HealthPoint Home Health Inc.
Helping to Achieve the Highest Point of your Health

Accredited by the Joint Commission since 2011

Home Health Services Referral Intake Form

2137 HERNDON AVE, SUITE # 103, CLOVIS, CA 93611 TEL: 559.412.7953 FAX: 559.492.3503 eFAX: 559-513-8126

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____

Address: _____

Telephone #: _____ SSN: _____

Pt Representative Name and Tel #: _____

Primary Health Insurance: _____ Policy #: _____

REFERRAL INFORMATION

Ordering Physician: _____ Tel #: _____

Is ordering physician the primary care physician? ❒ YES ❒ NO, pls. complete info below

Primary Care Physician: _____ Tel #: _____

CMS FACE-TO-FACE ATTESTATION

I **certify and attest,** under the penalty of perjury, that this patient is **homebound** and confined to his/her home and **needs intermittent skilled** nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is **under my care**, and I have authorized services on this **plan of care** and will **periodically review the plan**. The patient had a **face-to-face encounter** with an allowed provider type on _____ and the encounter was related to the primary reason for home health care.

HOMEBOUND REQUIREMENT: must meet Criteria One and Two

Criteria One: Does the physician/facility documentation indicate that the patient requires a:	**Criteria Two**: Does the physician/facility documentation support:
❒ Mobility assist device, or ❒ Special transportation, or ❒ Assistance of another person to leave the home, or ❒ Has a condition that leaving the home is medically contraindicated	❒ The patient has a normal inability to leave the home, **AND** requires a considerable and taxing effort to leave the home

CLINICAL FINDINGS

- Disease manifestations/signs/symptoms: _____
  _____
- Contributing Diagnosis: _____
- Assistive Devices: _____
- Skilled Services Needed: ❒ RN/LVN ❒ PT/PTA ❒ OT/COTA ❒ ST ❒ MSW ❒ Other: _____

Physician's Signature: _____ **Date:** _____

FOR HEALTHPOINT HHA OFFICE USE ONLY

Referral Received on: _____ by: _____ MD Pecos-registered: Y / N Pt eligible: Y / N

Verified w/ Ordering MD office: Staff name: _____ Date: _____ H&P received on: _____

Verified HH order w/ pt on _____: ❒ Agreed, SOC scheduled for: _____ ❒ Refused HHA services