ATTN: Please send the most recent clinical note with referral along with any other supporting documentation. Thank you.

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Referral/Order/Face To Face

Date:_____ Patient Name:_____☐ Male☐ Female

DOB_____ Phone#( )_____Address: _____

Primary Insurance_____Policy#_____

Secondary Insurance_____Policy#_____

Attestation: I certify and attest that this patient is under my care and that I – or a nurse practitioner (NP) or physician's assistant (PA) working as an ancillary provider under my supervision – had a face-to-face (F2F) encounter that meets the physician F2F encounter requirements as required by CMS.

Date of visit was: Month_____ Day:_____ Year:_____ **A valid visit must be 90 days prior to or 30 days after referral.

Medical Condition/Necessity for Home Care

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

_____

_____

_____

_____

_____

_____

Clinical Findings in Support of Patient's Eligibility

I certify that, based on my clinical findings, the following services are medically necessary home health services, to include the specific need for intermittent skilled nursing and/or therapy services. (face to face visit finding must be related to the primary reason for home health admission).

Skilled Home Care Services Needed (Check all that apply)

□ *Skilled Nursing Assessment*	□ *PT Eval/Admit & Set Freq*	□ OT Eval. & Set Freq.
□ Medication Teaching	□ PT to evaluate and perform	□ ST Eval. & Set Freq.
□ Wound VAC	lymphedema treatment	□ Cardiac Rehab
□ Wound Care	□ PT to perform wound care	□ Cardiac/Pulmonary Therapy
□ Venipuncture	□ Fall Reduction Training	□ Home Safety Evaluation
□ Foley Insertion/Management	□ Post-Surgical Management	□ Pain Management
□_____Ostomy Care	□ Ortho Edema Management	□ Vitamin B12 Injection

□ Other:_____

Statement of Homebound Status: I certify that my clinical findings support that this patient is homebound (i.e abscences from home require considerable and taxing effort and are for medical reasons, religious services and/or of short duration when for other reasons.

□ Patient unable to leave residence without assistance or one or more persons due to exacerbation of disease process and/or general weakness □ Other:_____

Assistive Device Used (List All) □Wheelchair □Walker □Cane □Supervision/ Caregiver Help

Service Frequency: SN_____ PT_____ OT_____ ST_____Other_____

Certifying Non- Physician Signature:_____Date:_____

Certifying Physician Signature:_____Date:_____

Certifying Physician Name:_____NPI:_____

AMISTAD Homecare, Inc.

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Dear provider. Medicare has recently enacted changes that have placed a greater burden on home health agencies and their providers in regards to documentation qualifying a patient for home health. Please review the following components and fill out all aspects of the referral/Face to Face forms appropriately. Thank you.

The Necessary Components of a Home Health Referral

1. **Face to Face:** A Face to Face visit is needed to refer for home health. This would be an in person visit or audio and video tele-visit 90 days prior to the referral. A clinic note with the appropriate date range would suffice as justification for services.
2. **Insurance:** Some insurances require authorization or the primary care MD to authorize visits. Please be as accurate as possible in regards to writing out insurance information as this will help us obtain authorization faster. Also, per Medicare regulations, a patient can only receive home health services from one home health at a time. If the patient has another home health, they will have to discharge from their services prior to us admitting. Additionally, patient cannot receive outpatient and home health therapy at the same time.
3. **Appropriate Signing Provider:** Home health services must be performed under the oversight of an appropriate clinical provider. This can be an MD, DO, DPM, NP or PA. The provider must be PECOS enrolled. The provider will be responsible for signings all necessary orders in a timely manner and being the point of contact for any changes or updates to the patient's care.
4. **Diagnosis/Comorbidities:** List all diagnoses and past medical history. This is very important for justification of services. On the referral it is ok to write out the major diagnosis to justify services however we will require clinical notes that have all additional diagnosis and medications if this is available.
5. **Home Bound Status:** For most insurances, including Medicare, a patient is required to be homebound to acquire home health services. The signing provider can certify a patient as home bound. It is also hopefully to list the functional deficits that attribute to the home bound status such as:
    a. High fall risk while performing activities of daily living.
    b. Shortness of breath while walking around the home.
    c. Inability to perform self-care.
    d. Unsafe to drive due to medication side effects.
    e. Impaired vision for safe walking.
    f. High risk for COVID-19.
    g. Abnormality of gait.
    h. Reliance on assistive device for ambulation.
6. **Skilled Care:** Home Health is a skilled service. A patient will need either nursing or therapy services to justify care. Please be specific on the type of services need:
    a. Home health nursing to admit for medication management.
    b. Home health physical therapy evaluate and treat for lymphedema management and wound care.
7. **Medical Justification:** By meeting the above criteria, a patient will meet medical justification for services. If there are any other reasons for services not listed on the form please free hand them in.

Thank you for understanding. By filling out documentation correctly, we can see patients sooner.

Clinic Visit + Authorization + Provider + Diagnosis + Home Bound + Skilled Care Need = Admission