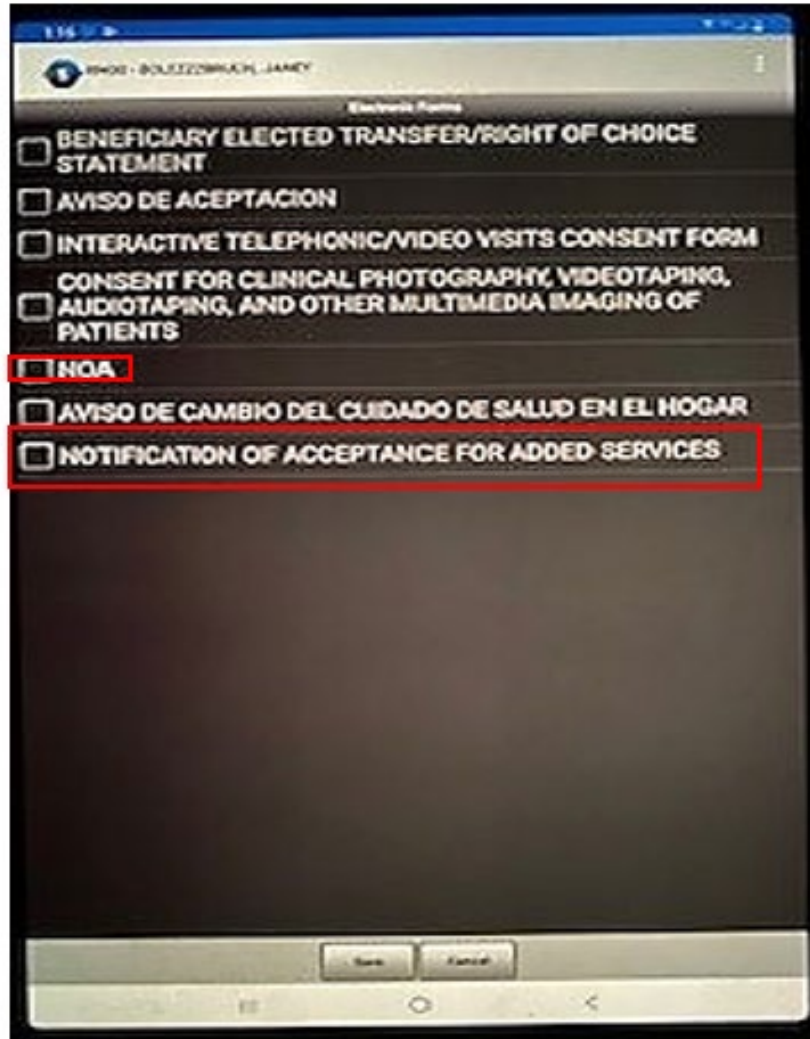
**If there is not a compliant NOA in the home; completely filled out, signed and dated, **then** a new paper NOA would need to be obtained within 24 hours.**

- Return to the patient's home,
  - Bring with you two new paper copies of the NOA. One will be returned to the office and one will be left with the patient
- The new NOA needs be completely filled out, signed and dated with the current date.
- Deliver back to the manager

- **Must be added at the start of the visit**



- Select the form to be completed



1:16

19400 - BOLLIZZORNAH, JAMEY

Electronic Forms

- BENEFICIARY ELECTED TRANSFER/RIGHT OF CHOICE STATEMENT
- AVISO DE ACEPTACION
- INTERACTIVE TELEPHONIC/VIDEO VISITS CONSENT FORM
- CONSENT FOR CLINICAL PHOTOGRAPHY, VIDEOTAPING, AUDIOTAPING, AND OTHER MULTIMEDIA IMAGING OF PATIENTS
- NOA**
- AVISO DE CAMBIO DEL CUIDADO DE SALUD EN EL HOGAR
- NOTIFICATION OF ACCEPTANCE FOR ADDED SERVICES

Back Cancel

- Scroll down to review the form, then select Next

1:17:31 PM  
JANICE - BOLLEZZERAKH, JANICE  
MOA

**NOTICE OF ACCEPTANCE**  
**MEDICARE CERTIFIED HOME HEALTH SERVICES**

**INSTRUCTIONS**

THIS FORM IS USED TO ACKNOWLEDGE RECEIPT OF THE PATIENT ADMISSION HANDBOOK AND CONFIRMS THE PATIENT'S UNDERSTANDING AND AGREEMENT WITH ITS CONTENTS. YOUR SIGNATURE IMAGE IN OUR ELECTRONIC HEALTH RECORD INDICATES YOUR ACCEPTANCE OF THIS NOTICE AS VALID, ENFORCEABLE AND ADMISSIBLE.

