**A**

*A “face-to-face encounter” (medical visit) is required for traditional Medicare patients within the 90 days prior to, or the 30 days following the start of home care services. Please complete this form based on your most recent patient visit that relates to the patient’s current need for home care.*

**PATIENT NAME:**   **D.O.B: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_**

**FACE to FACE ENCOUNTER:** I certify this patient is under my care and I, or a valid non-physician practitioner (NP/ PA) working with me, had a face-to face encounter on: \_\_\_\_\_\_ / \_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mon Day Year

**PRIMARY DIAGNOSIS & REASON FOR HOME HEALTHCARE:** The encounter with the patient was in whole, or in part, for the primary reason for home health care. *List medical condition(s):*

**MEDICALLY NECESSARY SERVICES:** I certify that, based on my findings, the following services are medically necessary home health services (Mark all that apply):

[ ] **Nursing**  [ ] **Physical Therapy** [ ] **Speech Therapy**

**Additional Services Needed: [ ] Occupational Therapy [ ] Social Work [ ] Aide**

**CLINICAL FINDINGS TO SUPPORT THE NEED FOR SERVICES**:

**EVIDENCE THAT PATIENT IS HOMEBOUND:** I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons) because:

**Physician\* Signature:**   **DATE**

**Physician Printed Name:**

**[ ] I WILL sign the medical orders/ plan of care for home care.**

**[ ] I will NOT sign the medical orders/ plan of care for home care. Physician for ongoing care and certification and signature of home care plan of care is:**

# Examples for Form Completion

Examples of Medical Conditions – List as many as apply:

● Heart failure, pneumonia, COPD, Diabetes (new or exacerbation)

● Stroke (after-effects)/ Hypertension

● MS/ALS

● UTI/pneumonia/URI (or any condition requiring a medication change)

● Osteoarthritis/DJD

● Wound (specify new/ intected/deteriorating/pressure/diabetic/surgical)

● Cellulitis/Osteomyelitis/fracture (specify site)

Examples of Clinical Findings to support home health care – List as many as apply:

● Abnormal/fluctuating vital signs/lung sounds

● Edema/ weight changes/dyspnea/dehydration/incontinence

● Declinie in physical system/functional decline

● Abnormal labs/blood sugars/INR

●Medication issues – new/changed/adverse effects, needs RN for injections/teaching

●Catheter (straight cath/foley)

● Multiple hospitalizations related to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

● Knowledge deficit related to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

● Debility/deconditioning

● Joint replacement

● Dysphagia/colostomy/ileostomy

● Pain related to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

● Falls due to ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examples of Homebound criteria (indicates a great or taxing effort to leave home) – List as many as apply:

● Requires the use of an assistive device (cane/walkter/wheelchair/crutches)

● Requires special transportation/assistance to leave home

● Decline in mobility or is non-ambulatory

● Poor balance/unsteady

● Hemiplegia/hemiparesis/paralysis

● Neurological issues (neuropathy/ALS)

● Respiratory impairment/dyspnea

● Cardiac insufficiency/diminished ejection fraction

● Mentally impaired –unsafe alone/unaccompanied

● Medically contraindicated –high infection risk/immunosuppressed

● Pt is receiving chemotherapy and is immunosuppressed. Pt is at risk for infection if exposed to sick contacts at health clinics/hospitals/in the community

(Do not return this page when faxing Face to Face Form to agency)