Certification of Patient Eligibility for Medicare Home Health Benefit

Patient Name:_____ DOB: _____

Date of Face to Face Encounter: _____ Physician's Name: _____

Medical Condition requiring home care service: _____

Skilled, Intermitted Nursing/Therapy/Social Work services indicated

Skilled Nursing:

- ☐ Medication management (reconciliation, teaching)
- ☐ Chronic disease management (assess and report to PCP)
- ☐ Wound care: [type of wound (pressure ulcer, surgical, stasis, cellulitis) and treatment]
- ☐ Administer SQ/IM/IV meds
- ☐ Cath care
- ☐ Trach or GT care

Physical Therapy:

- ☐ Functional mobility training
- ☐ Home exercise program to strengthen, increase ROM
- ☐ Fall prevention training
- ☐ Home maintenance program for chronic disease

Speech Therapy:

- ☐ Swallow evaluation and training
- ☐ Speech and language training
- ☐ Cognitive training to process, organize, and/or recall information

Occupation Therapy:

- ☐ ADL management
- ☐ Home adaptation and equipment
- ☐ Energy conservation
- ☐ Cognitive training

- ☐ **Social Work: Community Support Services**

Clinical Findings: Please attach documentation (physician discharge summary or progress note) that supports the patient's eligibility for home health services.

Patient must be confined to home: a condition exists in which there is a normal inability to leave home, and leaving home would require a considerable and taxing effort; infrequent absences from home of short duration or absences that are attributable to the need to receive health care treatment are allowable.

Homebound due to:

- ☐ **Pain, decreased strength and endurance that severely limits ambulation**
- ☐ **Severe SOB and fatigue at rest and /or with ambulation**
- ☐ **Unsteady gait, impaired transfers and inability to negotiate stairs unassisted**
- ☐ **Limited weight bearing**
- ☐ **Requires supervision due to mental status changes**
- ☐ **Medically indicated due to recent hospitalization ; recent surgery**
- ☐ **Medically indicated due to complicated wound**

Physician who will follow patient in the community: _____

Physician Signature: _____ Date:____ _____