

| Home Health Certification and Plan of Care                                                                                                                                                                                                                                                                      |  |                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Order ID: 1150/15229            |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--|
| 1. Patient s HI claim No.                                                                                                                                                                                                                                                                                       |  | 2. Start Of Care Date                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 3. Certification Period         |  |
| 8RP5G71YX50                                                                                                                                                                                                                                                                                                     |  | 01/03/2026                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | From: 01/03/2026 To: 03/03/2026 |  |
| 4. Medical Record No.                                                                                                                                                                                                                                                                                           |  | 5. Provider No.                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 11619                           |  |
| 217058                                                                                                                                                                                                                                                                                                          |  |                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                 |  |
| 6. Patient's Name and Address                                                                                                                                                                                                                                                                                   |  |                                                               | 7. Provider's Name, Address and Telephone Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                 |  |
| Jeffrey Brown<br>5941 Prince George ST,<br>GWYNN OAK, MD 21207-<br>443-717-3713                                                                                                                                                                                                                                 |  |                                                               | HomeCentris Healthcare LLC<br>10 Crossroads Drive, Suite 102<br>Owings Mills, MD 21117-8284<br>410-321-8448<br>1487113239                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                 |  |
| 8. DOB                                                                                                                                                                                                                                                                                                          |  |                                                               | 9. Sex                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |  |
| 08/09/1955                                                                                                                                                                                                                                                                                                      |  |                                                               | Male                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |  |
| 11. ICD                                                                                                                                                                                                                                                                                                         |  | Principal Diagnosis                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Date                            |  |
| G31.84                                                                                                                                                                                                                                                                                                          |  | Mild cognitive impairment of uncertain or unknown etiology    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| 13. ICD                                                                                                                                                                                                                                                                                                         |  | Other Pertinent Diagnoses                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Date                            |  |
| I12.9                                                                                                                                                                                                                                                                                                           |  | Hypertensive chronic kidney disease w stg 1-4/unspr chr kdny  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| N18.32                                                                                                                                                                                                                                                                                                          |  | Chronic kidney disease stage 3b                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| K21.9                                                                                                                                                                                                                                                                                                           |  | Gastro-esophageal reflux disease without esophagitis          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| E78.5                                                                                                                                                                                                                                                                                                           |  | Hyperlipidemia unspecified                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| G47.00                                                                                                                                                                                                                                                                                                          |  | Insomnia unspecified                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| J43.9                                                                                                                                                                                                                                                                                                           |  | Emphysema unspecified                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| F17.200                                                                                                                                                                                                                                                                                                         |  | Nicotine dependence unspecified uncomplicated                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| M48.061                                                                                                                                                                                                                                                                                                         |  | Spinal stenosis lumbar region without neurogenic claud        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| N40.0                                                                                                                                                                                                                                                                                                           |  | Benign prostatic hyperplasia without lower urinary tract symp |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| D50.9                                                                                                                                                                                                                                                                                                           |  | Iron deficiency anemia unspecified                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| F33.42                                                                                                                                                                                                                                                                                                          |  | Major depressive disorder recurrent in full remission         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| K59.00                                                                                                                                                                                                                                                                                                          |  | Constipation unspecified                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| F41.9                                                                                                                                                                                                                                                                                                           |  | Anxiety disorder unspecified                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| F11.91                                                                                                                                                                                                                                                                                                          |  | Opioid use unspecified in remission                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| I70.0                                                                                                                                                                                                                                                                                                           |  | Atherosclerosis of aorta                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| E53.8                                                                                                                                                                                                                                                                                                           |  | Deficiency of other specified B group vitamins                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| Z79.82                                                                                                                                                                                                                                                                                                          |  | Long term (current) use of aspirin                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01/03/26                        |  |
| 14. DME and Supplies:                                                                                                                                                                                                                                                                                           |  |                                                               | 15. Safety Measures:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |  |
| None of the above                                                                                                                                                                                                                                                                                               |  |                                                               | transfer with assist, , activity supervision                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                 |  |
| 16. Nutrition:                                                                                                                                                                                                                                                                                                  |  |                                                               | 17. Allergies:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                 |  |
| cardiac diet                                                                                                                                                                                                                                                                                                    |  |                                                               | no known allergies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                 |  |
| 18.A. Functional Limitations                                                                                                                                                                                                                                                                                    |  |                                                               | 18.B. Activities Permitted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                 |  |
