Rockaway Home Care
Licensed Home Care Agency

150 Beach 9th Street, Far Rockaway, NY 11691
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Intake@RockawayHC.com

Date: _____

Referral Recommendation For Home Care Services

Patient Information

Patient Name:			
Address:			
City:	State:	Zip:	
Phone #:	Sex:	Living Arrangements:	
DOB:	Language 1:	Language 2:	SS #:
Emergency Contact / Relationship:		Phone #:	

Insurance

Medicare #:	Medicare HMO #:
Medicaid #:	Medicaid HMO #:
Other Insurance:	Veterans Benefits:

Physician Information

Physician Name:	License #:	NPI #:
Phone #:	Fax #:	
Address:		

Patient Diagnoses

1.	4.
2.	5.
3.	6.

Patient Conditions

Ambulation Status:	Mental Status:
Allergies:	Diet:

Services Requested

Registered Nurse ☐	Physician Care ☐	Homemaking ☐	Speech Therapy ☐	Housekeeping ☐	Social Worker ☐
Home Health Aide ☐	Occupational Therapy ☐	Physical Therapy ☐	Audiology ☐	Nutritionist ☐	Social Day Program ☐

MD Stamp Signature	Date:

Home Health Face-To-Face Encounter Certification

PATIENT NAME: _____ **ADMISSION ID:** _____

PHYSICIAN SIGNING CERTIFICATION: _____ **PHYSICIAN NPI:** _____

I, a Medicare-enrolled ☐ physician, or a ☐ non-physician practitioner* (Check One) had a face-to face encounter with the above-named patient on _____/_____/_____ for the following medical condition (s) _____ which is related to the primary reason the patient needs home care.

I certify that the patient is homebound and that upon completion of this FTF encounter has the need for intermittent skilled nursing, physical therapy, and/or speech therapy services in their home for their current diagnosis as outlined in the initial plan of care. These services will continue to be monitored by _____ who will periodically reviews and update the plan of care as required.

The following clinical findings support that the patient is HOMEBOUND (homebound means that there exists a normal inability to leave home, and consequently, leaving home requires considerable and taxing effort) and that the patient requires an assistive device _____ or the assistance of a person to leave the home.

_____

_____

_____

The patient requires intermittent SKILLED NURSING, PHYSICAL OR SPEECH THERAPY to provide the following treatments:

_____

_____

_____

_____ _____

PHYSICIAN SIGNATURE **DATE**

Per CMS's regulation (42 C.F.R §424.22), "the physician responsible for performing the initial certification must document that the face to face patient encounter, which is related to the primary reason the patient requires home health services, has occurred." This documentation must include the "date of the encounter, an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing or therapy services as defined in §409.42 (a) and (c)." ** A non-physician practitioner includes a nurse practitioner, clinical nurse specialist working in collaboration with the physician, a certified nurse midwife or a physician assistant under the supervision of the physician.