

Home Health Certification and Plan of Care						Order ID: 1150/14703			
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period		4. Medical Record No.		5. Provider No.	
5A97T15GD69		11/05/2025		From: 11/05/2025 To: 01/03/2026		FaxTest01		217058	
6. Patient's Name and Address Test Fax 12 Boston St., BALTIMORE, MD 21213 999-999-9999					7. Provider's Name, Address and Telephone Number HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239				
8. DOB 08/15/1960 9.Sex Male					10. Medications: Dose/Frequency/Route (N)ew (C)hanged Metformin - Metformin Hydrochloride 500 mg by mouth once a day Simvastatin - Simvastatin 20 mg 1 Tablet by mouth in the evening				
11. ICD 110.		Principal Diagnosis Essential (primary) hypertension			Date 11/05/25				
13. ICD E11.9		Other Pertinent Diagnoses Type 2 diabetes mellitus without complications			Date 11/05/25				
14. DME and Supplies: walker					15. Safety Measures: walker precautions				
16. Nutrition: diabetic					17. Allergies: no known allergies				
18.A. Functional Limitations None of the above					18.B. Activities Permitted Walker				
19. Mental & Psychosocial Status:					COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 2. Sometimes, BEHAVIORAL ISSUES: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required, HISTORY OF DEPRESSION: No				
20. Prognosis:					fair				
22. A Rehabilitation Potential: SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.					22.B.Discharge Plans family/caregiver 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				
Clinical Condition Requiring Homecare:					Diabetes, Hypertension				
SN Careplans					SN Goals				
SN WK1: 1 (11/05/25-11/08/25) ,WK2: 1 (11/09/25-11/15/25) ,WK3: 1 (11/16/25-11/22/25) ,WK4: 1 (11/23/25-11/29/25) ,WK5: 1 (11/30/25-12/06/25)					PATIENT-STATED GOAL: I want to walk without a walker				
PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5, blood sugar < 60 > 300					GOALS patient/caregiver recalls * how to take the patient's blood pressure * record the reading * recalls related medication(s) purpose, schedule				
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance					patient/caregiver recalls * diabetic medication management * blood sugar testing * diabetic foot care * exercise * diabetic diet * recalls related medication(s) purpose, schedule				
HOSPITALIZATION RISKS: 10. None of the above					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				
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; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed. Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day. Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions. Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake. Provide education content at patient's level of health literacy. Assess/Instruct Pt/Pcg: Safety measures to prevent injury. Assess: Musculoskeletal status. Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage. Pt/Pcg educated in pain management techniques including positioning and relaxation techniques Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education., Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.					patient/caregiver recalls * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain * teach relaxation skills and diversional activities * recalls related medication(s) purpose, schedule				
; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all					patient/caregiver recalls * management of mental health condition including joining a peer group * maintaining regular contact with mental health professional * avoiding known stressors * controlling impulses * recalls related medication(s) purpose, schedule				
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by MHCB Team, Other on 11/05/2025					25. Date HHA Received Signed POT				
24. Physician's Name and Address Jane Doe 16600 W Outer DR Wayne County, MI 2449 PHONE: 789-254-7777 FAX: 12072219995 NPI: 7856984123					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 : 11/03/2025				
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				

Home Health Certification and Plan of Care				Order ID: 1150/14703
1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
5A97T15GD69	11/05/2025	From: 11/05/2025 To: 01/03/2026	FaxTest01	217058
6. Patient's Name and Address Test Fax 12 Boston St., BALTIMORE, MD 21213 999-999-9999		7. Provider's Name, Address and Telephone Number HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
new/change meds Advance Directive:No Advance Directive PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, D0700 - Social Isolation, M2020 - Oral Med Management, M1400 - Dyspnea, chest pain, lightheadedness, abnormal BS < 70/140 > mg/dL, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor, coordinate/arrange resources for vision-impaired, coordinate/arrange long-term socialization activities TEACH PATIENT/CAREGIVER: * how to take the patient's blood pressure record the reading, related medication(s) purpose, schedule, * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * diabetic medication management blood sugar testing diabetic foot care exercise diabetic diet, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, * strategies to increase socialization, related medication(s) purpose, schedule		patient/caregiver recalls * strategies to increase socialization * recalls related medication(s) purpose, schedule		

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by MHCB Team, Other	11/05/2025