

Claimant: Nevaeh Hope Adams	SSN: 794-01-8055
Level: Hearing	Claim type: T16
Alleged onset: 07/21/2015	Last Insured:
Application: 11/20/2018	Last Changed: 01/12/2021

A. Payment Documents/Decisions

Title	Decision Date	Pg
1A: ALJ Hearing Decision - ALJDEC	11/07/2018	24
2A: Disability Determination Explanation - DDE	04/29/2019	14
3A: Disability Determination Transmittal - 831	04/29/2019	1
4A: Disability Determination Explanation - DDE	06/24/2019	13
5A: Disability Determination Transmittal - 831	06/24/2019	1

B. Jurisdictional Documents/Notices

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1B: Fee Agreement for Representation before SSA - FEEAGRMT	12/17/2018	1
2B: SSA-1696 - Claimant's Appointment of a Representative - 1696	12/17/2018	1
3B: T16 Notice of Disapproved Claim - L444	04/30/2019	9
4B: Request for Reconsideration - 561	06/14/2019	3
5B: T16 Disability Reconsideration Notice - L1130	06/24/2019	7
6B: Request for Hearing by ALJ - 501	08/19/2019	3
7B: Request for Hearing Acknowledgement Letter - HRGACK	09/23/2019	15
8B: Outgoing ODAR Correspondence - OUTODARC	07/21/2020	6
9B: Hearing Notice - 507	09/16/2020	22
10B: Misc Disability Development and Documentation - MDF E	10/21/2020	1
11B: Notice Of Hearing Reminder - HA503	11/04/2020	6
12B: Notice Of Hearing Reminder - HA503	11/18/2020	2
13B: Fee Agreement for Representation before SSA - FEEAGRMT	09/29/2020	1
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D. Non-Disability Development

Title	Document Date	Pg
1D: Misc Non-Disability Development - MDF D	11/20/2018	1
2D: Application for Supplemental Security Income Benefits - 8000	12/14/2018	6
3D: New Hire, Quarter Wage, Unemployment Query (NDNH) - NDNH	10/15/2019	1
4D: Detailed Earnings Query - DEQY	10/15/2019	1
5D: Detailed Earnings Query - DEQY	10/15/2019	1
6D: New Hire, Quarter Wage, Unemployment Query (NDNH) - NDNH	11/13/2020	1

E. Disability Related Development

Title	Source	Treatment Date	Pg
1E: Function Report - Child Age 3 to 6 - 3377	Nevaeh Hope Adams / Kelli Mar...		10
2E: Disability Report - Field Office - 3367	Field Office		2
3E: Disability Report - Child - 3820	Nevaeh Hope Adams / Kelli Mar...		6
4E: Disability Report - Appeals - 3441	Jan Dils		6
5E: Disability Report - Field Office - 3367	Nevaeh Hope Adams / Kelli Mar...		2
6E: Disability Report - Field Office - 3367	Nevaeh Hope Adams / Kelli Mar...		2

E. Disability Related Development - cont.

Title	Source	Treatment Date	Pg
7E: Disability Report - Appeals - 3441	Jan Dils		6
8E: Education Records - Non Medical - EDRECNMD	McDowell County Schools		15
9E: Exhibit List to Rep PH2E - EXHIBITLISTREP	OHO - Office of Hearings Oper...		11
10E: Education Records - Non Medical - EDRECNMD	Fall River Elementary School		25
11E: Correspondence regarding efforts to obtain evidence - EALTR	Jan Dils		1
12E: Misc Disability Development and Documentation - MDF E	unknown/undated		2
13E: Representative Correspondence - REPLTR			1
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F. Medical Records

Title	Source	Treatment Date	Pg
1F: CE Child Psychology - CECHILDP	Elizabeth Bodkin, MA	-07/07/2016	4
2F: Office Treatment Records - OFFCREC	Looney Enterprises, LLC	-10/10/2017	2
3F: Progress Notes - PROGRESSNOTES	RAU 7 WV Birth to Three	12/01/2017-12/29/2017	36
4F: Education Records - Medical - EDREC	McDowell County Schools - Tan...	-06/03/2018	7
5F: Progress Notes - PROGRESSNOTES	Shriners Hospitals for Childr...	11/27/2017-07/25/2018	6
6F: Outpatient Hospital Records - OUTHOSP	Welch Comm Hosp.	12/11/2017-08/31/2018	239
7F: Office Treatment Records - OFFCREC	Mercer Medical Group ENT	-09/25/2018	5
8F: HIT MER - HITMER	WVU Medicine / CAMC Womens & ...	05/08/2017-11/13/2018	26
9F: HIT MER - HITMER	Carilion Clinic / Clinical Ge...	07/22/2015-11/27/2018	90
10F: HIT Response - HITRSP	University of Virginia Health...	-12/20/2018	1
11F: Outpatient Hospital Records - OUTHOSP	CAMC	-01/02/2019	8
12F: HIT MER - HITMER	WVU Medicine #2	01/02/2019-01/11/2019	27
13F: Office Treatment Records - OFFCREC	Pediatric Cardiology	-01/15/2019	10
14F: CE Pediatric Physical Examination - CEPEDPE	Logan Pediatrics, Inc.	-02/12/2019	5
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18F: Office Treatment Records - OFFCREC	WVU Physicians of Charleston ...	-03/14/2019	7
19F: Outpatient Hospital Records - OUTHOSP	Shriners Hospital for Childre...	-02/10/2020	5
20F: Office Treatment Records - OFFCREC	Mercer Medical Group ENT	-10/29/2020	6
21F: Education Records - Medical - EDREC	McDowell County Schools	12/12/2019-04/27/2020	12



SOCIAL SECURITY ADMINISTRATION

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Office of Hearings Operations
 Charleston Fed Center
 500 Quarrier Street
 Suite 100
 Charleston, WV 25301-2186

Date: November 7, 2018

Kelli Adams on behalf of
 Nevaeh Hope Adams
 C/O Kelli Adams
 P.O. Box 46
 Big Sandy, WV 24816

Notice of Decision – Unfavorable

I carefully reviewed the facts of your case and made the enclosed decision. Please read this notice and my decision.

