

Patient's Name:
Date of Birth:
Start of Homecare:

Fax: 860-358-5623

Face to Face Encounter Form

For this attestation to be valid, questions 1, 2, 3, and 4 must be completed.

1. **Date of face to face encounter** (must be within 90 days before and 30 days after start of homecare)

Month

Day

Year

2. **Reason for face to face encounter: patient diagnosis, or presenting clinical problem** (must be related to the reason for homecare services).

3. Eligibility for Medicare home health benefit related to the patient's need for skilled home health services: (Possible skilled home health services might be medication management, new diagnosis, new treatment plan, multiple hospital admissions, wound care, pain control/symptom management, declining physical status, decline in ability to perform ADLs, language skills, cognitive deficit, requires home medical procedure.)

The following clinical findings support the need for skilled services because: _____

4. Eligibility for Medicare home health benefit related to patient being homebound does **NOT** require the patient to be bedridden, but that the patient cannot leave home without considerable and taxing effort. (describe the patients physical and or mental limitations that render the patient home bound)

I certify that this patient is homebound because: _____

Certification for Home Health Services

Based on the above findings, I certify that this patient is confined to the home 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 I have initiated the establishment of the plan of care. This patient will be followed by a physician who will periodically review the plan of care.

Physician's signature: _____ **Date:** _____

Physician's name printed: _____

CMS requires that the **physician sign and date** this attestation. CMS does **NOT** accept signature, date stamps or signatures/co signatures by PA's or APRN's.