| Endurance, Ambulation                                                                                                                                                                                                                                                                                           |  |                                                               | Exercises Prescribed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |  |
| 19. Mental & Pyschosocial Status:                                                                                                                                                                                                                                                                               |  |                                                               | COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, 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: Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                 |  |
| 20. Prognosis:                                                                                                                                                                                                                                                                                                  |  |                                                               | fair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |  |
| 22. A Rehabilitation Potential:                                                                                                                                                                                                                                                                                 |  |                                                               | 22.B.Discharge Plans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                 |  |
| 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. |  |                                                               | family/caregiver will be responsible for managing treatment<br>patient will be responsible for managing treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                 |  |
| Homebound status:                                                                                                                                                                                                                                                                                               |  |                                                               | Due to diagnosis of Mild Cognitive Impairment Of Uncertain Or Unknown Etiology, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                 |  |
| Clinical Condition Requiring Homecare:                                                                                                                                                                                                                                                                          |  |                                                               | <div>The patient is a 70-year-old male recently admitted to home health services following hospitalization and subacute rehabilitation for congestive heart failure (CHF) and altered mental status secondary to a urinary tract infection, for which he received intravenous antibiotics. His past medical history is significant for hypertension, coronary artery disease, hyperlipidemia, chronic kidney disease, emphysema with history of tobacco use, gastroesophageal reflux disease, benign prostatic hyperplasia, spinal stenosis, depression, severe opioid use disorder, and mild cognitive impairment with intermittent confusion. The patient is currently residing in his daughter's multi-level home, where she provides assistance with all activities of daily living (ADLs) and instrumental activities of daily living (IADLs) as needed and manages his medications. At the time of start of care, the patient declined home health aide services; occupational therapy was ordered to assess needs, and both physical and occupational therapy evaluations were completed.&nbsp; On <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, the patient was alert and oriented to person, place, and time. He denied pain and shortness of breath. Lung sounds were diminished bilaterally. Appetite was reported as good, with last bowel movement occurring the day prior to <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>. The patient was ambulatory within the home without the use of an assistive device and demonstrated no strength deficits. Vital observations were stable, and no acute distress was noted. He was independent with upper and lower body dressing, bathing in the shower, sit-to-stand transfers, toilet transfers, and tub/shower transfers. Bilateral upper extremity muscle strength was within normal limits at 5/5 on manual muscle testing. Although previously independent with ambulation prior to hospitalization, his functional status had been intermittently limited by cognitive changes; however, at this time he demonstrated safe independent mobility with no skilled physical therapy needs identified. Occupational therapy evaluation likewise determined that no further OT services were required, as the patient remained independent in self-care tasks and mobility, with assistance needed only for medication management and IADLs.&nbsp; Skilled nursing reviewed all medications with the patient and his daughter, including doses, frequency, indications, and pertinent side effects. A medication profile with medication purposes was created and placed in the home. Education was initiated regarding CHF management, including disease process and general self-monitoring principles. Both the patient and his daughter were receptive to all education provided and demonstrated understanding. The skilled nursing frequency was established as 1 week for 1 week, then 2 weeks for 1 week, followed by 3 weeks for 1 week. The patient has a follow-up appointment scheduled with his primary care provider on 01/06/26. The plan of care includes continued skilled nursing |                                 |  |
| 23. Signature and Date of Verbal SOC Where Applicable:                                                                                                                                                                                                                                                          |  |                                                               | 25. Date HHA Received Signed POTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                 |  |
| Electronically Signed by Messick, Charles RN on 01/03/2026                                                                                                                                                                                                                                                      |  |                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                 |  |
| 24. Physician's Name and Address                                                                                                                                                                                                                                                                                |  |                                                               | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                 |  |