If You Disagree With My Decision

If you disagree with my decision, you may file an appeal with the Appeals Council.

How To File An Appeal

To file an appeal you or your representative must ask in writing that the Appeals Council review my decision. You may use our Request for Review form (HA-520) or write a letter. The form is available at www.socialsecurity.gov. Please put the Social Security number shown above on any appeal you file. If you need help, you may file in person at any Social Security or hearing office.

Please send your request to:

**Appeals Council
 5107 Leesburg Pike
 Falls Church, VA 22041-3255**

Time Limit To File An Appeal

You must file your written appeal **within 60 days** of the date you get this notice. The Appeals Council assumes you got this notice 5 days after the date of the notice unless you show you did not get it within the 5-day period.

The Appeals Council will dismiss a late request unless you show you had a good reason for not filing it on time.

Form HA-L76-OP2 (03-2010)

Suspect Social Security Fraud?

**Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline
 at 1-800-269-0271 (TTY 1-866-501-2101).**

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What Else You May Send Us

You or your representative may send us a written statement about your case. You may also send us new evidence. You should send your written statement and any new evidence **with your appeal**. Sending your written statement and any new evidence with your appeal may help us review your case sooner.

How An Appeal Works

The Appeals Council will consider your entire case. It will consider all of my decision, even the parts with which you agree. Review can make any part of my decision more or less favorable or unfavorable to you. The rules the Appeals Council uses are in the Code of Federal Regulations, Title 20, Chapter III, Part 416 (Subpart N).

The Appeals Council may:

- Deny your appeal,
- Return your case to me or another administrative law judge for a new decision,
- Issue its own decision, or
- Dismiss your case.

The Appeals Council will send you a notice telling you what it decides to do. If the Appeals Council denies your appeal, my decision will become the final decision.

The Appeals Council May Review My Decision On Its Own

The Appeals Council may review my decision even if you do not appeal. If the Appeals Council reviews your case on its own, it will send you a notice within 60 days of the date of this notice.

When There Is No Appeals Council Review

If you do not appeal and the Appeals Council does not review my decision on its own, my decision will become final. A final decision can be changed only under special circumstances. You will not have the right to Federal court review.

New Application

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If you disagree with my decision and you file a new application instead of appealing, you might lose some benefits or not qualify for benefits at all. If you disagree with my decision, you should file an appeal within 60 days.

If You Have Any Questions

We invite you to visit our website located at www.socialsecurity.gov to find answers to general

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questions about social security. You may also call (800) 772-1213 with questions. If you are deaf or hard of hearing, please use our TTY number (800) 325-0778.

If you have any other questions, please call, write, or visit any Social Security office. Please have this notice and decision with you.

Enclosures:

Decision Rationale
Form HA-L39 (Exhibit List)

cc: Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

**SOCIAL SECURITY ADMINISTRATION
Office of Hearings Operations**

DECISION

IN THE CASE OF

Nevaeh Hope Adams

(Claimant)

(Wage Earner)

CLAIM FOR

Supplemental Security Income

794-01-8055

(Social Security Number)

JURISDICTION AND PROCEDURAL HISTORY

On March 24, 2016, an application for supplemental security income was protectively filed on behalf of the claimant, a child under age 18, with an alleged disability onset date of July 21, 2015. The claim was denied initially on October 17, 2016, and upon reconsideration on January 4, 2017. Thereafter, the claimant filed a written request for hearing on January 27, 2017 (20 CFR 416.1429 *et seq.*). On September 12, 2018, the undersigned held a video hearing (20 CFR 416.1436(c)). The claimant and Kelli Adams, her mother, appeared in Logan, West Virginia, and the undersigned presided over the hearing from Charleston, West Virginia. The claimant's main representative is Jan Denise Dils, an attorney. Kevin Walker, an attorney and co-representative, appeared at the hearing.

The claimant submitted or informed the Administrative Law Judge about all written evidence at least five business days before the date of the claimant's scheduled hearing (20 CFR 416.1435(a)).

ISSUES

The issue is whether the claimant is disabled under section 1614(a)(3)(C) of the Social Security Act. An individual under the age of 18 will be considered disabled if she has a medically determinable physical or mental impairment that results in marked and severe functional limitations, and that can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. Notwithstanding the above, no individual under the age of 18 who engages in substantial gainful activity may be considered to be disabled.

Although supplemental security income is not payable prior to the month following the month in which the application was filed (20 CFR 416.335), the undersigned has considered the complete medical history consistent with 20 CFR 416.912.

After careful consideration of all the evidence, the undersigned concludes the claimant has not been under a disability within the meaning of the Social Security Act since March 24, 2016, the date the application was filed.

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APPLICABLE LAW

Under the authority of the Social Security Act, the Social Security Administration has established a three-step sequential evaluation process to determine whether an individual under the age of 18 is disabled (20 CFR 416.924(a)).

At step one, the undersigned must determine whether the claimant is engaging in substantial gainful activity. Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. “Substantial work activity” is work activity that involves doing significant physical or mental activities (20 CFR 416.972(a)). “Gainful work activity” is work that is usually done for pay or profit, whether or not a profit is realized (20 CFR 416.972(b)). Generally, if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that she has demonstrated the ability to engage in substantial gainful activity (20 CFR 416.974 and 416.975). If the claimant engages in SGA, she is not disabled regardless of her medical condition(s), age, education, or work experience (20 CFR 416.924(b)). If the individual is not engaging in SGA, the analysis proceeds to the second step.

At step two, the undersigned must determine whether the claimant has a medically determinable impairment that is “severe” or a combination of impairments that is “severe” (20 CFR 416.924(a)). For an individual who has not attained age 18, a medically determinable impairment or combination of impairments is not severe if it is a slight abnormality or a combination of slight abnormalities that causes no more than minimal functional limitations (20 CFR 416.924(c)). If the claimant does not have a severe medically determinable severe impairment or combination of impairments, she is not disabled. If the claimant has a severe impairment(s), the analysis proceeds to the third step (20 CFR 416.924(a)).

