



1110 Kingwood Drive Suite 200JK Kingwood, TX 77339

Face-to-Face Encounter Certification

Fax completed form to 281-358-2680

Patient Information	Patient Name: _____ DOB: _____ Episode Start Date: _____
Face to Face Encounter Addendum	1. Face to Face Encounter Date: (within 90 days before or 30 days after admission) _____ mm/dd/yyyy
	2. This encounter with the patient was necessitated by the following medical condition(s), which is the primary reason for home health care: _____ _____ <p>Based on the above findings, the following are medically-necessary home health services (Check All That Apply):</p> <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy
Face to Face Encounter Addendum	3. Home Bound (complete part 1 & 2) <p style="text-align: center;">1. <u>Illness or Injury</u></p> <p><i>Patient IS homebound because an illness or injury renders him/ her :</i></p> <input type="checkbox"/> Patient requires another individual and leaving the home requires a considerable and taxing effort. Patient needs the assistance of another individual to leave the home because: <input type="checkbox"/> High fall risk due to gait instability and muscle weakness caused by _____ <input type="checkbox"/> Cognitive deficits impact judgement, impair ability to safely navigate and prevent decision making for safety <input type="checkbox"/> Shortness of breath/distress after ambulating more than 10 feet results in high fall risk. <input type="checkbox"/> Unable to leave home without aid of a supportive device (i.e. cane, walker, wheelchair) and leaving the home requires a taxing effort. <input type="checkbox"/> Medical condition of _____ results in instability, weakness, and/or pain with ambulation. <input type="checkbox"/> Recent lower extremity joint replacement results in instability, weakness, and/or pain with ambulation. <input type="checkbox"/> Patient is bedbound due to: _____
	<p style="text-align: center;">2. <u>Inability to Leave Home</u></p> <p><i>This patient IS homebound because an illness or injury renders him/ her normally unable to leave home as it is medically Contraindicated and leaving the home requires a considerable and taxing effort. It is medically contraindicated for this patient to leave home because:</i> _____</p>

By signing below, I certify that the patient meets criteria 1814(a) and 1835(a) for confined to the home, 1814(a)(2)(C) and Section 1835 (a)(2)(A) of the Action patient has skilled need , Is under care of qualifying physician per 1814 (a)(2)(C) and section and 42 CFR 424.22(a)(1)(iii), and 42 CFR 424.22(a)(1), and 42 CFR 424.22(a)(1)(v)(A). I certify that the patient is under my care and that I or a Nurse Practitioner/PA working with me, had a face to face visit encounter that meets CMS required elements for home health care services.

Physician:

Fax:

Physician Signature _____

Date: ____/____/____