| Shirley Lee<br>7141 Security Blvd<br>Baltimore, MD 21244<br>PHONE: (443) 663-6000 FAX: 14436636295 NPI: 1730398819                                                                                                                                                                                              |  |                                                               | F2F date : 12/25/2025                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                 |  |
| 27. Attending Physician's Signature and Date Signed                                                                                                                                                                                                                                                             |  |                                                               | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |  |
| Date of physician last face-to-face                                                                                                                                                                                                                                                                             |  |                                                               | PAGE 1 of 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                 |  |

| Home Health Certification and Plan of Care                                                                       |                       |                                                                                                                                                                               |                       | Order ID: 1150/15229 |
|------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------|
| 1. Patient s HI claim No.                                                                                        | 2. Start Of Care Date | 3. Certification Period                                                                                                                                                       | 4. Medical Record No. | 5. Provider No.      |
| 8RP5G71YX50                                                                                                      | 01/03/2026            | From: 01/03/2026 To: 03/03/2026                                                                                                                                               | 11619                 | 217058               |
| 6. Patient's Name and Address<br>Jeffrey Brown<br>5941 Prince George ST,<br>GWYNN OAK, MD 21207-<br>443-717-3713 |                       | 7. Provider's Name, Address and Telephone Number<br>HomeCentris Healthcare LLC<br>10 Crossroads Drive, Suite 102<br>Owings Mills, MD 21117-8284<br>410-321-8448<br>1487113239 |                       |                      |

<mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-1 CE-FMS-visits">visits</mh> for ongoing <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-8 CE-FMS-assessment">assessment</mh>, medication management oversight, CHF education reinforcement, and monitoring of cardiopulmonary and cognitive status, with continued family support for ADLs and IADLs.</div><div><br></div><div><span style="white-space: pre; white-space: normal;"> </span></div><div>Date of Order</div><div>01/03/2026</div><div>Orders</div><div>Physician Face-to-Face Date: 12/25/2025</div><div>Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval &amp; treat ot-eval &amp; treat hha-adl's due to Mild Cognitive Impairment Of Uncertain Or Unknown Etiology</div><div>Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</div><div><br></div><div><span style="white-space: pre; white-space: normal;"> </span></div><div><div>1 - SOC - SN Notes: soc</div><div>PT Eval Notes:</div><div>OT Eval Notes:</div><div><br></div><div>Physician</div><div>Lee, Shirley</div>

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>SN Careplans</p> <p>SN WK1: 1 (01/03/26-01/03/26) ,WK2: 1 (01/04/26-01/10/26) ,WK3: 1 (01/11/26-01/17/26) ,WK4: 1 (01/18/26-01/24/26) ,WK5: 1 (01/25/26-01/31/26) ,WK6: 1 (02/01/26-02/07/26) ,WK7: 1 (02/08/26-02/14/26)</p> <p>PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature &lt; 95 &gt; 100.5, heart rate &lt; 50 &gt; 110, respiratory rate &lt; 8 &gt; 22, blood pressure systolic &lt; 90 &gt; 169, blood pressure diastolic &lt; 60 &gt; 90, O2 saturation &lt; 88 &gt; 100, pain &lt; 0 &gt; 5</p> <p>CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance</p> <p>HOSPITALIZATION RISKS: 5. Decline in mental, emotional, or behavioral status in the past 3 months, 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 7. Currently taking 5 or more medications, 8. Currently reports exhaustion</p> <p>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; 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 new/change meds<br/>Advance Directive:No Advance Directive</p> <p>PROBLEMS IDENTIFIED ON ASSESSMENT: M1745 - Behavioral Issues, D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, lung sounds not clear, limited strength, limited endurance, balance deficit</p> <p>PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises</p> <p>TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage cardiac condition including symptom management diet changes regular exercise getting enough sleep, 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 medicatio, * prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related m, * how to keep home safe for patient with dementia coping strategies for the caregiver, related medication(s) purpose, schedule, * how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet exercise monitoring of blood pressure blood sugar home, related medication(s) purpose, sch, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, * 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, * how to promote optimized mobility with strength balance dexterity range-of-motion therapeutic exercises promotion of peripheral circulation fluid and diet intake to promote healing prevent cons, * strategies to minimize fatigue and exhaustion including work simplification energy conservation lifestyle changes diet, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, meal preparation is available to patient for all meals</p> | <p>SN Goals</p> <p>PATIENT-STATED GOAL: i want my health to improve</p> <p>GOALS</p> <p>patient/caregiver recalls</p> <ul style="list-style-type: none"><li>* how to keep home safe for patient with dementia</li><li>* coping strategies for the caregiver</li><li>* recalls related medication(s) purpose, schedule</li></ul> <p>patient/caregiver recalls</p> <ul style="list-style-type: none"><li>* how to incorporate lifestyle modifications to optimize renal condition including renal-specific diet</li><li>* exercise</li><li>* monitoring of blood pressure</li><li>* blood sugar</li><li>* home</li><li>* recalls related medication(s) purpose, sch</li></ul> <p>patient/caregiver recalls</p> <ul style="list-style-type: none"><li>* lifestyle modifications to manage respiratory condition including diet changes and regular exercise</li><li>* strategies to control