Face-to-Face Encounter Facility Form

Patient Name:_____DOB:_____

1. I certify that this patient is under my care and that I, or an allowed non-physician providers or a resident working with me, had a face-to-face encounter with this patient on: _____
(Month, day, year)

2. The encounter with the patient was in whole, or in part, for the following medical conditions/ diagnoses which are the primary reason for home health care *(list conditions/diagnoses)*:_____

_____

_____

3. I certify that, based on my findings, the following services listed here are medically necessary home health services (*Check all that apply):*

☐ Nursing	☐ Occupational therapy
☐ Physical therapy	☐ Medical Social Worker
☐ Speech language pathology	☐ Home Health Aide

4. Based on the clinical findings of this encounter, the patient has a need for skilled services because: *(describe the services ordered for each discipline):*_____

_____

_____

_____

5. Based on the clinical findings of this encounter, the patient is homebound because the following assistance is required to leave home *(Check all that apply)*:

☐ Supportive device: *(Describe)*_____

☐ Assistance of another person because:_____

☐ Special transportation: (*Describe)*_____

OR ☐ Leaving home is medically contraindicated because:_____

_____

AND there exists a normal inability to leave home because (specific reason):_____

_____

_____

AND it would be a considerable and taxing effort to leave home because *(specific reason)*:

_____

_____

I certify that the above stated patient is homebound and that upon completion of this face-to-face encounter has a need for intermittent skilled nursing, physical therapy and/or speech therapy or occupational therapy for their current diagnoses as outlined in their initial plan of care. These services will continue to be monitored by myself or another physician who will periodically review and update the plan of care as required.

Physician Printed Name_____

Physician Signature _____Date_____