At step three, the undersigned must determine whether the claimant has an impairment or combination of impairments that meets or medically equals the severity of a listing, or that functionally equals the listings. In making this determination, the undersigned must consider the combined effect of all medically determinable impairments, even those that are not severe (20 CFR 416.923, 416.924a(b)(4), and 416.926a(a) and (c)). If the claimant has an impairment or combination of impairments that meets or medically equals the severity of, or functionally equals, the listings, and it has lasted or is expected to last for a continuous period of at least 12 months, she is presumed to be disabled. If not, the claimant is not disabled (20 CFR 416.924(d)).

In determining whether an impairment or combination of impairments functionally equals the listings, the undersigned must assess the claimant’s functioning in terms of six domains: (1) acquiring and using information; (2) attending and completing tasks; (3) interacting and relating with others; (4) moving about and manipulating objects; (5) caring for yourself; and (6) health and physical well-being. In making this assessment, the undersigned must compare how appropriately, effectively and independently the claimant performs activities compared to the performance of other children of the same age who do not have impairments. To functionally equal the listings, the claimant’s impairment or combination of impairments must result in “marked” limitations in two domains of functioning or an “extreme” limitation in one domain (20 CFR 416.926a(d)).

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In assessing whether the claimant has “marked” or “extreme” limitations, the undersigned must consider the functional limitations from all medically determinable impairments, including any impairments that are not severe (20 CFR 416.926a(a)). The undersigned must consider the interactive and cumulative effects of the claimant’s impairment or multiple impairments in any affected domain (20 CFR 416.926a(c)).

Social Security regulation 20 CFR 416.926a(e)(2) explains that a child has a “marked limitation” in a domain when her impairment(s) “interferes seriously” with the ability to independently initiate, sustain, or complete activities. A child’s day-to-day functioning may be seriously limited when the impairment(s) limits only one activity or when the interactive and cumulative effects of the impairment(s) limit several activities. The regulations also explain that a “marked” limitation also means:

1. A limitation that is “more than moderate” but “less than extreme.”
2. The equivalent of functioning that would be expected on standardized testing with scores that are at least two, but less than three, standard deviations below the mean. For a child who has not attained age 3, functioning at a level that is more than one-half but not more than two-thirds of her chronological age when there are no standard scores from standardized tests in the record.
3. A valid score that is two standard deviations or more below the mean, but less than three standard deviations, on a comprehensive standardized test designed to measure ability or functioning in that domain, and her day-to-day functioning in domain-related activities is consistent with that score.
4. For the domain of health and physical well-being, frequent episodes of illnesses because of the impairment(s) or frequent exacerbations of the impairment(s) that result in significant, documented symptoms or signs that occur: (a) on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more; (b) more often than 3 times in a year or once every 4 months, but not lasting for 2 weeks; or (c) less often than an average of 3 times a year or once every 4 months but lasting longer than 2 weeks, if the overall effect (based on the length of the episode(s) or its frequency) is equivalent in severity.

Social Security regulation 20 CFR 416.926a(e)(3) explains that a child has an “extreme” limitation in a domain when her impairment(s) interferes “very seriously” with her ability to independently initiate, sustain, or complete activities. A child’s day-to-day functioning may be very seriously limited when her impairment(s) limits only one activity or when the interactive and cumulative effects of her impairments(s) limit several activities. The regulations also explain that an “extreme” limitation also means:

1. A limitation that is “more than marked.”

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2. The equivalent of functioning that would be expected on standardized testing with scores that are at least three standard deviations below the mean. For a child who has not attained age 3, functioning at a level that is one-half of her chronological age or less when there are no standard scores from standardized tests in the record.
3. A valid score that is three standard deviations or more below the mean on a comprehensive standardized test designed to measure ability or functioning in that domain, and her day-to-day functioning in domain-related activities is consistent with that score.
4. For the domain of health and physical well-being, episodes of illness or exacerbations that result in significant, documented symptoms or signs substantially in excess of the requirements for showing a “marked” limitation.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After careful consideration of the entire record, the undersigned makes the following findings:

1. **The claimant was born on July 21, 2015. Therefore, she was a newborn/young infant on March 24, 2016, the date application was filed, and is currently an older infant/toddler (20 CFR 416.926a(g)(2)).**
2. **The claimant has not engaged in substantial gainful activity since March 24, 2016, the application date (20 CFR 416.924(b) and 416.971 *et seq.*).**
3. **The claimant has the following severe impairments: Turner syndrome, bilateral hip impairment with status post surgeries, recurrent ear infections, and developmental delays (20 CFR 416.924(c)).**
4. **The claimant does not have an impairment or combination of impairments that meets or medically equals the severity of one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 416.924, 416.925 and 416.926).**

The claimant's Turner syndrome is evaluated under Section 104.06 for congenital heart disease. However, there is no evidence of cyanotic heart disease with persistent chronic hypoxemia; secondary pulmonary vascular obstructive disease with pulmonary arterial systolic pressure elevated to at least k7 percent of the systemic arterial systolic pressure symptomatic acyanotic heart disease with ventricular dysfunction interfering very seriously with the ability to independently initiate, sustain, or complete activities; or life-threatening congenital heart impairment that will require or already has required surgical treatment in the first year of life, and the impairment is expected to be disabling until the attainment of at least 1 year of age (Exhibit 4F).

The claimant's bilateral hip dysplasia with surgery is evaluated under Section 101.02 for major dysfunction of a joint. However, there is no evidence that his condition resulted in an inability to ambulate effectively (Exhibits 22F and 27F).

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The claimant's recurrent ear infections are most closed evaluated under Section 102.10 of the Listings. However, there is no evidence of hearing loss as a result of this condition Exhibits 10F, p. 3; 19F, p. 3; 21F, p. 5; 24F, p. 33; 28F, pp. 24, 47; 30F, p. 6; and 31F.

