Vitality Home Care, Inc.

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Tel: (313) 914-7468 Fax: (313) 914-7498

SOC DATE:

Continuing Plan of Care

Patient's Last Name: First Name: M.I:	Date of Birth:	M.R.#

Patient Address:	Referring Physician:	Referred to:

Phone:	Gender: ☐ Male ☐ Female Marital Status: __S __ M __ D __W __ Sep	Medicare No:

Responsible Relative or Friend: Relationship: Phone:	Medicaid No:	Other Insurance:

FACE-TO-FACE ENCOUNTER

A face-to-face encounter that meets the CMS requirements for this patient occurred on:
DATE OF FACE-TO-FACE ENCOUNTER: _____/_____/_____
Month Day Year

The encounter/assessment with the patient was in whole, or in part, for the following medical condition(s), which is the primary reason for home health care. *List medical conditions:*

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 ☐ MSW ☐ CHHA

Clinical findings that support the need for home health service(s):

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

I certify that the patient above is under my care and has had a face-to-face encounter by myself or Nurse Practitioner or Physician's Assistant working collaboratively with me. Patient requires the Home Health Services, and is confined to his/her home. These professional services are to be provided on an intermittent bases and I will review the established plan at least every 2 months. These services are related to the diagnosis stated above and conditions for which he/she has recently received treatment.

Physician Name: _____ **Address:** _____

Phone: _(_____)_____ **Fax:** ___(_____)_____

Physician Signature: _____ **Date:** _____