Home Health Certification and Plan of Care

Order ID: 179/13592

1. Patient s HI claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
0000000000	09/08/2026	From: 09/08/2026 To: 11/06/2026	8809	242353

6. Patient's Name and Address

Kalen Test
151211 123rd Street Apt #12B,
CHICAGO, IL 60609-
602-515-5461

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 05/02/1954 | **9.Sex** Male

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

There are no Medications for this Plan of Care

11. ICD	Principal Diagnosis	Date
E11.29	Type 2 diabetes mellitus w oth diabetic kidney complication	09/08/26

13. ICD	Other Pertinent Diagnoses	Date
I11.9	Hypertensive heart disease without heart failure	09/08/26
I10.	Essential (primary) hypertension	09/08/26

14. DME and Supplies:

None of the above

15. Safety Measures:

None of the above

16. Nutrition:

Z. NO PHYSICIAN-ORDERED DIET

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: The patient has a condition which makes it medically contraindicated and/or difficult to leave the home: needs assist with activities or ambulation.

Clinical Condition Requiring Homecare: Wound Care

SN Careplans

SN frequency WK1: 1 (09/08/26-09/12/26)

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

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

09/08/2026 Problems : M1400 - Dyspnea
M2020 - Oral Med Management
chest pain
abnormal blood pressure
headache
limited strength
abnormal BS < 70/140 > mg/dL

PROCEDURES: cough/deep breathing exercises, incentive spirometer, glucose testing via monitor

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: i want to be 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 self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

23. Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by Buhain, Ivan PT on 09/08/2026

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 : 09/08/2026

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 Buhain, Ivan PT on 09/08/2026

Date