

**PATIENT AND INSURANCE INFORMATION**
**PATIENT INFORMATION**

 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male Female  
 Patient Address \_\_\_\_\_  
 Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Primary Phone \_\_\_\_\_  
 Other Phone \_\_\_\_\_  
 Language Spoken \_\_\_\_\_  
 Emergency Contact/Relationship \_\_\_\_\_  
 Contact Primary Phone \_\_\_\_\_  
 Was the patient discharged in the past 14 days? Yes No  
 If so, facility name \_\_\_\_\_  
**DATE OF DISCHARGE** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Was this stay Inpatient? Yes No? ED Visit Yes No?  
 Observation Stay Yes No?

**REFERRAL SOURCE** Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_

**PATIENT INSURANCE INFORMATION**

 Medicare No. \_\_\_\_\_  
 Medicaid No. \_\_\_\_\_  
 Insurance Carrier (Name and Authorization No.) \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Policy No. \_\_\_\_\_  
 Group No. \_\_\_\_\_  
**Secondary Insurance Information**  
 Insurance Carrier (Name and Authorization No.) \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Policy No. \_\_\_\_\_  
 Group No. \_\_\_\_\_  
**REQUESTED START OF CARE DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**FACE-TO-FACE CERTIFICATION**
 **FOR HOME HEALTH SERVICE UNDER MEDICARE:**
**I am a Medicare PECOS enrolled physician and I certify that:**  
 This patient is confined to the home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, and additionally may need occupational therapy. The patient is under my care. A plan of care has been established and will be reviewed periodically by a physician. A face-to-face encounter occurred no more than 90 days prior or 30 days after the start of home health and was related to the primary reason the patient requires home health services; the encounter was performed by a physician or allowed non-physician practitioner on

 **FOR HOME HEALTH SERVICE UNDER MEDICAID:**
**I am a Medicaid OPRA enrolled physician and I certify that:**  
 This patient needs nursing care, physical therapy and/or speech therapy and additionally may need occupational therapy that is medically necessary. This patient is under my care. A plan of care has been established and will be reviewed periodically by a physician. A face-to-face encounter occurred no more than 90 days prior or 30 days after the start of home health and was related to the primary reason the patient requires home health services; the encounter was performed by a physician or allowed non-physician practitioner on

 \_\_\_\_\_/\_\_\_\_/\_\_\_\_ **ENCOUNTER DATE**
**HOME CARE DIAGNOSIS**
**DIAGNOSES (Please attach Medical history)**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**HOME CARE ORDERS**
**SKILLED NURSING SERVICES**

 Observation/Assessment/Education (Specify plan) \_\_\_\_\_  
 Medication Management \_\_\_\_\_  
 Disease Management \_\_\_\_\_  
 Wound Care \_\_\_\_\_  
 Injections \_\_\_\_\_  
 IV Therapy (Medicare) \_\_\_\_\_  
 Behavioral Health (Medicare) \_\_\_\_\_  
 Other Skilled Nursing Service \_\_\_\_\_

**THERAPY SERVICES**
 Physical Therapy \_\_\_\_\_  
 Occupational Therapy \_\_\_\_\_  
 Speech Language Pathology \_\_\_\_\_

**ADDITIONAL SERVICES**
 Other \_\_\_\_\_  
 Other \_\_\_\_\_

**PHYSICIAN**

 Print Physician Name \_\_\_\_\_ Physician Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Physician Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Office Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

## What is the definition of being “homebound?”

“Homebound” means a patient is unable to leave home without considerable and taxing effort.

CRITERIA 1	AND	CRITERIA 2
Needing the aid of a <b>supportive device</b> due to illness or injury: <ul style="list-style-type: none"> <li>■ Crutches, canes</li> <li>■ Wheelchair</li> <li>■ Walker</li> <li>■ Use of special transportation</li> <li>■ Assistance of another person in order to leave home, including for cognitive or psychiatric impairments</li> </ul> <p><b>OR</b> Having a condition where leaving home is medically contraindicated.</p>		Normal inability to leave home and leaving home requires considerable and taxing effort: <ul style="list-style-type: none"> <li>■ Exacerbated symptoms from leaving home, e.g., shortness of breath, pain, anxiety, confusion, fatigue</li> </ul>

Patients who leave home infrequently for short durations or for health care **MAY STILL** be considered homebound. These situations may include (but are not limited to):

- Attending a religious service
- Attending a family event, funeral, graduation or other unique event
- Going to get a haircut
- Receiving outpatient kidney dialysis
- Walking around the block
- Receiving outpatient chemotherapy or radiation therapy

Physician documentation in the patient record must support **how/why the patient is homebound** and requires skilled services.

EXAMPLE 1	EXAMPLE 2
Patient is confined to the home due to unsteady gait and needs assistance to ambulate secondary to CVA. The patient needs home nursing care for medication teaching and disease management and physical therapy for falls risk reduction and a home exercise program.	Patient is confined to the home due to s/p recent total knee replacement and currently walker dependent with painful ambulation. PT is needed for therapeutic exercise and gait training.