

Home Health Certification and Plan of Care				Order ID: 1150/16075	
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period	
4YG6EJ3TE76		09/17/2025		From: 01/15/2026 To: 03/15/2026	
4. Medical Record No.		5. Provider No.			
9045		217058			
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
John Zareva 570 Bellerive Drive, ANNAPOLIS, MD 21409- 301-655-9931			HomeCentris Healthcare LLC 10 Crossroads Drive, Suite 102 Owings Mills, MD 21117-8284 410-321-8448 1487113239		
8. DOB			9. Sex		
04/05/1938			Male		
11. ICD		Principal Diagnosis		Date	
G89.29		Other chronic pain		09/17/25	
13. ICD		Other Pertinent Diagnoses		Date	
M25.551		Pain in right hip		09/17/25	
M25.561		Pain in right knee		09/17/25	
M79.605		Pain in left leg		09/17/25	
E11.40		Type 2 diabetes mellitus with diabetic neuropathy unsp		09/17/25	
I10.		Essential (primary) hypertension		09/17/25	
I25.10		AthscI heart disease of native coronary artery w/o ang pctrsl		09/17/25	
E78.5		Hyperlipidemia unspecified		09/17/25	
E03.9		Hypothyroidism unspecified		09/17/25	
F32.A		Depression unspecified		09/17/25	
I25.2		Old myocardial infarction		09/17/25	
Z95.1		Presence of aortocoronary bypass graft		09/17/25	
Z91.51		Personal history of suicidal behavior		09/17/25	
Z79.84		Long term (current) use of oral hypoglycemic drugs		09/17/25	
Z79.82		Long term (current) use of aspirin		09/17/25	
14. DME and Supplies:			15. Safety Measures:		
rolling walker, walker,			activity supervision		
16. Nutrition:			17. Allergies:		
Z. NO PHYSICIAN-ORDERED DIET			no known allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
Endurance, Dyspnea With Minimal Exertion, Ambulation, Hearing			Exercises Prescribed, Walker, Independent at Home		
19. Mental & Psychosocial Status:			COGNITION: 0. Able to get to and from the toilet and transfer independently with or without a device., ANXIETY: , SOCIAL ISOLATION: 2 independent, BEHAVIORAL ISSUES: 2 independent, HISTORY OF DEPRESSION:		
20. Prognosis:			fair		
22. A Rehabilitation Potential:			22.B.Discharge Plans		
SELF-CARE: na, MOBILITY: na			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:hypertension, type 2 diabetes mellitus, hypothyroidism, recurrent falls, and recent hospitalization for a mechanical fall resulting in a splenic subcapsular hematoma and left eyebrow laceration. He was hospitalized for two weeks, followed by two weeks of inpatient rehabilitation, and has since transitioned to a single-level apartment in Annapolis arranged by his daughter, Kelly, who resides nearby and provides daily check-ins. The patient also receives home care services and physical therapy. He ambulates with a front-wheeled walker (FWW) and utilizes adaptive equipment such as a bath bench. Despite these supports, he reports experiencing approximately 6-7 falls in the past two months and 9-10 falls in the past year, describing his legs as "giving out" during episodes. His primary goal is to regain functional mobility and return to safe community ambulation without falls. On assessment, the patient is alert and oriented 3, ambulated to the front door to greet the clinician, and denied chest pain, dizziness, or palpitations. He endorses shortness of breath with minimal exertion, which has been ongoing for the past 3-4 months. Lung sounds are clear, bowel sounds are normoactive with a bowel movement documented this morning, urination is without complication, pedal pulses are intact, and no peripheral edema is noted. He reports numbness and tingling in the lower extremities and has cellulitis-related pain in the right leg. He is preparing for upcoming cataract surgery. Functionally, the patient demonstrates right lower extremity pain, bilateral lower extremity weakness, decreased balance, impaired transfers, unsteady gait, and reduced safety awareness. He requires supervision to minimal assistance for safe ambulation with a walker, with cues provided for proper positioning and improved step height and length. Sit-to-stand and turning movements remain challenging. Patient completed seated therapeutic exercises, including hip flexion, long arc quadriceps, hip abduction, and pillow squeezes (115 each). A home exercise program (HEP) was provided and reviewed, with instructions to perform exercises twice daily. Education was provided on safe walker use, fall prevention, and the importance of consistent walker use at all times. The patient verbalized understanding of all instructions. Given his history of frequent falls, functional decline, poor safety awareness, and high risk for further injury, the patient is considered homebound, as leaving the home requires human assistance and an assistive device. He will benefit from skilled physical therapy services to improve lower extremity strength, endurance, functional mobility, transfers, balance, and safety awareness to support independence and reduce fall risk. The plan of care includes home PT with frequency beginning September 17, 2025 (1 visit week one, 2 <mh class="chrome-extension-FindManyStrings chrome-extension-FindManyStrings-style-9 CE-FMS-visits">visits</mh> week two [Tues/Thu], 1 visit week six [Tues]). The patient is in agreement with the PT plan of care. Ongoing skilled services remain medically necessary to optimize safety, prevent further decline, and promote return to prior level of function. Date of Order 01/13/2026 Orders Physician Face-to-Face Date: 09/04/2025 Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat due to Other Chronic Pain Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home 4 -					
23. Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT		
Electronically Signed by Messick, Charles RN on 01/13/2026					
24. Physician's Name and Address			26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.		
Alise Burke 2002 Medical Pkwy Annapolis, MD 21401 PHONE: 4434811150 FAX: 14102240065 NPI: 1891354296			F2F date : 09/04/2025		
27. Attending Physician's Signature and Date Signed			28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.		
02/17/2026 Date of physician last face-to-face			PAGE 1 of 3		

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maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, Oral Hygiene - 06. Independent, Lower Body Dressing - 06. Independent, Shower/Bathe Self - 06. Independent, Toileting Hygiene - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Therapeutic exercise , Medication review , Balance training				

Signature of Physician:	Date
	PAGE 3 of 3
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Messick, Charles RN	01/13/2026