

Home Health Certification and Plan of Care					Order ID: 179/12723				
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period		4. Medical Record No.		5. Provider No.	
5W46E57XN05		11/03/2025		From: 11/03/2025 To: 01/01/2026		7671		242353	
6. Patient's Name and Address Jeff Hardey 4014 E Pima Street, TUCSON, AZ 85712 988-768-6323					7. Provider's Name, Address and Telephone Number Home Health Cares 579# EAST MARKET@STREETS HARRISONBURG, VA 22801-1234 540-433-7146 1234567891				
8. DOB 04/02/1947 9.Sex Male					10. Medications: Dose/Frequency/Route (N)ew (C)hanged Tylenol Extra Strength - Acetaminophen 500 mg by mouth once a day 0 - Acetaminophen: Oxycodone Hydrochloride 5 mg by mouth once a day Plavix - Clopidogrel Bisulfate eq 300 mg base by mouth once a day				
11. ICD J44.9		Principal Diagnosis Chronic obstructive pulmonary disease unspecified			Date 11/03/25				
13. ICD		Other Pertinent Diagnoses			Date				
14. DME and Supplies: cane					15. Safety Measures: None of the above				
16. Nutrition: Z. NO PHYSICIAN-ORDERED DIET					17. Allergies: no known allergies				
18.A. Functional Limitations None of the above					18.B. Activities Permitted Cane				
19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No									
20. Prognosis: fair									
22. A Rehabilitation Potential: SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.					22.B.Discharge Plans patient will be responsible for managing treatment				
Homebound status: PLACEHOLDER									
Clinical Condition Requiring Homecare: Asthma									
SN Careplans SN WK1: 1 (11/03/25-11/08/25) ,WK2: 1 (11/09/25-11/15/25) ,WK3: 1 (11/16/25-11/22/25) ,WK9: 1 (12/28/25-01/01/26) PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 98 > 99, heart rate < 50 > 80, respiratory rate < 8 > 15, blood pressure systolic < 100 > 150, blood pressure diastolic < 50 > 100, O2 saturation < 98 > 101, pain < 0 > 5 CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance HOSPITALIZATION RISKS: 10. None of the above STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits Advance Directive:No Advance Directive PROBLEMS IDENTIFIED ON ASSESSMENT: , A1250 - Lack of Necessary Transportation, M2020 - Oral Med Management, Financial, Home Safety, M1400 - Dyspnea, cramping calves/thighs/hips, weak hand grips PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange repair of inadequate heating, coordinate/arrange access to medicine/medical supplies considering patient inability to pay, coordinate/arrange transportation services 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, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient has adequate heating, patient has access to medicine/medical supplies considering inability to pay					SN Goals PATIENT-STATED GOAL: to feel better GOALS 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 self-administers medications as prescribed * recalls related medication(s) purpose, schedule patient's transportation needs are met patient has adequate heating patient has access to medicine/medical supplies considering inability to pay				
PT Careplans PT WK1: 1 (11/03/25-11/08/25) ,WK2: 1 (11/09/25-11/15/25) ,WK3: 1 (11/16/25-11/22/25) PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0170F1 - Toilet Transfer, GG0170D1 - Sit to Stand, GG0170E1 - Chair to Bed to Chair, GG0170G1 - Car Transfer, GG0170I1 - Walk 10 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170K1 - Walk 150 Feet, GG0170L1 - Walk 10 ft on Uneven Surface, GG0170M1 - 1 - Step (curb), GG0170N1 - 4 Steps, GG0170O1 - 12 Steps, GG0170P1 - Picking Up Object PROCEDURES: cough/deep breathing exercises, incentive spirometer, gait training on uneven surfaces, gait training/stair training, transfers training TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath					PT Goals PATIENT-STATED GOAL: add patient-stated goal GOALS Chair to Bed to Chair - 06. Independent Toilet Transfer - 06. Independent 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				
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by Smith, Sandra PT PTA on 11/03/2025							25. Date HHA Received Signed POT		
24. Physician's Name and Address Joy De Castro maine, ME PHONE: 2077499791 FAX: 12072219995 NPI: 1801093968					26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan. F2F date :				
27. Attending Physician's Signature and Date Signed : Date of physician last face-to-face					28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws. PAGE 1 of 2				

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OT Careplans			OT Goals		
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PROBLEMS IDENTIFIED ON ASSESSMENT: M1400 - Dyspnea, GG0130B1 - Oral Hygiene, GG0130F1 - Upper Body Dressing, GG0130G1 - Lower Body Dressing, GG0130H1 - Don/Doff Footwear, GG0130E1 - Shower/Bathe Self, GG0130C1 - Toileting Hygiene, GG0130A1 - Eating					

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Smith, Sandra PT PTA	11/03/2025