**Documentation of Face-to-Face Encounter**

1. **Patient Name and Date of Birth:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Certification and Date of Face-to-Face Encounter**

I certify that this patient is under my care and that I, or a nurse practitioner, clinical nurse specialist or physician’s assistant working with me, had a face-to-face encounter with this patient on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Date of Encounter*)

1. **Medical Condition Related to Home Health Services**

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Certification of Medical Necessity**

I certify that based on my clinical findings the following services are medically necessary home health services (*check all that apply):*

🞏Nursing Services 🞏Therapy Services 🞏C.N.A Services 🞏 MSW 🞏Telehealth

1. **Certification of Homebound Status**

My clinical findings from this encounter support the patient is homebound due to:

🞏Leaving home requires a considerable and taxing effort

🞏Absences from home are infrequent, of short duration or to receive healthcare treatment

🞏Medically restricted due to immunosuppression, infectious illness, risk of infection or injury, or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Physician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_