The claimant's developmental delay disorder is evaluated under Section 112.14 of the Listings. However, there is no evidence of a delay or deficit in the development of age-appropriate skills or a loss of previously acquired skilled with extreme limitation in one or marked limitation in two of the following developmental abilities: 1. plan and control motor movement, 2. learn and remember, 3. interact with others, and 4. regulate physiological functions, attention, emotion, and behavior as required by the Listing (Exhibits 8F and 17F).

5. The claimant does not have an impairment or combination of impairments that functionally equals the severity of the listings (20 CFR 416.924(d) and 416.926a).

Based on the requirements of 20 CFR 416.924a(a) and SSR 09-2p, the undersigned has considered all of the relevant evidence in the case record. "All of the relevant evidence" includes objective medical evidence and other relevant evidence from medical sources; information from other sources, such as school teachers, family members, or friends; the claimant's statements (including statements from the claimant's parent(s) or other caregivers); and any other relevant evidence in the case record, including how the claimant functions over time and in all settings (i.e., at home, at school, and in the community).

As provided in 20 CFR 416.926a(b) and (c) and explained in SSR 09-1p, the undersigned has evaluated the "whole child" in making findings regarding functional equivalence. The undersigned has first evaluated how the child functions in all settings and at all times, as compared to other children the same age who do not have impairments. The undersigned has also assessed the interactive and cumulative effects of all of the claimant's medically determinable impairment(s), including any impairments that are not "severe" in all of the affected domains. In evaluating the claimant's limitations, the undersigned has considered the type, extent, and frequency of help the claimant needs to function.

In determining the degree of limitation in each of the six functional equivalence domains, the undersigned has considered all symptoms and the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 416.929 and SSR 16-3p. The undersigned has considered the medical source opinions in accordance with 20 CFR 416.927.

In considering the claimant's symptoms, the undersigned must follow a two-step process in which it must first be determined whether there is an underlying medically determinable physical or mental impairment(s)--i.e., an impairment(s) that can be shown by medically acceptable clinical or laboratory diagnostic techniques--that could reasonably be expected to produce the claimant's pain or other symptoms.

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Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce the claimant's pain or other symptoms has been shown, the undersigned must evaluate the intensity, persistence, and limiting effects of the claimant's symptoms to determine the extent to which they limit the claimant's functional limitations. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the undersigned must consider other evidence in the record to determine the claimant's functional limitations.

At the hearing, the claimant's mother testified that the claimant is showing some improvement. She said she has to have an aid at school due to being a fall risk. She said she is now running and playing. She said she plays with her sisters. She said she does not wear glasses because they cannot afford the co-payment. She said her heart still leaks and could stay this way the rest of her life or could change and she would need surgery. She said the claimant has an IPAD and watches ABCs on it. She said she goes to visit her maw-maw on the weekend. She said she is supposed to start taking growth hormones if insurance will pay for them. She said the claimant was 33 1/2 inches tall and weighed 31 pounds during last visit at Shriners Hospital. She stated the claimant is not potty trained and has not gained weight over the past year. She said the claimant loses focus easy and loses concentration. She said the claimant has ear infections and stays sick. She said when the claimant wakes up her balance is off. She said she is able to use her hands on certain things but her fine motor skills are delayed.

After considering the evidence of record, the undersigned finds that the claimant's medically determinable impairments could reasonably be expected to produce the alleged symptoms; however, the statements concerning the intensity, persistence and limiting effects of these symptoms are not entirely consistent with the medical evidence and other evidence in the record for the reasons explained in this decision.

The record reveals the claimant was born in July 2015 with hip dysplasia and Turner's syndrome, which was confirmed by cytogenetic testing (Exhibit 4F, p. 30). At birth, she had moderate to severe right pedal edema and mild neck webbing (Exhibit 4F p. 15). A pediatric echocardiogram performed July 22, 2015, revealed the claimant had bicuspid aortic valve disease but with normal function and no stenosis or insufficiency. The claimant's aortic arch appeared unusual and indicated her patent ductus arteriosus (PDA) was open (Exhibit 4F, pp. 17 and 55). However, an echocardiogram performed two days later on July 24, 2015, revealed the claimant's PDA had completely closed and there was no obstruction of the aortic arch (Exhibit 4F, p. 3).

A progress note dated October 2015 indicated that the claimant had been growing and thriving. Her development had been excellent. Her chromosomes did show Turner's syndrome, but she has had no symptoms of cyanosis, tachypnea, or poor weight gain (Exhibit 4F, p. 3). A note dated May 2016 revealed the claimant had Turner syndrome but with normal heart, normal kidneys, and so far normal eyes (Exhibit 19F, p. 3). Physical examination in October 2015 revealed ejection click was heard over the apex, but no murmur was heard. An echocardiogram showed bicuspid aortic valve without stenosis or insufficiency. She had normal pulses and normal blood pressure. Her aortic arch appeared normal. She was noted to be doing well (Exhibit 14F, p. 4). In August 2016, the claimant was not walking yet but was talking well. She

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had developed short stature due to history of Turner's syndrome and needed referred to endocrinology to discuss growth hormones (Exhibit 9F, p. 3).

When seen by an endocrinologist on May 11, 2017, the claimant weighed about 30 pounds and was about 2'10" tall. She was well appearing and in no distress. Cardiovascular examination was normal. The impressions were Turner syndrome with testing for growth hormone deficiency ordered and short stature with x-rays ordered. The lab testing revealed the claimant's IGF-1 level was 49 three months ago and her Z-score was -.67 with normal range being -2.0 to 2.0. Additionally, x-rays revealed normal bone age and noted that the claimant's bone age would best fit that of a female skeletal standard 2 years of age and the claimant's chronological age was 2 years and 9 months, which was just within 2 standard deviations (Exhibit 26F). At the hearing, the claimant's mother testified that she is not on growth hormone and that she was supposed to be seen in August and will start taking them if insurance pays for them because they are very expensive.

Eye examination in October 2017 revealed the claimant had esotropia of the right eye and the claimant was referred to a pediatric ophthalmologist (Exhibit 23F). There is no evidence in the record that the claimant was seen by a pediatric ophthalmologist. Further, at the hearing the claimant's mother testified that the claimant does not wear glasses because they cannot afford the co-pay.

