

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Home Health Certification and Plan of Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                   |  | Order ID: 1150/15314                                                                                                                                                                                                                                                                                                              |  |
| 1. Patient s HI claim No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2. Start Of Care Date                             |  | 3. Certification Period                                                                                                                                                                                                                                                                                                           |  |
| 721034412                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12/24/2025                                        |  | From: 12/24/2025 To: 02/21/2026                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                   |  | 4. Medical Record No.                                                                                                                                                                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                   |  | 7193                                                                                                                                                                                                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                   |  | 5. Provider No.                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                   |  | 217058                                                                                                                                                                                                                                                                                                                            |  |
| 6. Patient's Name and Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                   |  | 7. Provider's Name, Address and Telephone Number                                                                                                                                                                                                                                                                                  |  |
| Mary Botto                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                   |  | HomeCentris Healthcare LLC                                                                                                                                                                                                                                                                                                        |  |
| 276 Mackintosh Drive,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                   |  | 10 Crossroads Drive, Suite 102                                                                                                                                                                                                                                                                                                    |  |
| GLEN BURNIE, MD 21061-                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                   |  | Owings Mills, MD 21117-8284                                                                                                                                                                                                                                                                                                       |  |
| 410-768-1279                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                   |  | 410-321-8448                                                                                                                                                                                                                                                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                   |  | 1487113239                                                                                                                                                                                                                                                                                                                        |  |
| 8. DOB 07/07/1951                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                   |  | 9. Sex Female                                                                                                                                                                                                                                                                                                                     |  |
| 11. ICD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Principal Diagnosis                               |  | Date                                                                                                                                                                                                                                                                                                                              |  |
| G89.29                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | Other chronic pain                                |  | 12/24/25                                                                                                                                                                                                                                                                                                                          |  |
| 13. ICD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Other Pertinent Diagnoses                         |  | Date                                                                                                                                                                                                                                                                                                                              |  |
| M54.50                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | Low back pain unspecified                         |  | 12/24/25                                                                                                                                                                                                                                                                                                                          |  |
| M25.552                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | Pain in left hip                                  |  | 12/24/25                                                                                                                                                                                                                                                                                                                          |  |
| J44.9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | Chronic obstructive pulmonary disease unspecified |  | 12/24/25                                                                                                                                                                                                                                                                                                                          |  |
| M41.9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | Scoliosis unspecified                             |  | 12/24/25                                                                                                                                                                                                                                                                                                                          |  |
| F41.9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | Anxiety disorder unspecified                      |  | 12/24/25                                                                                                                                                                                                                                                                                                                          |  |
