

Jefferson County Public Health Service
531 Meade Street
Watertown, NY 13601
(315) 786-3770

Documentation of Face to Face Encounter for Home Care

Patient Name and Identification: (If not elsewhere on this page):

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

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

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

<input type="checkbox"/> Nursing	<input type="checkbox"/> MSW
<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Home Health Aide
<input type="checkbox"/> Speech language pathology	<input type="checkbox"/> Occupational therapy

To provide the following care/treatments: (Required only when the physician completing the face to face encounter documentation is different than the physician completing the plan of care):

Name of physician that will provide care in the community: _____

My clinical findings support the need for the above services because:

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons) because:

Physician Signature _____

Date of Signature _____

Physician Printed Name _____

Please fax completed form to (315) 786-3751. Thank you.