Regarding her hips, a note dated September 1, 2015, revealed the claimant was placed in a harness for hip stabilization (Exhibit 4F, p. 6). On September 28, 2015, the claimant's mother reported that the claimant's hips were not popping out (Exhibit 2F). The record indicates that the claimant was later beginning to walk but then underwent open reduction of right hip on January 6, 2017, and on left hip on January 20, 2017 (Exhibit 22F p. 12). Further, on February 16, 2017 she underwent bilateral hip arthrography and application of hip spica cast (Exhibit 22F, p. 57). In March, she was transitioned from cast to a Rhino brace (Exhibit 22F, p. 40). A follow-up note dated May 2017 revealed she was doing well with the hip surgery. Although she had not tolerated the Rhino brace, she was now crawling, pulling to stand, and cruising (Exhibit 22F, p. 46). In July 2017, the claimant's mother and father reported she was doing extremely well, and that she had been walking and running around without difficulty. In fact, she was using a trampoline and performing tricks without difficulty (Exhibit 22F, p. 44). Follow-up in November 2017 revealed the claimant continued to do well and was not having problems with pain when ambulating (Exhibit 22F, p. 3). Physical examination revealed stable hips on internal and external rotation with good flexion and extension. The claimant had grossly intact motor and sensation in bilateral lower extremities. X-rays revealed bilateral proximal femurs reduced within the acetabular cups with increased size in the ossific nuclei of the femoral heads. There was also slight increased acetabular coverage of hips compared to last time. The physician was pleased with the claimant's current progress of the hips and recommended continued management and observation for acetabular coverage without the use of braces and repeat x-rays in six months (Exhibit 22F, p. 4). A note from Shriners Hospital dated July 2018 indicated the claimant was doing well. She was running, playing, and keeping up with peers. The note indicated the claimant was on growth hormones per her endocrinologist, but the claimant's mother testified at the hearing that she told them the claimant was going to start growth

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hormones, which has not happened yet. Moreover, x-rays revealed her deformity appeared to be slowly correcting and she was doing well (Exhibit 27F, p. 4).

The record reveals evidence of recurrent ear infections treated with antibiotics (Exhibits 10F, p. 3; 19F, p. 3; 21F, p. 5; 24F, p. 33; 28F, pp. 24, 47; 30F, p. 6; and 31F). In fact, in June 2017 the claimant was treated in the emergency room for confusion and disorientation. However, the claimant's work-up was negative. A computed tomography (CT) of her head/brain was normal. She was placed on IV and hydrated. She was urinating well upon discharge. The impressions were acute otitis media and acute upper respiratory infection (Exhibit 18F, p. 18). A pediatric note dated May 2018 indicated the claimant's mother reported she was told the claimant needed ear tubes due to her recurrent acute otitis media but the mother refused at that time (Exhibit 26F, p. 2). The records reveals the claimant was seen by an ear/nose/throat specialist in September 2018 and examination of her ears was within normal limits (Exhibit 31F).

Regarding developmental delays, in July 2016 the claimant was 11 and ½ months old and underwent a consultative psychological evaluation. Results of the Early Learning Accomplishment Profile (ELAP) indicated her gross motor, fine motor, and cognition skills were at the level of an 8 month old and her language, self-help, and social-emotional skills were at the age level of a 10 month old. The impression was global developmental delay (Exhibit 8F). A birth to 3 assessment dated December 2016 indicated the claimant had demonstrated excellent progress since beginning services. She continued with decreased muscle tone throughout her body but her range of motion was within function limits. She was able to crawl, pull to stand beside furniture, take a few steps with hands held, and actively reach using both arms. At age 15 months, she had no delay in fine motor skills; 6 percent delay in cognitive, communication, social emotional, and adaptive functioning; and 32 percent delay in gross motor function that was improved from December 2015 (Exhibit 17F, pp. 26-29).

As for the opinion evidence, the undersigned gives significant weight to the opinions of the State agency consultants who concluded the claimant had less than marked limitation or no limitation in functioning as this is well supported by the physical examination findings at Exhibits 4F, 22F; diagnostic testing at Exhibit 14F; x-ray findings at Exhibits 26F and 27F; and birth to 3 assessments at Exhibit 17F.

In terms of the six functional equivalence domains, the undersigned finds the following regarding limitations caused by the claimant's impairments:

a. Acquiring and Using Information

Acquiring and using information concerns how well a child is able to acquire or learn information, and how well a child uses the information she has learned. This domain involves how well children perceive, think about, remember, and use information in all settings, which include daily activities at home, at school, and in the community (20 CFR 416.926a(g) and SSR 09-3p).

Social Security rules provide that a young infant (i.e., a child from birth to attainment of age 1) without an impairment should be able to show interest in, and explore, her environment (e.g.,

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reaches for a toy). At first, the child's actions are random (e.g., a child may accidentally touch a crib mobile). Eventually, the child's actions should become deliberate and purposeful, such as shaking noisemaking toys like a bell or rattle. The child should begin to recognize, and then anticipate, routine situations and events, such as grinning with expectation at the sight of her stroller. The child should also recognize and gradually attach meaning to everyday sounds, such as hearing a telephone or her name. Eventually, the child should recognize and respond to familiar words, including family names and what her favorite toys and activities are called (20 CFR 416.926a(g)(2)(i) and SSR 09-3p).

Social Security rules provide that an older infant or toddler (i.e., a child age 1 to attainment of age 3) without an impairment should be learning about the world around her. When the child is playing, she should learn how objects go together in different ways. The child should learn that by pretending, her actions can represent real things. This helps the child understand that words represent things, and that words are simply symbols or names for toys, people, places, and activities. The child should refer to herself and things around her by pointing and eventually by naming. The child should form concepts and solve simple problems through purposeful experimentation (e.g., taking toys apart), imitation, constructive play (e.g., building with blocks), and pretend play activities. The child should make simple choices between two things. The child should begin to respond to increasingly complex instructions and questions, and to produce an increasing number of words and grammatically correct simple sentences and questions (20 CFR 416.926a(g)(2)(ii) and SSR 09-3p).