| 10. Medications: Dose/Frequency/Route (N)ew (C)hanged                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Albuterol (PROAIR/PROVENTIL/VENTOLIN) 90 mcg/act, Inhale 2 puffs by mouth every 4 hours as needed for cough , shortness of breath or wheezing (Rescue inhaler)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Paxil - Paroxetine Hydrochloride eq 40 mg base 40 MG, 1 tab by mouth once a day depression                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Lorazepam - Lorazepam 0.5 mg 0.5mg; 1 tab by mouth three times a day anti-anxiety                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Latuda - Lurasidone Hydrochloride 40 mg 40mg; 1 tab by mouth once a day mood                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Prozac - Fluoxetine Hydrochloride eq 20 mg base 20mg; 1 tab by mouth in the evening depression                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Zofran - Ondansetron Hydrochloride eq 4 mg base 4mg; 1 tab by mouth as necessary 3 times a day for nausea                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Arava - Leflunomide 20 mg 20 mg, take 1 tablet by mouth once a day arthritis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Xeljanz - Tofacitinib Citrate 5mg; 1 tab by mouth twice a day arthritis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Zocor - Simvastatin 10 mg 10 MG, TAKE 1 TABLET by mouth once a day cholesterol                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Singulair - Montelukast Sodium eq 10 mg base 10 mg, take 1 tablet by mouth once a day allergies                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Prilosec - Omeprazole 20 mg 20 mg, take 1 capsule by mouth twice a day stomach                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Spiriva Respimat - Tiotropium Bromide 2.5 mcg/act, Inhale 2 puffs by mouth once a day copd                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Budesonide-Formoterol (BREYNA) 160-4.5 mcg/actuation, Inhale 2 puffs by mouth four times a day With spacer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| COPD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Fosamax - Alendronate Sodium eq 70 mg base 70 MG, TAKE 1 TABLET by mouth once a week Take in the morning with 8 ounces of water at least 30 minutes before the first food, drink or other medication of the day. Do not lie down for at least 30 minutes after swallowing this medication                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| 14. DME and Supplies:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                   |  | 15. Safety Measures:                                                                                                                                                                                                                                                                                                              |  |
| walker, cane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                   |  | ambulates with device, walker precautions, , ambulates with assistance, transfer with assist, supervision at all times, activity supervision                                                                                                                                                                                      |  |
| 16. Nutrition:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                   |  | 17. Allergies:                                                                                                                                                                                                                                                                                                                    |  |
| Z. NO PHYSICIAN-ORDERED DIET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                   |  | advair diskus lithium methotrexate codeine plaquenil                                                                                                                                                                                                                                                                              |  |
| 18.A. Functional Limitations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                   |  | 18.B. Activities Permitted                                                                                                                                                                                                                                                                                                        |  |
| Endurance, Ambulation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                   |  | Up As Tolerated, Cane, Walker, Exercises Prescribed                                                                                                                                                                                                                                                                               |  |
| 19. Mental & Pyschosocial Status: COGNITION: 1. Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions., ANXIETY: 1. In new or complex situations only, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| 20. Prognosis: fair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| 22. A Rehabilitation Potential:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                   |  | 22.B.Discharge Plans                                                                                                                                                                                                                                                                                                              |  |
| SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                   |  | family/caregiver will be responsible for managing treatment                                                                                                                                                                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                   |  | patient will be responsible for managing treatment                                                                                                                                                                                                                                                                                |  |
| Homebound status: Due to diagnosis of Other Chronic Pain, 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><span style="font-size: 14px;">The patient is a 73-year-old female with a complex medical history significant for chronic lower back pain, chronic hip pain, kyphosis/scoliosis, worsening mobility limitations, COPD, anxiety with reported panic attacks, arthritis, and a prior L1 compression fracture sustained approximately two years ago. Additional past medical history includes left hip degenerative changes, mild left hip abductor tendinopathy, sinus tachycardia, left ovarian cyst, cholelithiasis, and colonic diverticulosis without evidence of diverticulitis. The patient is known to this clinician from a prior episode of care approximately five to six months ago. She resides in a split-foyer home with her daughter, Toni, who provides frequent assistance. The patient remains on the main level of the home, which requires negotiation of seven steps, and she ambulates only short distances using a rollator due to kyphotic posture, unsteady gait, decreased balance, and reduced endurance. No falls have been reported within the past year; however, she remains at high risk for falls and functional decline.&nbsp; On assessment, the patient was awake, alert, and oriented to person, place, and time, and responded appropriately throughout the visit. She reported severe lower back pain rated at 9/10 and worsening tremors, along with heightened anxiety and near-panic symptoms, during which she requested evaluation in the emergency department. No signs of acute distress were observed, and the patient denied shortness of breath. Lung sounds were clear to auscultation throughout. Appetite was reported as fair, and the last bowel movement occurred on the day of assessment. Kyphotic posture was clearly noted, with slow, unsteady gait requiring the use of a rollator for safe ambulation. The patient also reported intermittent bilateral tingling and numbness in her feet. She requires significant assistance with bathing and demonstrates decreased functional mobility, impaired transfers, poor safety awareness, and increased risk for deconditioning related to chronic pain.&nbsp; The patient is followed by a pain management specialist whom she sees approximately every four months and receives corticosteroid injections to the mid-lower back. She reports transient pain relief lasting approximately one month following injections and is currently due for her next injection at the end of January. She also |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| 23. Signature and Date of Verbal SOC Where Applicable:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                   |  | 25. Date HHA Received Signed POT                                                                                                                                                                                                                                                                                                  |  |
| Electronically Signed by Messick, Charles RN on 12/24/2025                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| 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. |  |
| Umme Yasmin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                   |  | F2F date : 12/19/2025                                                                                                                                                                                                                                                                                                             |  |
| 7670 Quaterfield Rd                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| Pasadena, MD 21122                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| PHONE: 410-508-7650 FAX: 1-410-553-2465 NPI: 1164702874                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                   |  |                                                                                                                                                                                                                                                                                                                                   |  |
| 27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                   |  | 28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.                                                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                   |  | PAGE 1 of 3                                                                                                                                                                                                                                                                                                                       |  |

