| Individual's Name | Qualifying Treating Physician's Name |
|---|---|
| Individual's Medicaid Billing Number | Qualifying Treating Physician's Billing Number |

***SECTION II of III***

**Certificate of Medical Necessity of Home Health Services for Individuals Discharged from a Covered Inpatient Hospital Stay**

***Check all boxes that apply:***

☐ The above-named individual was discharged from an inpatient hospital stay of three or more days in length.

Discharge Date: _____

☐ By my signature below, I certify that I am the qualifying treating physician for the above-named individual. I certify that the individual needs home health nursing services and/or a skilled therapy at least once per week, and I ordered these needed services.

☐ By my signature below, I certify that I, or a collaborating advanced practice nurse, or a physician assistant under my supervision, conducted and a documented a face-to-face encounter with the above-named individual within ninety days prior to the home health services start of care date, or within thirty days following the start of care date, preceding this certification of medical necessity.

☐ By my signature below, I certify that the above-named individual has a level of care comparable to an institutional level of care as evidenced by the fact that the individual is enrolled on a waiver, or though not enrolled on a waiver, still meets at least one of the following criteria (*Check all boxes that apply*):

- ☐ Requires hands-on assistance with at least two activities of daily living (ADLs).
- ☐ Requires hands-on assistance with one ADL, and needs medication and is unable to self-administer those medications.
- ☐ Requires awake supervision on a 24-hour basis to prevent harm due to cognitive impairment.
- ☐ Is below age five and exhibits at least three developmental delays (adaptive behavior, physical development, communication, andcognition, social or emotional development) and would benefit from services to promote acquisition of skills and decrease or prevent regression.
- ☐ Is age six through 15 with at least one other diagnosed condition, other than mental illness, that is likely to continue indefinitely, has functional limitations in three or more major life areas (capacity for independent living, communication, learning, mobility, personal care and self-direction and economic self-sufficiency), and would benefit from services that promote acquisition of skills and prevent or decrease regression in the performance of tasks in the major life areas.
- ☐ Is age 16 and older with at least one other diagnosed condition other than mental illness, the condition manifested before the individual's 22nd birthday and is likely to continue indefinitely, functional limitations in three or more major life areas (capacity for independent living, communication, learning, mobility, personal care, self-direction and economic self-sufficiency) and would benefit from services that promote acquisition of skills and prevent or decrease regression in the performance of tasks in the major life areas.
- ☐ Needs at least a skilled nursing service to be delivered 7 days a week and/or PT, OT or speech-language pathology to be delivered at least 5 days a week, ordered by a physician and delivered by a licensed and/or certified professional due to either:
  - The instability of the individual's condition, meaning that the individual's condition changes frequently and rapidly requiring constant monitoring and/or frequent adjustment to the treatment regime, and the complexity of the prescribed service; or
  - The instability of the individual's condition, meaning that the individual's condition changes frequently and rapidly requiring constant monitoring and/or frequent adjustment to the treatment regime, and the presence of special medical complications.

| Name and Credentials of Person who Conducted the Face-to-Face Encounter | Face-to-Face Encounter Date |
|---|---|
| Certifying Physician's Signature and Credentials | Certifying Physician's Signature Date |