

Home Health Certification and Plan of Care					Order ID: 179/12446				
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period		4. Medical Record No.		5. Provider No.	
1EG4TE5MK73		11/01/2025		From: 11/01/2025 To: 12/30/2025		7507		242353	
6. Patient's Name and Address France Pearson 3251 Richard Avenue, BALTIMORE, MD 21215 410-952-3140					7. Provider's Name, Address and Telephone Number Home Health Cares 579# EAST MARKET@STREETS HARRISONBURG, VA 22801-1234 540-433-7146 1234567891				
8. DOB 06/14/1967 9.Sex Male					10. Medications: Dose/Frequency/Route (N)ew (C)hanged Metformin - Metformin Hydrochloride 1 tablet intramuscular once a day				
11. ICD E11.44		Principal Diagnosis Type 2 diabetes mellitus with diabetic amyotrophy			Date 11/01/25				
13. ICD		Other Pertinent Diagnoses			Date				
14. DME and Supplies: None of the above					15. Safety Measures: None of the above				
16. Nutrition: Z. NO PHYSICIAN-ORDERED DIET					17. Allergies: no known allergies				
18.A. Functional Limitations None of the above					18.B. Activities Permitted No Restrictions				
19. Mental & COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Psychosocial Status: Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No									
20. Prognosis: fair									
22. A Rehabilitation Potential: SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.					22.B.Discharge Plans patient will be responsible for managing treatment				
Homebound status: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home, medical condition could get worse if patient leaves home									
Clinical Condition Requiring Homecare: Dementia									
SN Careplans					SN Goals				
PT Careplans PT WK1: 1 (11/01/25-11/01/25) PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object					PT Goals				
OT Careplans OT WK1: 1 (11/01/25-11/01/25) PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 98 > 99, heart rate < 50 > 80, respiratory rate < 8 > 15, blood pressure systolic < 100 > 150, blood pressure diastolic < 50 > 100, O2 saturation < 98 > 101, pain < 0 > 0 CAREGIVER: 0. No assistance needed - patient is independent or does not have needs in this area HOSPITALIZATION RISKS: 10. None of the above STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits Advance Directive:No Advance Directive PROBLEMS IDENTIFIED ON ASSESSMENT: GG0130A1 - Eating, GG0130B1 - Oral Hygiene, GG0130C1 - Toileting Hygiene, GG0130E1 - Shower/Bathe Self, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, M1400 - Dyspnea, nausea/vomiting PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, equipment training, work simplification/energy conservation, coordinate/arrange transportation services TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition					OT Goals PATIENT-STATED GOAL: Move Independently GOALS patient/caregiver recalls * diabetic medication management * blood sugar testing * diabetic foot care * exercise * diabetic diet * recalls related medication(s) purpose, schedule patient/caregiver recalls * lifestyle modifications to manage respiratory condition including * diet changes and regular exercise * strategies to control shortness of breath * home remedies to keep lungs healthy * recalls related medication(s) purpose, schedule patient self-administers medications as prescribed * recalls related medication(s) purpose, schedule patient's transportation needs are met Oral Hygiene - 06. Independent Lower Body Dressing - 06. Independent Shower/Bathe Self - 06. Independent				
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Antonelli, Antonio SN RN on 11/01/2025							25. Date HHA Received Signed POT		
24. Physician's Name and Address Dr. John Doe 3932 Wesley Chapel, FL 33543 PHONE: 333-510-5044 FAX: 12072219995 NPI: 1801093968					26. I certify/recertify that this patient is 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 the services on this plan of care and will periodically review the plan. F2F date :				
27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face					28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws. PAGE 1 of 2				

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including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 06. Independent, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent		Toileting Hygiene - 06. Independent Don/Doff Footwear - 06. Independent Eating - 06. Independent		

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Antonelli, Antonio SN RN	11/01/2025