**SERVICE STATEMENTS**

**I CONSENT FOR CARE AND SERVICES**

- I AUTHORIZE THE AGENCY TO PROVIDE HOME HEALTH TREATMENT AS ORDERED BY MY PHYSICIAN.
- I UNDERSTAND THAT I HAVE THE RIGHT TO MAKE DECISIONS CONCERNING MY MEDICAL CARE, INCLUDING THE RIGHT TO ACCEPT OR REFUSE MEDICAL OR SURGICAL TREATMENT.
- I UNDERSTAND THAT I AND/OR MY FAMILY/CAREGIVER WILL RECEIVE INSTRUCTIONS TO ASSIST WITH MY CARE AND THAT I AM RESPONSIBLE FOR MY CARE IN THE ABSENCE OF AGENCY CERTIFIED HOME HEALTH CARE STAFF IN MY PLACE OF RESIDENCE.

**II. PATIENT RIGHTS AND RESPONSIBILITIES**

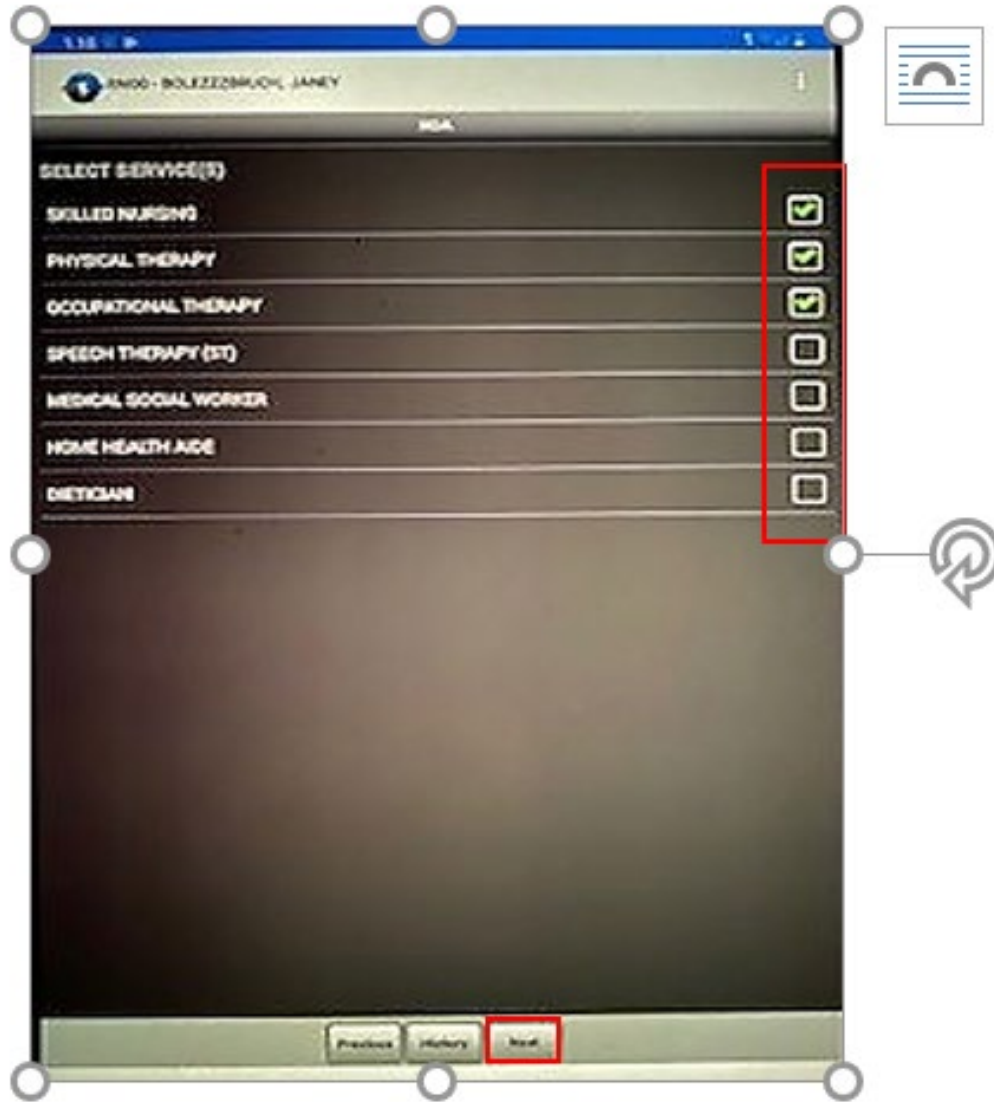
- I HAVE RECEIVED THE STATEMENT OF RIGHTS AND RESPONSIBILITIES AND IT HAS BEEN EXPLAINED TO ME.
- I HAVE RECEIVED THE MASSACHUSETTS HOME HEALTH HOTLINE PHONE NUMBER AND THIS RESOURCE HAS BEEN EXPLAINED TO ME.
- I HAVE RECEIVED INFORMATION ABOUT MEDICARE'S REQUIREMENT FOR A FACE-TO-FACE ENCOUNTER WITH PHYSICIANS OR CERTAIN NON-PHYSICIAN PRACTITIONER WITHIN 90 DAYS PRIOR TO OR 30 DAYS FROM MY START OF HOME HEALTH CARE FOR MATTERS RELATED TO MY NEED FOR HOME HEALTH SERVICES.
- I UNDERSTAND THAT IF, FOR ANY REASON, I DO NOT HAVE A MEDICARE QUALIFYING ENCOUNTER WITHIN THIS TIME FRAME THAT I AM NOT ELIGIBLE FOR MEDICARE PAYMENT OF MY HOME HEALTH SERVICES.
- I UNDERSTAND THAT MY HOME HEALTH SERVICES MAY BE DISCONTINUED IF THE REQUIRED PHYSICIAN ENCOUNTER DOES NOT OCCUR WITHIN THE TIME PERIOD SET BY MEDICARE.

