Portland service area	Phone: 503-215-4646	Referral Fax: 503-215-4671
Central Willamette Valley (Providence Benedictine)	Phone: 503-845-9226	Referral Fax: 1-855-809-4954
Clark County service area	Phone: 360-369-6108	Referral Fax: 503-215-4671
Columbia Gorge service area	Phone: 541-387-6339	Referral Fax: 541-387-6347
Southern OR service area	Phone: 541-732-6500	Referral Fax: 541-732-7800

PROVIDENCE Home Services

Criteria for HH referral (all boxes MUST be checked):

- □ Patient meets Homebound criteria
- □ Name of provider to follow patient for HH orders:_____
- □ Signed order by MD, DO, DPM, NP, PA. ***Home Health cannot accept orders by Naturopathic Doctor***
- □ Face-to-Face attestation and date (**requirement for Medicare and DMAP patients**)
- □ Diagnosis and recent chart notes that support order/reason for HH (attached)
- □ Face Sheet/demographics/insurance info/H & P/Current vaccinations (attached)
- □ Recent facility stay dates: Hospital Date: _____ SNF Date: _____

Patient Name: **Last** **Middle** **First**

DOB:	**Sex:**	**SSN:**	**Interpreter needed? Y/N** **If yes, preferred language** _____

Insurance: **Policy #:**
Secondary Insurance: **Policy #:**

Address (Place of Service physical address – *No PO Boxes*):	**Phone #:**

POA (full name) and contact #:	**Ht/Wt:**	**Allergies:**	**Weight-bearing status (circle one):** As tolerated Partial Toe Touch Non WB

Primary diagnosis for HH (must use qualifying diagnosis related to HH skilled need):	**Surgery type/date (if applicable):**

Skilled Services/Interventions (Describe services the clinician will perform in the home):

Home Health RN

- □ Disease management/teaching
- □ Medication teaching
- □ Pain/Symptom management
- □ Foley Catheter management (size, date placed):_____
- □ Wound care (site): _____
- □ Lab draw: specify lab & date: _____
- □ Coag check: Date due: _____ Results to: _____
- □ Tube Feed teaching/management
- □ CVP assessment
- □ Other:_____

Home Health PT

- □ Mobility Training
- □ DME eval
- □ Therapeutic Exercises
- □ Other: _____

Palliative Care RN (please specify skilled need/interventions above)

- □ Disease management/teaching
- □ Pain/Symptom management
- □ Other:_____

Home Health OT**

- □ ADL training
- □ Cognitive Eval
- □ Other: _____
- □ Functional Exercises
- □ Equipment needs

Home Health MHRN

Mental Health diagnosis: _____

- □ Disease management/teaching
- □ Medication teaching □ Other _____

Home Health Speech/Language

- □ Speech □ Swallow
- □ Cognitive Eval
- □ Other _____

Home Health MSW**

- □ Psychosocial Support
- □ Short/Long Term Care Needs
- □ Other _____

Home Health Aide/Bath Aide

□ Bathing □ Dressing □ Change Linens
(must be paired with RN, PT, OT, or Speech Therapy)
Caregiver needs such as transportation, cooking, cleaning, dishes, food prep are not a home health covered benefit. Please contact an in-home care provider.

Infusion RN Interventions: _____
Note: If no skilled Home Health needed (RN, PT, OT, ST), fax document directly to 503-215-8435 and call Infusion @ 503-215-4377 for questions

****May need to be paired with qualifying discipline of RN, PT, or Speech Therapy per Medicare requirements**

I certify this patient is under my care and that a physician or a Medicare allowed provider working with me, had a face to face encounter that meets the F2F encounter requirements (a visit within 90 days preceding or no later than 30 days following certification).
Name of Provider who saw patient: _____
FACE TO FACE ENCOUNTER DATE (mm/dd/yy): _____ *Reminder: Attach visit note*

I certify, that based on my findings, this patient is homebound and skilled nursing and/or therapy services are medically necessary.
Physician name (printed): _____**NPI #:**_____
Physician signature: _____
Date signed: _____