Fishkill Home Care

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Addendum to Home Health Plan of Care

Documentation of Face-to-Face Encounter & Order for Services

Patient Name: _____ Date of Birth _____

Date of patient encounter: _____

The encounter with the patient was in whole, or in part, for the following medical condition(s), which is (are) the primary reason for home health care:

List medical diagnoses related to home care needs:

_____

_____

I certify that, based on my findings, the following services are medically necessary home health services: ***(Check all that apply and why):***

☐ **Skilled Nursing:** MUST include initial orders for wound care, IV dressing change if not on discharge summary
To provide the following care/treatment: _____

_____

☐ **Physical Therapy**:
To provide the following care/treatment:

_____

☐ **Other: □ OT □ ST □ MSW □ Aide**
To provide the following care/treatment_____

_____

Describe why the patient is essentially homebound: ***(for Medicare patients only)***

_____

_____

The findings from this face-to- encounter have been communicated to the patient's community physician _____ who will provide oversight of the patient's home health plan of care.

Physician Signature: ** _____ Date Signed: _____

Physician Printed Name: _____

***Medicare does not allow any non-physician practitioner signatures or stamped physician signature in home care.**