| Home Health Certification and Plan of Care                                                                     |                       |                                 |                                                                                                                                                                               | Order ID: 1150/15314 |
|----------------------------------------------------------------------------------------------------------------|-----------------------|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| 1. Patient s HI claim No.                                                                                      | 2. Start Of Care Date | 3. Certification Period         | 4. Medical Record No.                                                                                                                                                         | 5. Provider No.      |
| 721034412                                                                                                      | 12/24/2025            | From: 12/24/2025 To: 02/21/2026 | 7193                                                                                                                                                                          | 217058               |
| 6. Patient's Name and Address<br>Mary Botto<br>276 Mackintosh Drive,<br>GLEN BURNIE, MD 21061-<br>410-768-1279 |                       |                                 | 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 |                      |

reports receiving palliative care services through Kaiser, though she has not been seen by the palliative care team in over one month. The patient expressed ongoing frustration regarding the lack of a prescribed back brace, stating she has requested one from her primary care provider multiple times over the past three years without success.&nbsp; Psychiatrically, the patient is under the care of a psychiatrist and participates in regular behavioral therapy sessions. Recent medication adjustments were made by her physician to Paxil and Prozac in response to worsening anxiety and panic symptoms. The skilled nurse completed a comprehensive medication reconciliation, reviewing all medications, dosages, frequencies, and pertinent side effects. Education was provided emphasizing the importance of not self-adjusting or abruptly discontinuing antidepressant medications. The patient and caregiver verbalized understanding. The skilled nurse will continue to monitor the patient for therapeutic response and adverse effects related to recent antidepressant adjustments.&nbsp; During this visit, Kaiser was contacted to report the patient's acute symptoms of worsening pain, tremors, and anxiety. The patient's condition and concerns were communicated, and nursing staff indicated a provider follow-up call would be initiated. At the time of assessment, the patient exhibited no shortness of breath, hemodynamic instability, or signs of acute medical emergency.&nbsp; The patient demonstrates clear need for skilled home health services. Skilled nursing is ordered at a frequency of 1W12W11W5 to monitor pain, respiratory status, medication effectiveness, mental health symptoms, and overall condition. Physical and occupational therapy evaluations have been ordered to address chronic pain, decreased lower extremity strength, impaired balance, unsteady gait, difficulty with transfers and stair negotiation, and reduced functional mobility. Without skilled intervention, the patient remains at significant risk for falls, further functional decline, and loss of independence.&nbsp; The patient meets homebound criteria due to COPD, chronic low back pain, decreased endurance, dyspnea on exertion, impaired mobility, and increased fall risk. Leaving the home requires the use of a walker and caregiver assistance and results in excessive fatigue and heightened safety concerns. The plan of care focuses on pain management, functional mobility improvement, fall prevention, medication monitoring, patient and caregiver education, and coordination of care to support the patient's safety and quality of life within the home.</span></div><div><span style="white-space: pre; font-size: 14px; white-space: normal;"></span></div><div><span style="font-size: 14px;"><br></span></div><div><span style="font-size: 14px;">Date of Order</span></div><div><span style="font-size: 14px;">12/24/2025</span></div><div><span style="font-size: 14px;">Orders</span></div><div><span style="font-size: 14px;">Physician Face-to-Face Date: 12/19/2025</span></div><div><span style="font-size: 14px;">Clinical Condition Requiring Home Care per Certifying Physician: SN disease management, PR eval and treat, OT eval and treat HHA due to Other Chronic Pain</span></div><div><span style="font-size: 14px;">Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home</span></div><div><span style="white-space: pre; font-size: 14px; white-space: normal;"></span></div><div><span style="font-size: 14px;"><br></span></div><div><span style="font-size: 14px;">1 - SOC - SN Notes: soc</span></div><div><span style="font-size: 14px;">PT Eval Notes:</span></div><div><span style="font-size: 14px;">OT Eval Notes:</span></div><div><span style="font-size: 14px;"><br></span></div><div><span style="font-size: 14px;">Yasmin, Umme</span></div>

SN Careplans

SN WK1: 1 (12/24/25-12/27/25) ,WK2: 1 (12/28/25-01/03/26) ,WK3: 1 (01/04/26-01/10/26) ,WK4: 1 (01/11/26-01/17/26) ,WK5: 1 (01/18/26-01/24/26) ,WK6: 1 (01/25/26-01/31/26) ,WK7: 1 (02/01/26-02/07/26) ,WK8: 1 (02/08/26-02/14/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance

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

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  
Advance Directive:Living Will

