

CARE IN TOUCH HOME HEALTH AGENCY INC.
Addendum to Medicare Home Health Certification
Home Health Care Face to Face Encounter

Patient Name _____ Date of Birth _____
Home Health Start Date (SOC) _____

Encounter Date and Reason for Encounter

I certify that I, or a qualified non-physician practitioner working with me, had a face-to-face encounter with this patient on the date indicated below due to the medical condition also listed below, which relates to the primary reason the patient requires home health services.

Encounter Date _____

Description of Patient's Clinical Condition:

Need for Home Health Care

The following services are medically necessary home health care services:

_____ Skilled Nursing	_____ Medical Social Worker
_____ Physical Therapy	_____ Home Health Aide
_____ Speech Therapy	
_____ Occupational Therapy	

I certify that based on my findings:

- a. Home health services are medically necessary for this patient, including either intermittent skilled nursing and/or therapy, *and*
- b. This patient is homebound in that absences from home require considerable and taxing effort, are infrequent or of short duration, or are attributable to the need to receive health care.

My clinical findings support the need for these services because:

I certify that I, as the certifying physician, composed the above information based on my clinical judgment relating to this patient's medical condition.

Certifying physician signature _____ Date _____