Social Security regulation 20 CFR 416.926a(g)(3) and SSR 09-3p set forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have in acquiring and using information are: (i) does not understand words about space, size, or time (e.g., in/under, big/little, morning/night); (ii) cannot rhyme words or the sounds in words; (iii) has difficulty recalling important things learned in school yesterday; (iv) does not use language appropriate for age; (v) is not developing "readiness skills" the same as peers (e.g., learning to count, reciting ABCs, scribbling); (vi) has difficulty comprehending written or oral directions; (vii) struggles with following simple instructions; (viii) has difficulty solving mathematics questions or computing arithmetic answers; or (ix) talks only in short, simple sentences, and has difficulty explaining what she means.

The claimant has less than marked limitation in acquiring and using information. A Birth to three assessment dated December 2015 indicated that at age 5 months the claimant responded to sounds and noises, and would inspect her surroundings (Exhibit 17F, p. 28). A note dated December 2016, when the claimant was age 1 year and 4 months, revealed the claimant was very interested in sound toys and people, she loved to be talked to, and interacted with others. She was able to search for sounds by turning and looking and would turn her head when her name was called. At times she tried to imitate playful sounds with her mouth. She understood when being told "no." She loved to play with the family tablet and would look at pictures in a book. She placed a round puzzle piece in a base through trial and error (Exhibit 17F, pp. 24-25). An assessment dated May 2017, when the claimant was 22 months old, indicated she had a good

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vocabulary and could say many words. She called her sister by name and could say mommy and daddy. She was learning new words each day, could feed herself, and drank from a “sippy” cup. She was able to point to most of her body parts (Exhibit 17F, p. 4).

b. Attending and Completing Tasks

This domain considers how well a child is able to focus and maintain attention, and how well she is able to begin, carry through, and finish activities, including the mental pace at which she performs activities and the ease of changing activities. Attending and completing tasks also refers to a child’s ability to avoid impulsive thinking and her ability to prioritize competing tasks and manage her time (20 CFR 416.926a(h) and SSR 09-4p).

Social Security rules provide that at birth, a young infant without an impairment should be able to show sensitivity to her environment by responding to various stimuli (e.g., light, touch, temperature, movement). The child should be able to fix her gaze on a human face. The child should stop her activity when hearing voices or other sounds. Next, she should begin to attend to and follow various moving objects with her gaze, including people or toys. The child should be listening to her family’s conversations for longer and longer periods of time. Eventually, as the child is able to move around and explore the environment, she should begin to play with people and toys for longer periods of time. The child will still want to change activities frequently, but her interest in continuing an interaction or a game should gradually expand (20 CFR 416.926a(h)(2)(i) and SSR 09-4p).

Social Security rules provide that an older infant or toddler without an impairment should be able to attend to things that interest her (e.g., looking at picture books, listening to stories), and have adequate attention to complete some tasks (e.g., putting a toy away). As a toddler, she should demonstrate sustained attention, such as when building with blocks and when helping to put on her clothes (20 CFR 416.926a(h)(2)(ii) and SSR 09-4p).

Social Security regulation 20 CFR 416.926a(h)(3) and SSR 09-4p set forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe “marked” or “extreme” limitation in the domain. Some examples of difficulty children could have in attending and completing tasks are: (i) is easily startled, distracted, or over-reactive to everyday sounds, sights, movements, or touch; (ii) is slow to focus on, or fails to complete, activities of interest (e.g., games or art projects); (iii) repeatedly becomes side-tracked from activities or frequently interrupts others; (iv) is easily frustrated and gives up on tasks, including ones she is capable of completing; (v) requires extra supervision to remain engaged in an activity; or (vi) cannot plan, manage time, or organize self in order to complete assignments or chores.

The claimant has no limitation in attending and completing tasks. A Birth to three note dated December 2015 indicated that at age 5 months the claimant was a very happy baby, would smile, and established eye contact. She responded well when socially approached. She enjoyed social play and recognized her mother visually (Exhibit 17F, p. 29). A note dated December 2016 indicated the claimant was age 1 year and four months. At that time the claimant overall had a

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short attention span, but was able to turn her head when name called. She was able to look at picture books and had started to follow simple, familiar commands. She was playing more independently and content to go into her bedroom and play alone (Exhibit 17F, p. 24). In May 2017, she was learning new words daily (Exhibit 17F, p. 4).

c. Interacting and Relating with Others

This domain considers how well a child is able to initiate and sustain emotional connections with others, develop and use the language of the community, cooperate with others, comply with rules, respond to criticism, and respect and take care of the possessions of others. Interacting and relating with others relates to all aspects of social interaction at home, at school, and in the community. Because communication is essential to both interacting and relating, this domain considers the speech and language skills children need to speak intelligibly and to understand and use the language of their community (20 CFR 416.926a(i) and SSR 09-5p).

Social Security rules provide that a young infant without an impairment should begin to form intimate relationships at birth by gradually responding visually and vocally to her caregiver(s), through mutual gaze and vocal exchanges, and by physically molding her body to the caregiver's while being held. The child should eventually initiate give-and-take games (such as pat-a-cake and peek-a-boo) with her caregiver(s), and begin to affect others through purposeful behavior (e.g., gestures and vocalizations). The child should be able to respond to a variety of emotions (e.g., facial expressions and vocal tone changes) and should begin to develop speech by using vowel sounds and later consonants, first alone, and then in babbling (20 CFR 416.926a(i)(2)(i) and SSR 09-5p).

Social Security rules provide that an older infant or toddler without an impairment is dependent upon caregivers, but should begin to separate from them. The child should be able to express emotions and respond to the feelings of others. The child should begin initiating and maintaining interactions with adults, but also show interest in, then play alongside, and eventually interact with other children of the same age. The child should begin to understand the concept of "mine" and "his" or "hers." The child should be able to spontaneously communicate her wishes or needs, first by using gestures, and eventually by speaking words clearly enough that people who know she can understand the child most of the time (20 CFR 416.926a(i)(2)(ii) and SSR 09-5p).

