1. Patient Name: ____ **2. Date of Birth:** ____________

3. 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)

4. Primary Diagnosis: ____

5. 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** ☐ **PT** ☐ **OT** ☐ **ST** ☐ **Home Health Aide** ☐ **MSW**

6. Certification of Homebound Status
My clinical findings from this encounter support the patient is homebound due to:

{Must meet one of two criteria to qualify for home care}

☐ Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.

and / or

☐ Has a condition such that leaving his or her home is medically contraindicated.

{Must meet this criteria to qualify for home care}

☐ A normal inability to leave home must exist **and** leaving home must require a considerable and taxing effort.

Physician Signature: ____

Printed Name: __________________________________ Date of Signature: ____________________

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