“FACE-TO-FACE ENCOUNTER” DOCUMENTATION

Pt Name:_____

DOB:_____

P#_____

***DATE OF “FACE TO FACE ENCOUNTER”*: __ __ / __ __ / __ __ __ __**

90 days prior to or 30 days following start of care for homecare.

Please attach Visit Note to Face to Face Encounter Documentation

THE FOLLOWING SERVICES ARE MEDICALLY NECESSARY FOR HOME HEALTH CARE:

☐ **Skilled Nursing** ☐ **Medical Social Work** ☐ **Nutrition** ☐ **Home Health Aides**

☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **Speech Therapy** ☐ **Certified Wound Specialist**

SKILLED CARE NEEDS

☐The patient requires skilled nursing to:_____

☐Teach/ train the patient or family to:_____

☐Observe/assess the following condition (describe why there is a reasonable potential for future complication or acute episode. Observation and assessment are **not** reasonable and necessary where fluctuating signs and symptoms are part of a long standing pattern of the patient’s condition):_____

☐Perform skilled wound care, catheter, and ostomy care that the patient , family, caregiver cannot safely administer

☐Administer tube feedings that the patient, family, caregiver cannot safely administer

☐Administer infusion therapy that the patient, family, or caregiver cannot safely administer

☐Instruct in NG and Tracheostomy aspiration care that the patient, family, caregiver cannot safely administer

☐Other:_____

☐Physical Therapy is required to restore patient function

☐Occupational Therapy is required to restore patient function

☐Speech therapy is required to restore patient function

☐The patient requires medical social work to assist in social emotional assessment and community resources

☐Home Health Aide required for personal care

HOMEBOUND STATUS

☐ Patient unable to leave home w/out assist and ambulation severely limited d/to pain, decreased strength and endurance

☐Patient is unable to leave the home unassisted and experiences SOB and fatigue severely limiting ambulation distance

☐Patient is unable to leave home w/out assist due to unsteady gait, impaired transfers and inability to negotiate stairs unassisted

☐Patient needs assistance to ambulate, is minimally weight bearing and walking is restricted

☐Patient has a deteriorating mental status and is unable to leave the home unsupervised

☐Patient's cognitive impairment makes leaving the home unassisted unsafe

☐Patient is at risk for seizures and requires assist of another to ambulate

☐Leaving Home is medically contraindicated due to severe cognitive impairment or impaired mental status or high risk of infection

I am ordering and certify that based on my clinical findings, skilled home health services are medically necessary and that this patient meets the homebound criteria.

Physician Signature _____ Date of Signature_____/_____/_____

Physician Printed Name _____

Physician Co-Signature (if applicable):_____

The information requested on this form is mandated by the Affordable Care Act, effective April 1, 2011. Home Care services cannot be provided and billed to Medicare for this patient without completion of this document.

VNS Home Health Services
Phone: (401)788-2345
Fax: (401)788-2063