Home Health Certification and Plan of Care

Order ID: 179/13380

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1EG4TE5MK72	06/18/2026	From: 06/18/2026 To: 08/16/2026	8573	242353

6. Patient's Name and Address

Amanda Smith
253 MC Bernardo,
SCHENECTADY, NY 12345
209-000-5678

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 04/06/1962 | **9.Sex** Female

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

Paroxetine Hydrochloride - Paroxetine Hydrochloride eq 20 mg base
Symadine - Amantadine Hydrochloride 100 mg
Simvastatin - Simvastatin 20 mg
Lexapro - Escitalopram Oxalate eq 5 mg base
Fortamet - Metformin Hydrochloride 500 mg
Anaprox - Naproxen Sodium eq 250 mg base
Eliquis - Apixaban 500mg by mouth in the evening

11. ICD	Principal Diagnosis	Date
I10.	Essential (primary) hypertension	06/18/26

13. ICD	Other Pertinent Diagnoses	Date
E11.9	Type 2 diabetes mellitus without complications	06/18/26
L89.312	Pressure ulcer of right buttock stage 2	06/18/26
G21.8	Other secondary parkinsonism	06/18/26

14. DME and Supplies:

feeding tube supplies

15. Safety Measures:

non-weight bearing LLE, no stair use

16. Nutrition:

cardiac diet

17. Allergies:

no known allergies

18.A. Functional Limitations

Hearing

18.B. Activities Permitted

Transfer bed/Chair

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: good

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

family/caregiver 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

Clinical Condition Requiring Homecare: H

SN Careplans

SN WK1: 2 (06/18/26-06/20/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 100, O2 saturation < 88 > 101, pain < 0 > 6

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

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - 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: M2020 - Oral Med Management, Financial, Home Safety, M1400 - Dyspnea, coughing, chest pain, cramping calves/thighs/hips, abnormal sputum production, heartburn/indigestion, painful urination, Pain Effect on Sleep, Pain Interference with Therapy activities, Pain Interference with ADLs, B1000 - Vision Deficit, skin breakdown r/t incontinence, #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Buttock -

PROCEDURES: physician-ordered wound care: #1 - 2 - Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed. - Posterior Right Buttock -, cough/deep breathing exercises, incentive spirometer, physician-ordered wound care: Cover wound with Kerlix wrap., wound vacuum, glucose testing via monitor, coordinate/arrange repair of inadequate heating, coordinate/arrange access to medicine/medical supplies considering patient inability to pay

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, * 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 relaxation skills and diversional activities, related medication(s) purpose, schedule, * how to keep home safe for patient with vision loss including eliminating hazards enhancing lighting using mechanical aids, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient has adequate heating, patient has access to medicine/medical supplies considering inability to pay

SN Goals

PATIENT-STATED GOAL: I want to breathe better without oxygen.

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
* 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 relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for patient with vision loss including eliminating hazards
* enhancing lighting
* using mechanical aids

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

patient has adequate heating

patient has access to medicine/medical supplies considering inability to pay

kdscjasbfkjabsdkj

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Calija, Mae SN on 06/18/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Sung Kim
17542 17th St
, CA 91745
PHONE: 714-734-5500 FAX: 12072219995 NPI: 1235218967

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 : 06/16/2026

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.

Signature of Physician:

Date

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Optional Name/Signature of Nurse/Therapist:
Electronically Signed by Calija, Mae SN on 06/18/2026

Date