PROBLEMS IDENTIFIED ON ASSESSMENT: M1720 - Anxiety, D0160 - Depression, M2020 - Oral Med Management, meal preparation, M1033 - Exhaustion, M1400 - Dyspnea, limited strength, limited range of motion, muscle spasms, limited endurance, Pain Effect on Sleep, Pain Interference with ADLs, balance deficit

PROCEDURES: Medication Review- : Medications reviewed with patient/caregiver. , cough/deep breathing exercises

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, \* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxatio, \* prevention exacerbation of anxiety condition including coping patterns improved concentration strategies to reduce anxiety identification of anxiety precipitants, conflicts, and threats, related m, \* depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpos, \* 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

SN Goals

PATIENT-STATED GOAL: I WANT MY PAIN TO GET BETTER

GOALS  
patient/caregiver recalls  
\* prevention exacerbation of anxiety condition including coping patterns  
\* improved concentration  
\* strategies to reduce anxiety  
\* identification of anxiety precipitants, conflicts, and threats  
\* recalls related m

patient/caregiver recalls  
\* depression-prevention strategies including avoidance of isolation  
\* healthy eating  
\* sleeping habits  
\* identification of activities that bring pleasure  
\* preventive care  
\* recalls related medication(s) purpos

meal preparation is available to patient for all meals

patient/caregiver recalls  
\* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain  
\* teach relaxatio

patient/caregiver recalls  
\* strategies to minimize fatigue and exhaustion including work simplification  
\* energy conservation  
\* lifestyle changes  
\* diet  
\* recalls related medication(s) purpose, schedule

patient/caregiver recalls  
\* lifestyle modifications to manage respiratory condition including  
\* diet changes and regular exercise  
\* strategies to control shortness of breath  
\* home remedies to keep lungs healthy  
\* recalls related medicatio

patient/caregiver recalls  
\* 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

patient self-administers medications as prescribed  
\* recalls related medication(s) purpose, schedule

|                                              |             |
|----------------------------------------------|-------------|
| PT Careplans                                 | PT Goals    |
| Signature of Physician:                      | Date        |
|                                              | PAGE 2 of 3 |
| Optional Name/Signature of Nurse/Therapist:  | Date        |
| Electronically Signed by Messick, Charles RN | 12/24/2025  |

