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Please feel free to reach us at
718.627.7050 or fax to **718.627.4800**

HOMECARE: *Always Available*

Referral/Patient Information

Patient's Name: ____ Sex ☐ Male ☐ Female

Patient's Address: ____ Date of Birth: _____________________________

City: __________________________________ State: ________________ Zip: __________ SS# ________________________

Home Phone # ________________________ Cell #: ________________________

Emergency Contact:

Name: ____ Phone #: ______________ Relationship: __________________

Insurance Information

Medicare #: ______________________________________ Medicaid #: ____

Commercial Insurance Carrier (Name & Authorization #) ____

Subscriber __________________________ Policy # ______________________________ Group # _______________________

Language and Cultural Preferences ____

Face-to-Face Encounter Certification

I certify that a face-to-face encounter was performed on the above named patient on _______/_______/______

by_____________________________ who is a ☐ Medicaid Enrolled Physician or a ☐ Permissible non-Physician Practitioner.

The clinical reason for the encounter was ____

____

The following clinical findings support that the patient is homebound (Homebound means that there is a normal inability to leave home, and consequently, leaving home requires considerable and taxing efforts) and that the patient needs intermittent skilled Nursing and/Therapy (Physical or Occupational Therapy):

Skilled Need

Certificat ion of Medical Necessity

I certify that based on my clinical findings the following services are medically necessary for home care services:

- ☐ Skilled Nursing for: ____
- ☐ Physical Therapy for: ____
- ☐ Occupational Therapy for: ____
- ☐ Speech/Language Therapy for: ____
- ☐ HHA: ____

Homebound Status

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,
- ☐ Absence 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 ____

Physician Information

Name ____ Phone: ____

Address: __________________________________ City: ______________________ State: ___________ Zip ____________

LIC#: ____ UPIN#: ______________________ NPI#: ___________________

MD Signature: ____ Date: __________________________________

THANK YOU FOR THE REFERRAL PLEASE CALL AND CONFIRM RECEIPT OF TRANSMISSION

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