Face to Face Certification Statement

Patient Name: _____ **Date of Birth** _____

For Medicare / Medicaid Patients:

I certify that this patient is confined to his/her home (and meets homebound criteria-Medicare only) and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy.

The patient is under my care, and a plan of care has been initiated and will periodically be reviewed by a physician.

I (or an acute/post acute physician or collaborating NP / PA) had a Face-to-Face encounter with this patient on the following date _____, during which the primary reason for home health services was addressed.

_____ I am the certifying physician and will follow the patient in the community

_____ I am a certifying physician, but Dr. _____ ❑ MD ❑ DO ❑ DPM
will follow the patient in the community.

Certifying Physician Signature / Credentials:

X _____ ❑ MD ❑ DO ❑ DPM

Date: _____

Physician Printed Name: _____
(First and Last)

Physician Progress Note for Face to Face Encounter and Certification of Eligibility for Home Health Services

Patient Name: _____ **Date of F2F Encounter:** _____ **DOB:**_____

Information for Physician / NP / PA Conducting the Visit:

First and Last name (please print): _____

Credentials: ❑ MD / DO / DPM ❑ NP / PA ❑ Other: _____

Diagnosis for which face to face encounter was conducted and home health care services were ordered:

_____

Patient Encounter Findings:
(Subjective Information / Patient Complaints)

_____

_____

_____

Objective Information: (physical exam findings, test results, progress / lack of progress, functional losses)

_____

_____

_____

BP: **TEMP:** **RR:** **PR:** **HT:** **WT:**

Homebound Status:

Prior to this encounter, the patient was: ❑ Unable to safely leave home independently because of a medical condition
❑ Was able to leave home with minimal effort but there has been a change

The patient is now confined to the home because of the following medical conditions:

- ❑ Arthritis and weakness limits endurance and increases the risks for falls outside the home environment
- ❑ Unstable gait and muscle weakness due to _____
- ❑ Pain with activity which limits _____
- ❑ Shortness of breath develops after ambulating short distances and requires frequent rest periods
- ❑ Cognitive deficits which impairs orientation, judgment, or decision making
- ❑ Develops chest pain with exertion related to _____
- ❑ Recent surgery has activity restrictions _____
- ❑ It is medically contraindicated for the patient to leave home because _____
- ❑ Patient is bed bound because _____
- ❑ Other _____

Because of the conditions cited above, one or more of the following types of assistance to leave home is normally required:

- ❑ Assistance of another person is required for the patient to safely leave the home
- ❑ Supportive Devices are required to safely leave the home: ❑ Cane ❑ Walker ❑ Wheelchair ❑ Crutches
- ❑ Special Transportation is required to leave the home: ❑ Transport Van ❑ Ambulance

Patient Name: _____ **Date of F2F Encounter:** _____

Plan:

This patient requires skilled nursing to:	Teach the patient/caregiver to: _____ _____ ❑ Administer the following: ❑ IV ❑ IM ❑ SQ medication(s) that the patient/caregiver cannot safely administer: _____ _____ ❑ Provide skilled assessment and teaching of oral medications because: ❑ Regimen is highly complex ❑ Patient is confused ❑ Patient has new medications ordered ❑ Patient is experiencing side effects ❑ Non-adherence to medication regimen is suspected ❑ Other (explain): _____ _____ ❑ Administer infusion therapy that the patient/caregiver cannot safely administer ❑ Perform skilled: ❑ Wound Care ❑ Catheter Care ❑ Ostomy Care that the patient /caregiver cannot administer or there is no caregiver available to render the care ❑ Instruct on Disease Management: _____ ❑ Assess and provide instruction on pain management ❑ Other (explain): _____
This patient requires: ❑ Physical Therapy ❑ Occupational Therapy ❑ Speech Language Pathology	❑ To assess and provide instruction on improving functional mobility at home ❑ To assess and provide gait training, strengthening, and/or balance exercises to restore the patient's ability to ambulate or transfer safely ❑ To teach patient and caregivers on non-pharmacologic pain reduction techniques and strategies ❑ To increase strength and endurance and restore range of motion post-surgery Surgical procedure: _____ ❑ To evaluate the need for assistive/adaptive devices or environmental modifications needed to address functional deficits and improve safely in performing ADLs ❑ To provide and instruct on home exercise program ❑ To assess and provide instruction on managing dysphagia safely ❑ To assess and provide instruction on managing aphasia and other language disorders ❑ Other (describe): _____ _____
This patient requires: ❑ MSW ❑ HHA	Describe why the patient needs these additional services: _____ _____

Signature of Physician, Podiatrist, Nurse Practitioner, or Physician Assistant Completing the Encounter Documentation:

X _____

(Include Hand Written Date)