**III. GRIEVANCE AND COMPLAINT PROCEDURE**

- I HAVE RECEIVED INFORMATION ABOUT THE AGENCY'S GRIEVANCE AND

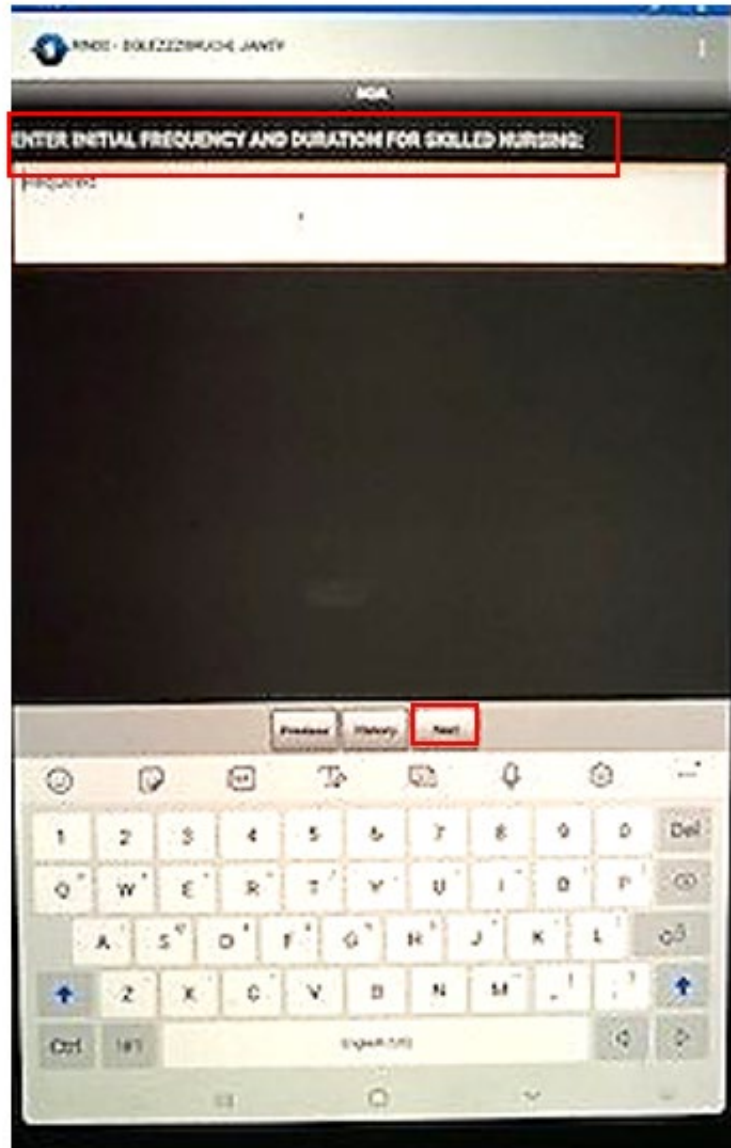
Previous Next **Next**

- **Select applicable Services and Next**





- Enter Frequency for each service and select Next



- Select applicable answers and select Next

1:19 PM  
JANVY - BOLZETTA, JANVY  
NDA

CONSENT FOR MEDICARE/INSURANCE  
I HAVE PROVIDED THE AGENCY WITH INFORMATION FOR THE MEDICARE  
SECONDARY PAYER QUESTIONNAIRE

