Home Health Certification and Plan of Care

Order ID: 179/13538

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1EG4TE5MK73	01/01/2026	From: 01/01/2026 To: 03/01/2026	7958	242353

6. Patient's Name and Address

Marah Pearson
6910 Marsue Drive Apt 1A,
TOWSON, MD 21204
667-352-9484

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 06/14/1967 | **9.Sex** Male

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

Actoplus - Metformin Hydrochloride: Pioglitazone Hydrochloride 1 tablet by mouth before meal

11. ICD	Principal Diagnosis	Date
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy	01/01/26

13. ICD	Other Pertinent Diagnoses	Date

14. DME and Supplies:
None of the above

15. Safety Measures:
None of the above

16. Nutrition:
1800cal ADA

17. Allergies:
no known allergies

18.A. Functional Limitations
None of the above

18.B. Activities Permitted
None of the above

19. Mental & Pyschosocial Status: COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, 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: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., 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: PLACEHOLDER

Clinical Condition Requiring Homecare: Dementia

SN Careplans

SN WK1: 1 (01/01/26-01/03/26) ,WK2: 1 (01/04/26-01/10/26) ,WK10: 1 (03/01/26-03/01/26)

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 > 0

CAREGIVER: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 10. None of the above

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

04/17/2026 Problems : M1400 - Dyspnea
M2020 - Oral Med Management
bleeding/painful gums
meal preparation

PROCEDURES: cough/deep breathing exercises, incentive spirometer, coordinate/arrange preparation of missing meals

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

SN Goals

PATIENT-STATED GOAL: Move Independently

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

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Aquino, EmyAnne LPN/LVN on 01/01/2026

25. Date HHA Received Signed POT

24. Physician's Name and Address
Dr. John Doe
3932
Wesley Chapel, FL 33543
PHONE: 333-510-5044 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 :

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 Aquino, EmyAnne LPN/LVN on 01/01/2026

Date