HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

ECHO Home Health Attestation Form

for the Provider

Beneficiary name: _____

Sponsor SSN: _____ Beneficiary date of birth: _____ / _____ / _____

In order to qualify for Extended Care Health Option (ECHO) Home Health Care (EHHC), the TRICARE beneficiary must be homebound and have skilled needs. TRICARE Policy Manual Chapter 9, Section 15.1 (ECHO Home Health Care (EHHC)) requires the provider attest the beneficiary is homebound. Please complete the attestation and identify the skilled needs required. This documentation may be required every 90 days.

A. Homebound: In order for this beneficiary to be eligible for EHHC, your attestation confirming the beneficiary is homebound as defined by 32 CFR 199.2 is required. 32 CFR 199.2 defines homebound as:

1. There exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort.
2. Absence from the home is for the need to receive health care treatment.
3. Other absences from the home are infrequent or of relatively short duration. For example, attending a religious service, an occasional trip to the barber, a walk around the block or a drive, only if the absences are undertaken on an infrequent basis and are of relatively short duration.
4. The patient is under the age of 18 or receiving maternity care AND leaving the home would place the patient at medical risk.
5. Absences from the patient's primary residence are for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state.

Technology (check all that apply)

- ☐ ventilator, continuous
- ☐ ventilator, intermittent
- ☐ tracheostomy
- ☐ CPAP, BiPAP
- ☐ oxygen, continuous
- ☐ oxygen, intermittent
- ☐ G-tube, continuous
- ☐ G-tube, continuous with reflux
- ☐ NG-tube, continuous
- ☐ NG-tube, bolus
- ☐ IV therapy, continuous
- ☐ last hospitalization: _____
- ☐ other: _____
_____
_____

Interventions (check all that apply)

- ☐ tracheostomy change and care
- ☐ trach suctioning: ◯ q 1 hr ◯ q 1-4 hrs ◯ q 4 hrs or >
- ☐ NG/G-tube feeds: ◯ continuous ◯ q 2-4 hrs ◯ q 4 hrs or >
- ☐ dressing changes: ◯ q 8 hrs ◯ > q 8 hrs
- ☐ intermittent cath: ◯ qd/prn ◯ q 4 hrs ◯ q 8 hrs ◯ q 12 hrs
- ☐ IV/TPN: ◯ Continuous ◯ q 8 - 16 hrs ◯ q 4 - 7 hrs ◯ < 4 hrs
- ☐ special therapy/description
  - QID Description: _____
  - TID Description: _____
  - BID Description: _____
  - QD Description: _____
- ☐ specialized monitor description (for example, I&O): _____
_____
- ☐ medication/route/frequency _____
_____

C. Number of hours requested based on skilled needs (hours cannot be requested to cover employment, seeking employment, deployment, or education of the primary caregiver):

_____hours per week and _____days per week

I attest this beneficiary (choose one): ◯ is homebound ◯ is not homebound

Provider's signature: _____ Date: _____/_____/_____

Provider's printed name: _____

Please complete this form and fax to 1-888-965-8438.