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HOME HEALTH AGENCY

HOME HEALTH REFERRAL FORM

PATIENT & REFERRAL INFORMATION

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Patient Phone: _____

Start of Care Date Needed: _____

Surgery Date (if applicable): _____

REFERRAL / PROVIDER INFORMATION

Referring Provider: _____

Contact Name: _____

Phone / Fax: _____

Referral Date: _____

Primary Diagnosis / Reason for Referral: _____

SERVICES REQUESTED

How we start care: *Our admitting RN or PT assesses the patient at the start of care and will request any additional disciplines needed. Fewer disciplines on the initial order means a faster start of care.*

SKILLED NURSING

☐ **Skilled Nursing** *(evaluate and treat)*

Includes as needed: medication management, wound care, pain management, ostomy / catheter care, IV medications and PICC line care, disease education

☐ Diabetic Education

PHYSICAL THERAPY

☐ **Physical Therapy** *(evaluate and treat)*

☐ **PT to evaluate and treat; assess for Occupational Therapy**

OT is added only if the PT assessment identifies a need

OTHER SERVICES (AS NEEDED)

☐ Speech Therapy ☐ Medical Social Worker ☐ Home Health Aide

☐ **Other Services / Therapies** (please write in): _____

☐ **DME:** _____

Specific Orders / Focus of Care / Special Instructions

Skilled need, specific orders, frequency / duration if known, wound care instructions, clinician preferences, etc.

_____

_____

_____

_____

PLEASE ATTACH - REQUIRED FOR A COMPLETE REFERRAL

☐ Patient Demographics / Face Sheet ☐ Insurance Info (card + subscriber) ☐ Visit notes w/ F2F or telehealth consult (past 90 days)

☐ History & Physical ☐ Current Medication List

HOMEBOUND STATUS

☐ **Patient is homebound** *(leaving home requires a considerable and taxing effort)*

FACE-TO-FACE & CERTIFICATION

Face-to-Face Encounter Date: _____ / _____ / _____ (In person or telehealth with audio and video)

I certify this patient is under my care; that I, or an allowed practitioner (NP, PA, or CNS) working with me, had a face-to-face encounter related to the primary reason for home health within 90 days before or 30 days after the start of care; and that the services above are reasonable and medically necessary.

Physician / Allowed Practitioner Signature: X _____

Credentials: _____ **Date:** _____

Please send referrals to: **referrals@cchha.com** **or Fax: 661.522.7766**

5201 California Ave, Suite 255 · Bakersfield 93309 · Office: 661.846.2833 · Fax: 661.522.7766

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REFERRAL READINESS CHECKLIST

Confirm each section before submitting. Complete referrals are processed faster and avoid delays in patient care.

BEFORE YOU FAX OR EMAIL, CONFIRM:

1. Focus of Care
- ☐ Primary clinical problem driving the admission
- ☐ Skilled need home health will address
- ☐ Consistent with diagnosis, orders & H&P

2. Primary (PDGM) Diagnosis
- ☐ Specific principal dx at highest specificity
- ☐ Maps to a PDGM clinical group (no symptom-only codes)
- ☐ Relevant secondary / comorbid diagnoses included

3. Face-to-Face (F2F) Encounter
- ☐ By certifying / allowed practitioner; related to HH reason
- ☐ Dated 90 days before or 30 days after start of care
- ☐ Encounter note signed & dated

4. History & Physical (H&P)
- ☐ Recent H&P or qualifying progress notes
- ☐ Supports dx, homebound status & skilled need

5. Medication List
- ☐ Current list: name, dose, frequency
- ☐ Flag meds the home health agency will administer

6. Need for Home Health (Eligibility)
- ☐ Homebound: leaving home is a taxing effort
- ☐ Skilled, intermittent need (SN and/or PT / SLP / OT)
- ☐ Under care of physician / allowed practitioner

7. Services Requested
- ☐ Disciplines: SN, PT, OT, SLP, MSW, HHA
- ☐ If known: frequency, duration, supplies, goals

8. Signed, Dated & Credentialed Orders
- ☐ Cert & POC signed/dated by MD, NP, PA or CNS
- ☐ Verbal / interim orders signed before billing
- ☐ Legible signature + credentials; no stamps

9. Insurance Information
- ☐ Insurance card (front & back)
- ☐ Subscriber info; authorization if applicable

✓ Ready to Submit
- ☐ All applicable boxes above are checked
- ☐ Referral form (front page) fully completed & signed

MOST COMMON REASONS REFERRALS ARE RETURNED

Incomplete or untimely face-to-face · Symptom-only / ungroupable diagnosis · Missing dose or frequency on medication list · Unsigned, undated, or stamped orders

Questions or help completing a referral? Call our office at 661.846.2833 or email **referrals@cchha.com**

Educational summary of CMS home health requirements; not legal advice.

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