shortness of breath</li><li>* home remedies to keep lungs healthy</li><li>* recalls related medicatio</li></ul> <p>patient/caregiver recalls</p> <ul style="list-style-type: none"><li>* how to promote optimized mobility with strength</li><li>* balance</li><li>* dexterity</li><li>* range-of-motion therapeutic exercises</li><li>* promotion of peripheral circulation</li><li>* fluid and diet intake to promote healing</li><li>* prevent cons</li></ul> <p>patient/caregiver recalls</p> <ul style="list-style-type: none"><li>* depression-prevention strategies including avoidance of isolation</li><li>* healthy eating</li><li>* sleeping habits</li><li>* identification of activities that bring pleasure</li><li>* preventive care</li><li>* recalls related medication(s) purpos</li></ul> <p>patient/caregiver recalls</p> <ul style="list-style-type: none"><li>* prevention exacerbation of anxiety condition including coping patterns</li><li>* improved concentration</li><li>* strategies to reduce anxiety</li><li>* identification of anxiety precipitants, conflicts, and threats</li><li>* recalls related m</li></ul> <p>patient/caregiver recalls</p> <ul style="list-style-type: none"><li>* lifestyle modifications to manage cardiac condition including symptom management</li><li>* diet changes</li><li>* regular exercise</li><li>* getting enough sleep</li><li>* recalls related medication(s) purpose, schedule</li></ul> <p>patient/caregiver recalls</p> <ul style="list-style-type: none"><li>* management of mental health condition including joining a peer group</li><li>* maintaining regular contact with mental health professional</li><li>* avoiding known stressors</li><li>* controlling impulses</li><li>* recalls related medication(s</li></ul> <p>patient/caregiver recalls</p> <ul style="list-style-type: none"><li>* strategies to minimize fatigue and exhaustion including work simplification</li><li>* energy conservation</li><li>* lifestyle changes</li><li>* diet</li><li>* recalls related medication(s) purpose, schedule</li></ul> <p>patient self-administers medications as prescribed</p> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                              |             |
|----------------------------------------------|-------------|
| Signature of Physician:                      | Date        |
|                                              | PAGE 2 of 3 |
| Optional Name/Signature of Nurse/Therapist:  | Date        |
| Electronically Signed by Messick, Charles RN | 01/03/2026  |

|                                                                                                                  |                       |                                                                                                                                                                               |                       |                      |
|------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------|
| Home Health Certification and Plan of Care                                                                       |                       |                                                                                                                                                                               |                       | Order ID: 1150/15229 |
| 1. Patient s HI claim No.                                                                                        | 2. Start Of Care Date | 3. Certification Period                                                                                                                                                       | 4. Medical Record No. | 5. Provider No.      |
| 8RP5G71YX50                                                                                                      | 01/03/2026            | From: 01/03/2026 To: 03/03/2026                                                                                                                                               | 11619                 | 217058               |
| 6. Patient's Name and Address<br>Jeffrey Brown<br>5941 Prince George ST,<br>GWYNN OAK, MD 21207-<br>443-717-3713 |                       | 7. Provider's Name, Address and Telephone Number<br>HomeCentris Healthcare LLC<br>10 Crossroads Drive, Suite 102<br>Owings Mills, MD 21117-8284<br>410-321-8448<br>1487113239 |                       |                      |

|  |                                                        |
|--|--------------------------------------------------------|
|  | * recalls related medication(s) purpose, schedule      |
|  | meal preparation is available to patient for all meals |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| PT Careplans<br><br>PT WK2: 1 (01/04/26-01/10/26)<br><br>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<br><br>PROCEDURES: gait training on uneven surfaces, gait training/stair training, transfers training<br><br>TEACH PATIENT/CAREGIVER: * 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 medicatio, Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance | PT Goals<br><br>PATIENT-STATED GOAL: To be mentally stable<br><br>GOALS<br>Chair to Bed to Chair - 06. Independent<br><br>Toilet Transfer - 06. Independent<br><br>Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance<br><br>1 - Step (curb) - 05. Setup or clean-up assistance<br><br>patient/caregiver recalls<br>* lifestyle modifications to manage respiratory condition including<br>* diet changes and regular exercise<br>* strategies to control shortness of breath<br>* home remedies to keep lungs healthy<br>* recalls related medicatio<br><br>Sit to Stand - 06. Independent<br><br>Car Transfer - 06. Independent<br><br>Walk 10 Feet - 05. Setup or clean-up assistance<br><br>Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance<br><br>Walk 150 Feet - 05. Setup or clean-up assistance<br><br>4 Steps - 05. Setup or clean-up assistance<br><br>12 Steps - 05. Setup or clean-up assistance<br><br>Picking Up Object - 05. Setup or clean-up assistance |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| OT Careplans<br><br>OT WK1: 6 (01/04/26-01/10/26)<br><br>PROBLEMS IDENTIFIED ON ASSESSMENT: M1400, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating<br><br>TEACH PATIENT/CAREGIVER: * 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 medicatio, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent | OT Goals<br><br>PATIENT-STATED GOAL: OT eval only<br><br>GOALS<br>Shower/Bathe Self - 05. Setup or clean-up assistance<br><br>patient/caregiver recalls<br>* lifestyle modifications to manage respiratory condition including<br>* diet changes and regular exercise<br>* strategies to control shortness of breath<br>* home remedies to keep lungs healthy<br>* recalls related medicatio<br><br>Oral Hygiene - 06. Independent<br><br>Toileting Hygiene - 06. Independent<br><br>Lower Body Dressing - 06. Independent<br><br>Don/Doff Footwear - 06. Independent<br><br>Eating - 06. Independent<br><br>Upper Body Dressing - 06. Independent |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                              |             |
|----------------------------------------------|-------------|
| Signature of Physician:                      | Date        |
|                                              | PAGE 3 of 3 |
| Optional Name/Signature of Nurse/Therapist:  | Date        |
| Electronically Signed by Messick, Charles RN | 01/03/2026  |