(631) 261-7200

CERTIFICATION OF FACE TO FACE ENCOUNTER FOR HOME CARE SERVICES

➔ Patient Name: ______________________________________ DOB: ____________

I CERTIFY THAT A FACE-TO-FACE ENCOUNTER WAS PERFORMED ON THE ABOVE NAME PATIENT.

➔ Encounter Date: ____/____/_______ By: ________________________

Who is a (check one) ☐Medicare Enrolled (or Medicare Opted-Out) Physician OR a
☐Non-Physician Practitioner

Patient will be followed in the community by: Dr.____

➔ This encounter with the patient was necessitated by the following diagnosis and symptom(s), which is the **PRIMARY REASON FOR HOME HEALTH CARE SERVICES**:

____

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The following clinical findings support that the **PATIENT IS ESSENTIALLY HOMEBOUND** *(homebound means that there exists a normal inability to leave home and consequently, leaving home requires considerable and taxing effort)* **AND** that the **PATIENT NEEDS INTERMITTENT SKILLED NURSING AND/OR PHYSICAL/ OCCUPATIONAL/SPEECH THERAPY:**

____

____

____

➔ **Homebound because:**

____

____

____

➔ ☐ **Skilled Nursing Care for** ____

____

____

☐ **Physical/Speech/Occupational Therapy for:** ________________________________

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➔ I certify that the above stated patient is homebound and that upon completion of the FTF encounter, has a need for intermittent skilled nursing, physical therapy and/or speech or occupational therapy services in their home for their current diagnosis as outlined in their initial plan of care. These services will continue to be monitored by myself or another physician.

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PHYSICIAN SIGNATURE PRINT NAME DATE