

Home Health Certification and Plan of Care						Order ID: 1195/974			
1. Patient s HI claim No.		2. Start Of Care Date		3. Certification Period		4. Medical Record No.		5. Provider No.	
5A97T15GD69		08/27/2026		From: 08/27/2026 To: 10/25/2026		FaxTest01		239350	
6. Patient's Name and Address Fax Test 12 Main Street, BALTIMORE, MD 21213 999-999-9999					7. Provider's Name, Address and Telephone Number Evergreen Home Health 403 W Main Street Suite A1 Gaylord, MI 49735-1887 989-214-1114 1184225021				
8. DOB 08/27/1960 9.Sex Male					10. Medications: Dose/Frequency/Route (N)ew (C)hanged Simvastatin - Simvastatin 40 MG / 1 Tablet by mouth in the evening Metformin - Metformin Hydrochloride 500 MG / 1 Tablet by mouth once a day				
11. ICD 10.		Principal Diagnosis Essential (primary) hypertension			Date 08/27/26				
13. ICD E11.9		Other Pertinent Diagnoses Type 2 diabetes mellitus without complications			Date 08/27/26				
14. DME and Supplies: walker					15. Safety Measures: walker precautions				
16. Nutrition: diabetic					17. Allergies: no known allergies				
18.A. Functional Limitations Endurance					18.B. Activities Permitted Walker				
19. Mental & Psychosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 2. Sometimes, 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: 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 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: Diabetes, Hypertension									
SN Careplans SN WK1: 1 (08/27/26-08/29/26) PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 94 > 101.0, heart rate < 50 > 100, respiratory rate < 12 > 20, blood pressure systolic < 90 > 150, blood pressure diastolic < 60 > 100, O2 saturation < 90 > 100, pain < 0 > 7, blood sugar < 70 > 130 CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance HOSPITALIZATION RISKS: 10. None of the above STANDING ORDERS: Home Health Clinician to provide ongoing patient and caregiver education regarding prevention of skin breakdown and pressure injuries during the home health episode as clinically indicated.; Home Health Clinician to assess fall risk and provide ongoing patient and caregiver education regarding fall prevention and home safety measures throughout the home health episode as clinically indicated.; Home Health Clinician to assess, monitor, educate, and implement non-pharmacological pain management interventions as clinically indicated throughout the home health episode. Notify physician/authorized provider of uncontrolled pain, significant changes in pain status, or adverse medication effects.; Home Health Clinician to assess, monitor, and provide patient/caregiver education regarding mood status, signs and symptoms of depression, and coping strategies throughout the home health episode. Notify physician/authorized provider of significant mood changes, safety concerns, or worsening depressive symptoms.; Home Health Clinician to implement standard and transmission-based infection control precautions as indicated and provide ongoing patient/caregiver education regarding infection prevention throughout the home health episode. Notify physician/authorized provider of suspected or confirmed infection or clinical deterioration.; Home Health Clinician to assess, review, and reinforce patient/caregiver emergency preparedness plan throughout the home health episode, recertifications and resumptions of care.; Home Health Clinician to assess patient advance directive status and provide education regarding advance care planning throughout the home health episode. Assist with identification, completion, or updating of advance directive documents as appropriate and within scope of practice. Advance Directive:No Advance Directive 08/27/2026 Problems : D0700 - Social Isolation M1745 - Behavioral Issues Pain Effect on Sleep Pain Interference with Therapy activities Pain Interference with ADLs M1400 - Dyspnea M2020 - Oral Med Management chest pain lightheadedness abnormal BS < 70/140 > mg/dL B1000 - Vision Deficit PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor,					SN Goals PATIENT-STATED GOAL: I want to walk without a walker 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 * 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/caregiver recalls * strategies to increase socialization * recalls related medication(s) purpose, schedule				
23. Signature and Date of Verbal SOC Where Applicable: Electronically Signed by LAWENDOWSKI, NOAH on 08/27/2026						25. Date HHA Received Signed POT			
24. Physician's Name and Address Test Physician 310, NATARAJAPURAM 4TH EAST STREET KVP, HI 628502 PHONE: 999-999-9999 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 : 08/25/2026				
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. PAGE 1 of 2				

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coordinate/arrange resources for vision-impaired, coordinate/arrange long-term socialization activities				
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, * 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, * strategies to increase socialization, related medication(s) purpose, schedule				

Signature of Physician:	Date
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Optional Name/Signature of Nurse/Therapist:	Date
Electronically Signed by LAWENDOWSKI, NOAH	08/27/2026