Around the Clock Home Care
"Always Time To Care"

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FACE-TO-FACE ENCOUNTER FOR HOME

Patient Name: ____ Patient D.O.B. : __/__/___

QUALIFYING ENCOUNTER TYPE (check applicable type)

☐ 1. Hospitalist provider conducted the face-to-face encounter and certification.
Date conducted __/__/___ Provider's name:_________________________________
Copy of face-to-face/certification documentation requested /obtained: Yes No

☐ 2. Face-to-face encounter conducted within 90 days of home care SOC.
Date conducted __/__/___ Provider's name:_________________________________
Copy of face-to-face/certification documentation requested /obtained: Yes No

☐ 3. Face-to-face encounter will be conducted within 30 days of the SOC.
SOC date: __/__/___ Date of 30th day__/__/___
Date of scheduled visit: __/__/___
Was physician's office contacted to verify appointment and purpose of appointment? Yes No If YES date contacted: __/__/__ If NO explain:_______________
____.

Additional Information:____
____.

To be filled out by physician conducting the initial certification/face-to-face encounter.

PHYSICIAN ATTESTATION

Home Health Certifying Physician (print name):_______________________________________

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements on: Date: __/__/___

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 (list medical condition):_________________________________
____
____
____.

My clinical findings support the need for the services listed because:____________________________
____
____.

I certify that my clinical findings support that this patient is homebound* because:________________
____
____.

(*i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons.)

I certify that the following home care services are medically necessary: (circle all that apply)

Nursing Therapy

PHYSICIAN, PLEASE SIGN AND RETURN WITHIN 2 DAYS

Physician's Signature:____ Date of Signature__/__/____