RCS
Residential Clinical Services
Setting the Standard in Home Health since 1987

Documentation of Face to Face Encounter

(Addendum to Plan of Care/485)

Patient Name: _____
Start of Care Date: _____

Centers for Medicare & Medicaid Services (CMS) require Face-to-Face (F2F) Encounter documentation relating to the need for home healthcare.

I certify this patient is under my care and I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter meeting the physician face-to-face encounter requirements with this patient on: (Insert date that visit occurred):

Date of F2F Encounter: _____
Month Day Year

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

_____Nursing
_____Physical therapy
_____Speech language pathology
_____Occupational Therapy
_____Medical Social Worker

My clinical findings support the need for the above services <u>because</u>: (Add/include diagnosis related home health need) **. PLEASE PLACE CHECK NEXT TO APPROPRIATE FINDINGS**

___ New medications, patient requires further teaching and assessment

___ Deconditioned due to hospitalization, requires further skilled services

___ Patient has a wound that requires continued skilled care

___ Patient with history of falls, problems with poor balance, gait instability

___ Status post ____, patient requires further skilled assessments and teaching

___ Infection requiring IV therapy

___ Indwelling urinary catheter requiring assessment, maintenance and teaching

___ Acute respiratory insufficiency requiring cardio pulmonary assessment

___ **OR** explanation as appropriate_____

___ Infection requiring IV therapy

Further, I certify that my clinical findings support that this patient is homebound per CMS guidelines due to: (Homebound definition: Absences from home that require considerable and taxing effort and are for medical reasons or religious services or infrequent or of short duration). **PLEASE PLACE CHECK NEXT TO APPROPRIATE GUIDELINES**

___ Unsteady gait/frequent falls/poor balance

___ Assistance of two persons to ambulate/transfer

___ Unable to leave home due to mental confusion/psychological impairment

___ Medically contraindicated due to recent surgery

___ Medically contraindicated due to infected/draining/complicated wound

___ Dyspnea at rest

___ Medically contraindicated due to immunosupression/serious risk of infection

___ Bedbound

___ Chairbound

___ Dyspnea with ambulation greater than _____ feet

___ **OR** explanation as appropriate_____

Physician Signature Date of Signature

Physician Printed Name

PLEASE RETURN COMPLETED FORM BACK TO RESIDENTIAL CLINICAL SERVICES, INC. AS SOON AS COMPLETED, A FACE TO FACE ENCOUNTER IS REQUIRED TO BEGIN START OF CARE ON MEDICARE PATIENTS. SEND TO ADDRESS OR FAX NUMBER LISTED BELOW. THANKS.

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