Home Health Certification and Plan of Care

Order ID: 179/13495

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1EG4TE5MK72	07/29/2026	From: 07/29/2026 To: 09/26/2026	8733	242353

6. Patient's Name and Address
Alfred Smith
253 MC Bernardo,
SCHENECTADY, NY 12345
390-271-0000

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 04/12/1952 | **9.Sex** Male

11. ICD	Principal Diagnosis	Date
I10.	Essential (primary) hypertension	07/29/26

13. ICD	Other Pertinent Diagnoses	Date
E11.9	Type 2 diabetes mellitus without complications	07/29/26
L89.312	Pressure ulcer of right buttock stage 2	07/29/26
G21.8	Other secondary parkinsonism	07/29/26

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
Eliquis - Apixaban 500mg by mouth once a day
Endocet - Ibuprofen: Oxycodone Hydrochloride 500mg by mouth once a day
Paroxetine Hydrochloride - Paroxetine Hydrochloride eq 10 mg base/5ml
Amantadine Hydrochloride - Amantadine Hydrochloride 100 mg
Simvastatin - Simvastatin 20 mg
Glucophage - Metformin Hydrochloride 500 mg

14. DME and Supplies:
oxygen supplies

15. Safety Measures:
posey while OOB

16. Nutrition:
cardiac diet

17. Allergies:
no known allergies

18.A. Functional Limitations
Hearing

18.B. Activities Permitted
Independent at Home

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: 1. Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required, 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
add discharge plan
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: HTN and DM

SN Careplans

SN WK1: 1 (07/29/26-08/01/26) ,WK2: 1 (08/02/26-08/08/26) ,WK3: 1 (08/09/26-08/15/26) ,WK9: 1 (09/20/26-09/26/26)

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: M1745 - Behavioral Issues, M2020 - Oral Med Management, Financial, Home Safety, cramping calves/thighs/hips, M1400 - Dyspnea, M1620 - Bowel Incontinence, heartburn/indigestion, M1610 - Urinary Incontinence, increased urine output, limited endurance, Pain Interference with ADLs, weak hand grips, Pain Interference with Therapy activities, Pain Effect on Sleep, B1000 - Vision Deficit, skin breakdown r/t incontinence

PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care, wound vacuum, glucose testing via monitor, bladder training, coordinate/arrange repair of inadequate heating, coordinate/arrange access to medicine/medical supplies considering patient inability to pay, coordinate/arrange resources for vision-impaired

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, * management of mental health condition including joining a peer group maintaining regular contact with mental health professional avoiding known stressors controlling impulses, related medication(s) purpose, schedule, * bowel incontinence management including dietary changes bowel training skin care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, 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,

SN Goals

PATIENT-STATED GOAL: test

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
* management of mental health condition including joining a peer group
* maintaining regular contact with mental health professional
* avoiding known stressors
* controlling impulses
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* bowel incontinence management including dietary changes
* bowel training
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* 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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Calija, Mae SN on 07/29/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Jane Doe
310, NATARAJAPURAM 4TH EAST STREET
KVP, HI 628502
PHONE: 999-999-9999 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 : 07/27/2026

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

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

HHA Careplans

HHA WK1: 2 (07/29/26-08/01/26)

PROCEDURES: assist with bathing, assist with toilet transferring, assist with toileting hygiene, assist with transferring, assist with mobility, assist with feeding/eating, assist with seizure precautions prn, assist with infection control, assist with fall prevention, assist with assistive devices prn, assist with O2 safety, assist with grooming, assist with lower body dressing, assist with upper body dressing

HHA Goals

PATIENT-STATED GOAL: add patient-stated goal

GOALS

Signature of Physician:

Date

Optional Name/Signature of Nurse/Therapist:

Electronically Signed by Calija, Mae SN

Date

07/29/2026