HOME CARE INC.

ATTESTATION OF FACE-TO-FACE ENCOUNTER

Patient Name: **Date of Birth**:

DR.

Patient Encounter on: _____/_____/_____ to Qualify Patient for Home Care Service
Month Day Year

Face-to-Face Contact
As certified below, I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter (within 90 days before, or 30 days after the start of home care) that meets the physician's face-to-face encounter requirements.

Medical Condition and Need for Skilled Services
This encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care (list medical condition):_____

Due to the medical condition listed above, patient requires skilled nursing and/or rehabilitation services for **(check all that apply)**

- ☐ Observation and assessment
- ☐ Teaching and training
- ☐ Rehab services
- ☐ Medication teaching and assessment
- ☐ Catheter insertion
- ☐ Ostomy care and management
- ☐ Central venous access care
- ☐ Wound care and assessment
- ☐ Other (please specify):_____

Based on the above findings, the following intermittent home health skilled services are medically necessary **(check all that apply)**

☐ Nursing ☐ Physical Therapy ☐ Speech Language Pathology

Homebound Status
Medicare considers the patient homebound if the patient needs assistance to leave the residence or if leaving the residence is medically contraindicated. Indicate below the patient's criteria for meeting of homebound status:

Complete both sections below.

(1)There must exist a normal inability to leave the home.
Patient is routinely unable or severely impaired from leaving home (except for medical appointments or rare milestones or exceptions such as religious services) due to either physical or mental/behavioral condition (Specify): _____
_____
_____

(2)Leaving home requires a considerable and taxing effort and/or supervision due to deteriorating mental and/or physical status

- ☐ Dementia ***(Circle all that apply)***
  Disorientation Wanders Cognitive dysfunction
- ☐ Mental Illness ***(Specify):*** _____
- ☐ Stroke/TBI (neurological/cognitive impairment)
- ☐ Ataxic Gait
- ☐ Bed Bound
- ☐ Other: _____

Poor endurance:

- ☐ Pain > 7/10 on ambulation
- ☐ Chest Pain/Weakness within ambulation > 20 feet
- ☐ Shortness of breath with minimal ambulation
- ☐ Other: _____

Other ***(Specify):*** _____

Complete either **A *or* B** below.

A. Patient Needs Assistance to Leave Residence
Because of the illness or injury, the patient needs supportive equipment, special transportation or assistance of another person to leave home ***(Check all that apply)***

- ☐ Requires assistance of another person to leave home due to (Specify Injury or Illness):
- ☐ Requires an assistive device to leave home (***Circle one***)
  Cane Crutches Wheelchair Walker
  Due to (Specify illness or injury): _____
  _____
- ☐ Requires special transportation (Specify):
- ☐ Modified Vehicle
- ☐ Ambulance
  - ☐ Stretcher Transport
- ☐ Other: _____

B. Leaving Home is Contraindicated
The patient has a condition which confines the patient to the home or such that leaving his/her home is medically contraindicated ***(Check all that apply)***

- ☐ Immunosuppression
- ☐ Infection
- ☐ Activity restrictions due to illness/surgery
- ☐ Wound- risk of deterioration/infection
- ☐ Post-op weakness/fatigue ambulation > 20 feet
- ☐ Other_____

I certify the above face to face encounter was performed, the patient is confined to home and requires intermittent Skilled Nursing, Physical Therapy and/or Speech Therapy and the patient's needs and eligibility for homecare was communicated to the community physician or I am the community physician establishing and periodically reviewing the Plan of Treatment. Face-to-Face documentation is retained in the patient's medical records.

☐ Patient referred to a community-based physician

Print Physician Name _____

Physician Signature _____ **Date:** _____