J&A HEALTH SERVICES, LLC. 1222 Avenue M, Suite 201, Brooklyn, NY 11230	**J&A Intake Department.**	
	Phone: 718-737-8012	**Fax: 718-303-0766**
	E-mail: mkharzis@jahealthservices.com	

Documentation of Face-to-Face Encounter Form

Patient Last Name:		**Patient First Name:**					
Patient Address:				**State:**		**Zip:**	
Date of Birth:		**Medicaid:**		**Patient Phone:**			
Medicare:		**Social Security:**					
Primary Language:		**Emergency Name:**					
Emergency Contact:		**Relationship for Patient:**					

1. Medical Condition Related to Home Health Services

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:

_____

2. Diagnosis/ICD-10: 1: _____ 2: _____

3. 3: _____ 4: _____

4. Certification of Medical Necessity

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

☐Nursing Services ☐Therapy Services ☐C.N.A Services ☐ MSW ☐Telehealth

5. Certification of Homebound Status

My clinical findings from this encounter support the patient is homebound due to:

☐Leaving home requires a considerable and taxing effort

☐Absences from home are infrequent, of short duration or to receive healthcare treatment

☐Medically restricted due to immunosuppression, infectious illness, risk of infection or injury, or_____.

Medications (name, dosage, route, frequency, *** indicate if a new or changed***)

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

Face-to-Face Encounter:

I certify that this patient is homebound and the above home health services medically necessary.			
I certify that this patient is under my care and I, or a nurse practitioner, clinical nurse specialist or physician's assistant working with me, had a face-to-face encounter with this patient on: following date: ___/___/_____			
Physician Printed Name:			
Physician Signature:		License #:	
Phone:		Fax:	

Stamp Required