Home Health Certification and Plan of Care

Order ID: 179/12941

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1EG4-TE5-MK72	03/16/2026	From: 03/16/2026 To: 05/14/2026	7900	242353

6. Patient's Name and Address

Kelly Smith
253 MC Bernardo,
SCHENECTADY, NY 12345
120-678-0467

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 03/09/1961 | **9.Sex** Female

11. ICD	Principal Diagnosis	Date
S12.001A	Unsp nondisp fx of first cervical vertebra init for clos fx	03/16/26

13. ICD	Other Pertinent Diagnoses	Date
I10.	Essential (primary) hypertension	03/16/26
E11.9	Type 2 diabetes mellitus without complications	03/16/26
G21.8	Other secondary parkinsonism	03/16/26

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

Eliquis - Apixaban 500mg by mouth once a day
Oxycet - Acetaminophen: Oxycodone Hydrochloride 325 mg;5 mg
Paroxetine Hydrochloride - Paroxetine Hydrochloride eq 10 mg base/5ml
Symadine - Amantadine Hydrochloride 100 mg
Simvastatin - Simvastatin 10 mg
Lexapro - Escitalopram Oxalate eq 5 mg base
Fortamet - Metformin Hydrochloride 500 mg

14. DME and Supplies:

walker, cane

15. Safety Measures:

supervision at all times, transfer with assist, fall precautions, ambulates with device, ambulates with assistance, walker precautions, activity supervision

16. Nutrition:

cardiac diet!diabetic

17. Allergies:

no known allergies

18.A. Functional Limitations

Ambulation, Endurance

18.B. Activities Permitted

Walker

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: 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: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.

22.B.Discharge Plans

patient will be responsible for managing treatment

Homebound status: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home, other

Clinical Condition Requiring Homecare: Fracture and hypertension

SN Careplans

SN Goals

PT Careplans

PT WK1: 2 (03/16/26-03/21/26)

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 < 1 > 8

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months

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: GG0130B1 - Oral Hygiene, GG0170P1 - Picking Up Object, GG0170O1 - 12 Steps, GG0170N1 - 4 Steps, GG0170M1 - 1 - Step (curb), GG0170L1 - Walk 10 ft on Uneven Surface, GG0170K1 - Walk 150 Feet, GG0170J1 - Walk 50 ft with 2 Turns, GG0170I1 - Walk 10 Feet, GG0170G1 - Car Transfer, GG0170D1 - Sit to Stand, GG0130C1 - Toileting Hygiene, GG0170F1 - Toilet Transfer, GG0130E1 - Shower/Bathe Self, GG0130H1 - Don/Doff Footwear, GG0130G1 - Lower Body Dressing, GG0130F1 - Upper Body Dressing, GG0130A1 - Eating, GG0170E1 - Chair to Bed to Chair, M2102c - Med Admin, M2102d - Caregiver Performs Treatment, Home Safety, M2020 - Oral Med Management, M1400 - Dyspnea, M1033 - Unintentional Weight Loss, limited range of motion, muscle weakness, limited strength, limited endurance

PROCEDURES: cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, glucose testing via monitor, home exercise program: issue HEP, equipment training, work simplification/energy conservation, gait training/stair training, transfers training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for maintenance of clean/uncluttered living area

PT Goals

PATIENT-STATED GOAL: walk 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 medication(s) purpose, schedule

patient/caregiver recalls
* strategies to increase caloric intake
* recalls related medication(s) purpose, schedule

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

patient's living environment is clean/uncluttered

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Sit to Stand - 05. Setup or clean-up assistance

Chair to Bed to Chair - 05. Setup or clean-up assistance

Toilet Transfer - 05. Setup or clean-up assistance

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

23. Signature and Date of Verbal SOC Where Applicable:

Electronically Signed by Calija, Mae SN on 03/16/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address

Vel Gabriel
310, NATARAJAPURAM 4TH EAST STREETs
KVP, AL 628502
PHONE: 3216549870 FAX: 12077802774 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 : 03/14/2026

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.

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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 medication(s) purpose, schedule, * strategies to increase caloric intake, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's living environment is clean/uncluttered, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, Sit to Stand - 05. Setup or clean-up assistance, Chair to Bed to Chair - 05. Setup or clean-up assistance, Toilet Transfer - 05. Setup or clean-up assistance, 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, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance, Toileting Hygiene - 05. Setup or clean-up assistance, Shower/Bathe Self - 03. Partial/moderate assistance, Upper Body Dressing - 05. Setup or clean-up assistance, Lower Body Dressing - 05. Setup or clean-up assistance, Don/Doff Footwear - 05. Setup or clean-up assistance, Eating - 06. Independent

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

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Toileting Hygiene - 05. Setup or clean-up assistance

Shower/Bathe Self - 03. Partial/moderate assistance

Upper Body Dressing - 05. Setup or clean-up assistance

Lower Body Dressing - 05. Setup or clean-up assistance

Don/Doff Footwear - 05. Setup or clean-up assistance

Eating - 06. Independent

Signature of Physician:	Date
	PAGE 2 of 2
Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by Calija, Mae SN	03/16/2026