YES

NO

NA-NOT APPLICABLE

MEDICARE WILL PAY IN FULL FOR HOME CARE SERVICES

MEDICAID WILL PAY IN FULL FOR HOME CARE SERVICES

MEDICAID WILL PAY FOR THE HOME CARE SERVICES WITH A CO-PAYMENT FROM ME OR

PRIVATE MEDICAL INSURANCE, MEDICAID CARE COMPANY OR THE THIRD PARTY   
PAYER WILL PAY AGENCY FOR THE CARE SERVICES PROVIDED WITH A CO-PAYMENT OR  
DEDUCTIBLE FROM ME ESTIMATED TO BE

PRIVATE PAY: I AM RESPONSIBLE FOR THE TOTAL AMOUNT OF THE BILL. CHARGES ARE

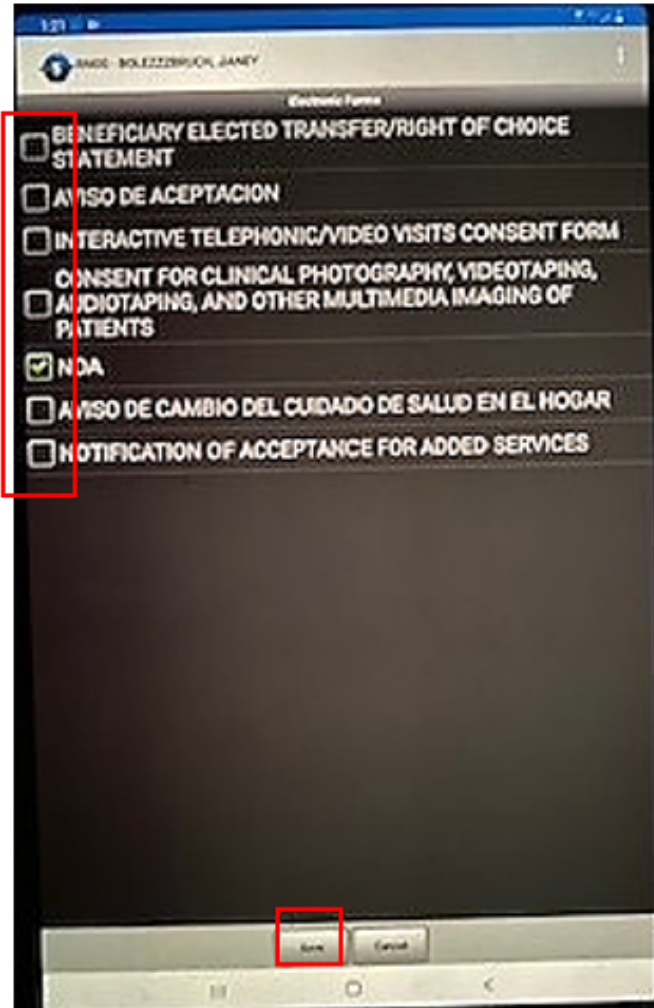
Previous Next **Next**

The image shows a mobile application interface for a Medicare/Insurance consent form. The form is titled "CONSENT FOR MEDICARE/INSURANCE" and "I HAVE PROVIDED THE AGENCY WITH INFORMATION FOR THE MEDICARE SECONDARY PAYER QUESTIONNAIRE". It lists several options for payment, each with a corresponding checkbox. A red box highlights the checkboxes for "YES", "NO", "NA-NOT APPLICABLE", "MEDICARE WILL PAY IN FULL FOR HOME CARE SERVICES", "MEDICAID WILL PAY IN FULL FOR HOME CARE SERVICES", "MEDICAID WILL PAY FOR THE HOME CARE SERVICES WITH A CO-PAYMENT FROM ME OR", "PRIVATE MEDICAL INSURANCE, MEDICAID CARE COMPANY OR THE THIRD PARTY PAYER WILL PAY AGENCY FOR THE CARE SERVICES PROVIDED WITH A CO-PAYMENT OR DEDUCTIBLE FROM ME ESTIMATED TO BE", and "PRIVATE PAY: I AM RESPONSIBLE FOR THE TOTAL AMOUNT OF THE BILL. CHARGES ARE". At the bottom of the screen, there are three buttons: "Previous", "Next", and "Next". The "Next" button is highlighted with a red box.

- After reviewing with patient, select Next through the series of statements



- After completing the form, you will be taken back to the list of forms. You can review the form here, select additional forms to complete, or select **Save** if you are done.
- You can select any section of the form to edit when reviewing the form, prior to obtaining the patient's signature.



- **Select the appropriate Signature Type and Save. The signature page will populate.**



- If No Signature is selected, you will be prompted to select a reason and then Save



**After saving, exit out of forms and DO NOT GO  
BACK INTO FORMS.**

**If you click on the forms field, you will ERASE  
THE PATIENT'S SIGNATURE!**