Social Security regulation 20 CFR 416.926a(i)(3) and SSR 09-5p set forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty that children could have in interacting and relating with others are: (i) does not reach out to be picked up and held by caregiver; (ii) has no close friends, or all friends are older or younger than the child; (iii) avoids or withdraws from people she knows, or is overly anxious or fearful of meeting new people or trying new experiences; (iv) has difficulty playing games or sports with rules; (v) has difficulty communicating with others (e.g., in using verbal and nonverbal skills to express herself, in carrying on a conversation, or in asking others for assistance); or (vi) has difficulty speaking intelligibly or with adequate fluency.

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The claimant has less than marked limitation in interacting and relating with others. Birth to three notes dated December 2016 indicated the claimant was age 1 year and four months. At that time the claimant loved when people talked to her and enjoyed social interaction. She was typically happy most of the time. She responded differently to different people. She made good eye contact during social interaction. She would have temper tantrums when upset and would kick her legs, scream, pull hair, and throw things (Exhibit 17F, p. 25). In May 2017, she was noted to be very friendly and interacted well with others (Exhibit 17F, p. 4).

d. Moving About and Manipulating Objects

This domain considers how well a child is able to move her body from one place to another and how a child moves and manipulates objects. These activities may require gross motor skills, fine motor skills, or a combination of both. Limitations in this domain can be associated with musculoskeletal and neurological impairments, other physical impairments, medications or treatments, or mental impairments (20 CFR 416.926a(j) and SSR 09-6p).

Social Security rules provide that a young infant without an impairment should begin to explore the immediate environment by moving her body and by using her limbs. The child should learn to hold her head up, sit, crawl, and stand, and sometimes hold onto a stable object and stand actively for brief periods. The child should begin to practice developing eye-hand control by reaching for objects or picking up small objects and dropping them into containers (20 CFR 416.926a(j)(2)(i) and SSR 09-6p).

Social Security rules provide that an older infant or toddler without an impairment should begin to explore actively a wider area of her physical environment, using her body with steadily increasing control and independence from others. The child should begin to walk and run without assistance, and climb with increasing skill. The child should frequently try to manipulate small objects and to use her hands to do or get something that she wants or needs. The child's improved motor skills should enable her to play with small blocks, scribble with crayons, and feed herself (20 CFR 416.926a(j)(2)(ii) and SSR 09-6p).

Social Security regulation 20 CFR 416.926a(j)(3) and SSR 09-6p set forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have in moving about and manipulating objects are: (i) difficulty with motor activities (e.g., stumbling, unintentionally dropping things) because of muscle weakness, joint stiffness, or sensory loss (e.g., spasticity, hypotonia, neuropathy, or paresthesia); (ii) difficulty with balance or climbing up and down stairs, or jerky or disorganized locomotion; (iii) difficulty coordinating gross motor movements (e.g., bending, kneeling, crawling, running, jumping rope, or riding a bike); (iv) difficulty with sequencing hand or finger movements (e.g., using utensils or manipulating buttons); (v) difficulty with fine motor movement (e.g., gripping or grasping objects); or (vi) poor eye-hand coordination when using a pencil or scissors.

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The claimant has less than marked limitation in moving about and manipulating objects. Birth to three notes dated December 2016 indicated the claimant was age 1 year and four months. At that time she was able to crawl, sit on her own, pull to stand beside furniture, cruise around the furniture while holding on with one hand, and walk behind a push toy. She was unable to hold more than two blocks at one time. She was able to hold and eat a cracker and/or cookie. She was able to shake and bang her toys during play. She held a crayon with a fisted grasp and made marks on paper (Exhibit 17F, p. 25).

e. Caring for Yourself

This domain considers how well a child maintains a healthy emotional and physical state, including how well a child satisfies her physical and emotional wants and needs in appropriate ways. This includes how the child copes with stress and changes in the environment and how well the child takes care of her own health, possessions, and living area (20 CFR 416.926a(k) and SSR 09-7p).

Social Security rules provide that a young infant without an impairment should be able to recognize her body's signals (e.g., hunger, pain, discomfort), to alert her caregiver to her needs (e.g., by crying), and to console herself (e.g., by sucking on her hand) until help comes. As the child matures, her capacity for self-consolation should expand to include rhythmic behaviors (e.g., rocking). The child's need for a sense of competence also emerges in things she tries to do for herself, perhaps before she is ready to do them, as when insisting on putting food in her mouth and refusing her caregiver's help (20 CFR 416.926a(k)(2)(i) and SSR 09-7p).

Social Security rules provide that an older infant or toddler without an impairment should be trying to do more things for herself that increase her sense of independence and competence in her environment as she grows. The child might console herself by carrying a favorite blanket. The child should be learning to cooperate with her caregivers, but the child should also want to show what she can do (e.g., pointing to the bathroom or pulling off a coat). The child should be experimenting with her independence by showing some degree of contrariness (e.g., "No! No!") and declaring her own identity (e.g., hoarding toys). Children this age typically insist on trying to feed themselves (20 CFR 416.926a(k)(2)(ii) and SSR 09-7p).

Social Security regulation 20 CFR 416.926a(k)(3) and SSR 09-7p set forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have in caring for themselves are: (i) continues to place non-nutritive or inedible objects in the mouth (e.g., dirt, chalk); (ii) often uses self-soothing activities that are developmentally regressive (e.g., thumb-sucking or re-chewing food); (iii) does not feed, dress, toilet, or bathe self age-appropriately; (iv) engages in self-injurious behavior (e.g., suicidal thoughts or actions, self-inflicted injury, or refusal to take medication), or ignores safety rules; (v) does not spontaneously pursue enjoyable activities or interests (e.g., listening to music, reading a book); (vi) has restrictive or stereotyped mannerisms (e.g., head banging, body rocking); or (vii) has disturbances in eating or sleeping patterns.

