THE VASINDA COMPANIES
AROUND THE CLOCK
INTEGRITY ~ TRUST ~ COMPASSION ~ HEALING

# In-Patient Home Health Certification

**Fax To:**

**ACHC - Attn: Intake Department**

**Fax: 661-864-1004**

**Ph: 661-395-5800**

**Referred From: _____**
**Dr. _____**
**Sent by: _____**
**Date: _____**
**Total # of pages: _____**
**Phone#:_____**

**Patient Name: _____ DOB: ____/____/_____**

**Include: ☐ Home Health Certification ☐ Face Sheet ☐ H&P ☐ Order Summary ☐ Progress Note ☐ Discharge Order**

**The findings from this face to face encounter indicate the reason(s) this patient requires intermittent skilled nursing care and/or therapy skilled services.**

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## Home Health Skilled Services:

| | | |
|---|---|---|
| ☐ Skilled Nursing | ☐ IV Therapy | ☐ Wound Specialty Nurse |
| ☐ Physical Therapy | ☐ G-Tube Feeding | ☐ NPWT |
| ☐ Occupational Therapy | ☐ Ostomy Care | ☐ Foley Catheter Care |
| ☐ Speech Therapy | ☐ Diabetic Care | ☐ Home Health Aide |

## This patient is confined to the home for the following reason(s):

☐ Unable to ambulate >_____ feet without rest periods

☐ SOB with exertion/activity requires frequent rest

☐ Requires assistance of device and/or aid of another to leave home: _____

☐ Medically restricted to home due to _____

☐ Leaving home requires a great and taxing effort due to_____

☐ Needs assistance with activities and/or ambulation

☐ Confusion/Cognitive limitations make it unsafe for patient to leave home

☐ IV Therapy contraindicated to be in the community

☐ Unable to leave home due to confirmed or suspected COVID19 diagnosis or a condition making them more susceptible to COVID19

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## MD Order & Instructions: _____

_____

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**I certify this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy, or continues to need occupational therapy. I have authorized the services on this initial plan of care which will be further developed by _____ who is overseeing the home health services. I further certify this patient had a face-to-face encounter that was performed on ___ /___ /____ by a physician or Medicare allowed non-physician practitioner that was related to the primary reason the patient requires home health services.**

_____ _____

**Physician Signature (This certification may only be signed by an MD/DO/DPM)** **Date**

_____

**Physician Printed Name**

Face to Face is a Medicare required document that must accompany any new Medicare patient referral. Please contact our Intake Department if you have questions @ **661-395-5800**