Family Home Care

Face-to-Face Encounter

Patient's Name: _____

Date of Birth: _____

Fax Back to 260.589.2085

Please provide any supporting documentation such as hospital discharge summary, labs, last office visit note, and medication profile. This may alleviate us having to contact you for additional information.

Encounter Date	I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, or a physician who cared for the patient in an acute or post-acute facility, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: ***(Insert date the face-to-face visit occurred)*** ____/____/_____
Need for Skilled Services	**Diagnosis/Medical Condition:** List the diagnosis/medical conditions that are the primary reason the patient requires home health care. _____ **Clinical Findings:** Signs and symptoms of medical condition exhibited by the patient during the encounter which support the need for all services being provided below. ***(please attach progress note)*** _____ _____ _____ **Skilled Services/Interventions:** Describe the services the nurse or therapist will perform in the home, ***e.g. assess, teach, medication management, wound care, gait training and activities of daily living.*** □ Skilled Nursing ***for***: _____ □ Physical Therapy ***for***: _____ □ Speech Therapy ***for***: _____ □ Occupational Therapy ***for***: _____
Homebound Status	**I certify that the clinical findings support that this patient is homebound due to:** **Describe** in narrative form clinical and/or physical findings and the functional limitations that prevent the patient from receiving care outside of the home. (**Check mark and describe all that apply**) □ Supportive Devices: e.g. *Because of illness or injury the patient needs supportive devices such as canes, walkers, and wheelchairs; use of special transportation; or assistance of another person in order to leave their place of residence.* _____ _____ _____ □ Inability to Leave Home/Requires Considerable Taxing Effort: e.g. *Requires considerable effort and taxes the patient which places patient at risk for injury due to fall risk; risk for re-hospitalization* _____ _____ _____
Physician's Signature	Physician's Signature: _____ Date: _____ Physician's Printed Name:_____