| Home Health Certification and Plan of Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                       |                                 | Order ID: 1150/15314                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                       |                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------|
| 1. Patient s HI claim No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 2. Start Of Care Date | 3. Certification Period         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4. Medical Record No. | 5. Provider No. |
| 721034412                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12/24/2025            | From: 12/24/2025 To: 02/21/2026 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 7193                  | 217058          |
| 6. Patient's Name and Address<br>Mary Botto<br>276 Mackintosh Drive,<br>GLEN BURNIE, MD 21061-<br>410-768-1279                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                       |                                 | 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                       |                 |
| <p>PT WK2: 1 (12/28/25-01/03/26) ,WK3: 2 (01/04/26-01/10/26) ,WK4: 2 (01/11/26-01/17/26) ,WK5: 2 (01/18/26-01/24/26) ,WK6: 1 (01/25/26-01/31/26) ,WK7: 1 (02/01/26-02/07/26) ,WK8: 1 (02/08/26-02/14/26)</p> <p>PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, M1400 Dyspnea, GG0170F1 - Toilet Transfer - 05. Setup or clean-up assistance, GG0170D1 - Sit to Stand - 02. Substantial/maximal assistance, GG0170E1 - Chair to Bed to Chair - 02. Substantial/maximal assistance, GG0170G1 - Car Transfer - 02. Substantial/maximal assistance, GG0170I1 - Walk 10 Feet - 02. Substantial/maximal assistance, GG0170J1 - Walk 50 ft with 2 Turns - 02. Substantial/maximal assistance, GG0170K1 - Walk 150 Feet - 02. Substantial/maximal assistance, GG0170L1 - Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance, GG0170M1 - 1 - Step (curb) - 02. Substantial/maximal assistance, GG0170N1 - 4 Steps - 02. Substantial/maximal assistance, GG0170O1 - 12 Steps - 02. Substantial/maximal assistance, GG0170P1 - Picking Up Object - 02. Substantial/maximal assistance</p> <p>PROCEDURES: cough/deep breathing exercises, heat application: Apply heat to low back x 20 minutes with necessary barrier and skin assessments q 5 minutes., home exercise program: Seated-LAQ hip flex, hip abd, pillow squeeze. Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training/stair training, transfers training, assist with fall prevention</p> <p>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, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxatio, Toilet Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Car Transfer - 05. Setup or clean-up assistance, Chair to Bed to Chair - 02. Substantial/maximal assistance, Sit to Stand - 06. Independent, Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance</p> |  |                       |                                 | <p>PATIENT-STATED GOAL: I want to be able to walk</p> <p>GOALS</p> <p>Toilet Transfer - 06. Independent</p> <p>patient/caregiver recalls</p> <p>* lifestyle modifications to manage respiratory condition including</p> <p>* diet changes and regular exercise</p> <p>* strategies to control shortness of breath</p> <p>* home remedies to keep lungs healthy</p> <p>* recalls related medicatio</p> <p>patient/caregiver recalls</p> <p>* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain</p> <p>* teach relaxatio</p> <p>Walk 150 Feet - 04. Supervision or touching assistance</p> <p>1 - Step (curb) - 04. Supervision or touching assistance</p> <p>4 Steps - 04. Supervision or touching assistance</p> <p>12 Steps - 04. Supervision or touching assistance</p> <p>Picking Up Object - 04. Supervision or touching assistance</p> <p>Car Transfer - 05. Setup or clean-up assistance</p> <p>Chair to Bed to Chair - 02. Substantial/maximal assistance</p> <p>Sit to Stand - 06. Independent</p> <p>Walk 10 ft on Uneven Surface - 02. Substantial/maximal assistance</p> <p>Walk 10 Feet - 04. Supervision or touching assistance</p> <p>Walk 50 ft with 2 Turns - 04. Supervision or touching assistance</p> |                       |                 |
| OT Careplans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                       |                                 | OT Goals                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                       |                 |
| <p>OT WK1: 1 (12/24/25-12/27/25) ,WK2: 1 (12/28/25-01/03/26) ,WK4: 1 (01/11/26-01/17/26) ,WK5: 1 (01/18/26-01/24/26)</p> <p>PROBLEMS IDENTIFIED ON ASSESSMENT: Pain Effect on Sleep, Pain Interference with ADLs, M1400 - Dyspnea, GG0130B1 - Oral Hygiene - 05. Setup or clean-up assistance, GG0130F1 - Upper Body Dressing - 05. Setup or clean-up assistance, GG0130G1 - Lower Body Dressing - 05. Setup or clean-up assistance, GG0130H1 - Don/Doff Footwear - 05. Setup or clean-up assistance, GG0130E1 - Shower/Bathe Self - 03. Partial/moderate assistance, GG0130C1 - Toileting Hygiene - 05. Setup or clean-up assistance, GG0130A1 - Eating - 05. Setup or clean-up assistance</p> <p>PROCEDURES: cough/deep breathing exercises, incentive spirometer, equipment training, work simplification/energy conservation</p> <p>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, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxatio, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                       |                                 | <p>PATIENT-STATED GOAL: to be more stable</p> <p>GOALS</p> <p>patient/caregiver recalls</p> <p>* lifestyle modifications to manage respiratory condition including</p> <p>* diet changes and regular exercise</p> <p>* strategies to control shortness of breath</p> <p>* home remedies to keep lungs healthy</p> <p>* recalls related medicatio</p> <p>patient/caregiver recalls</p> <p>* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain</p> <p>* teach relaxatio</p> <p>Toileting Hygiene - 06. Independent</p> <p>Lower Body Dressing - 06. Independent</p> <p>Don/Doff Footwear - 06. Independent</p> <p>Upper Body Dressing - 06. Independent</p> <p>Oral Hygiene - 06. Independent</p> <p>Shower/Bathe Self - 04. Supervision or touching assistance</p> <p>Eating - 06. Independent</p>                                                                                                                                                                                                                                                                                                                                                                                                                        |                       |                 |
| HHA Careplans                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                       |                                 | HHA Goals                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                       |                 |
| <p>HHA WK3: 1 (01/04/26-01/10/26) ,WK4: 1 (01/11/26-01/17/26) ,WK5: 1 (01/18/26-01/24/26) ,WK6: 1 (01/25/26-01/31/26)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                       |                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                       |                 |
| Signature of Physician:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                       |                                 | Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                       |                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                       |                                 | PAGE 3 of 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                       |                 |
| Optional Name/Signature of Nurse/Therapist:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                       |                                 | Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                       |                 |
| Electronically Signed by Messick, Charles RN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                       |                                 | 12/24/2025                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                       |                 |