The claimant has less than marked limitation in the ability to care for herself. A Birth to three note dated December 2015 indicated that at age 5 months the claimant was sleeping through the night and eating well but sometimes up at night due to reflux (Exhibit 17F, p. 29). A note dated

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December 2016 indicated the claimant was age 1 year and four months. At that time the claimant loved bath time and playing in the water, did fine when getting her fingernails and toenails cut, liked to have her hair and teeth brushed, and did okay with dressing and undressing herself most of the time. She tolerated diaper changes without any problem. She was able to eat with a fork or spoon but was messy. She was drinking from a “sippy” cup and started handing it to family members when she wanted something to drink. She did well in public until she saw something she wanted (Exhibit 17F, p. 25).

f. Health and Physical Well-Being

This domain considers the cumulative physical effects of physical and mental impairments and any associated treatments or therapies on a child’s health and functioning that were not considered in the evaluation of the child’s ability to move about and manipulate objects. Unlike the other five domains of functional equivalence, which address a child’s abilities, this domain does not address typical development and functioning. The “Health and Physical Well-Being” domain addresses how recurrent illness, the side effects of medication, and the need for ongoing treatment affect the child’s health and sense of physical well-being (20 CFR 416.929a(l) and SSR 09-8p).

Social Security regulation 20 CFR 416.926a(l)(3) and SSR 09-8p set forth some examples of limited functioning in this domain that children of any age might have; however, the examples do not necessarily describe marked or extreme limitation in the domain. Some examples of difficulty children could have involving their health and physical well-being are: (i) generalized symptoms, such as weakness, dizziness, agitation (e.g., excitability), lethargy (e.g., fatigue or loss of energy or stamina), or psychomotor retardation because of any impairment(s); (ii) somatic complaints related to an impairment (e.g., seizure or convulsive activity, headaches, incontinence, recurrent infections, allergies, changes in weight or eating habits, stomach discomfort, nausea, headaches or insomnia); (iii) limitations in physical functioning because of need for frequent treatment or therapy (e.g., chemotherapy, multiple surgeries, chelation, pulmonary cleansing, or nebulizer treatments); (iv) periodic exacerbations from an impairment(s) that interfere with physical functioning (e.g., pain crises from sickle cell anemia); or (v) medical fragility requiring intensive medical care to maintain level of health and physical well-being.

The claimant has less than marked limitation in health and physical well-being. The claimant has evidence of Turner syndrome with open PDA at birth that completely closed after a couple of days and now requires only monitoring (Exhibit 4F). Further, she was born with bilateral hip dysplasia and required surgery of her hips, but now is able to run and play as other children her age (Exhibits 22F and 27F). Additionally, she has evidence of recurrent ear infections requiring treatment with antibiotics (Exhibits 10F, p. 3; 19F, p. 3; 21F, p. 5; 24F, p. 33; 28F, pp. 24, 47; 30F, p. 6; and 31F).

Accordingly, the claimant does not have an impairment or combination of impairments that result in either “marked” limitations in two domains of functioning or “extreme” limitation in one domain of functioning.

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6. The claimant has not been disabled, as defined in the Social Security Act, since March 24, 2016, the date the application was filed (20 CFR 416.924(a)).

DECISION

Based on the application for supplemental security income protectively filed on March 24, 2016, the claimant is not disabled under section 1614(a)(3)(C) of the Social Security Act.

/s/ Jon K. Johnson

Jon K. Johnson
Administrative Law Judge

November 7, 2018

Date

LIST OF EXHIBITS

Payment Documents/Decisions

Component No.	Description	Received	Dates	Pages
HO 1A	Disability Determination Transmittal		10/17/2016	1
HO 2A	DDE T16: Childhood Disability Evaluation signed by signed by DDS Dr.		10/17/2016	14
HO 3A	Disability Determination Transmittal		01/04/2017	1
HO 4A	DDE T16: Childhood Disability Evaluation signed by signed by DDS Dr.		01/04/2017	15

Jurisdictional Documents/Notices

Component No.	Description	Received	Dates	Pages
HO 1B	T16 Notice of Disapproved Claim		10/17/2016	4
HO 2B	Request for Reconsideration		10/27/2016	3
HO 3B	Appointment of Representative-Jan Dils		10/27/2016	1
HO 4B	Representative Fee Agreement-Jan Dils		10/27/2016	1
HO 5B	T16 Disability Reconsideration Notice		01/04/2017	9
HO 6B	Request for Hearing by ALJ		01/27/2017	3
HO 7B	Request For Hearing Acknowledgement Letter		02/09/2017	15
HO 8B	Objection to Video Hearing		02/27/2017	1
HO 9B	Hearing Notice		05/09/2018	26
HO 10B	Notice of Postponement		05/21/2018	1
HO 11B	Hearing Notice		06/20/2018	29

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HO 12B	Acknowledge Notice of Hearing	07/26/2018	1
HO 13B	Notice Of Hearing Reminder	08/29/2018	6

Non-Disability Development

Component No.	Description	Received	Dates	Pages
HO 1D	Lead Protective Filing Worksheet		03/24/2016	2
HO 2D	Application for Supplemental Security Income Benefits		04/22/2016	6
HO 3D	Detailed Earnings Query		03/10/2018	1
HO 4D	Summary Earnings Query		03/10/2018	1
HO 5D	New Hire, Quarter Wage, Unemployment Query (NDNH)		03/10/2018	1
HO 6D	Certified Earnings Records		03/10/2018	1
HO 7D	New Hire, Quarter Wage, Unemployment Query (NDNH)		08/23/2018	1

Disability Related Development

Component No.	Description	Received	Source	Dates	Pages
HO 1E	Function Report - Child to Age 1		Kelli Marie Adams (Claimant's Mother)	to 03/27/2016	6
HO 2E	Disability Report - Field Office			to 04/22/2016	2
HO 3E	Disability Report - Child			to 04/22/2016	8
HO 4E	Disability Report - Field Office			to 10/28/2016	2
HO 5E	Disability Report - Appeals			to 10/28/2016	7

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HO 6E	Function Report - Child Age 1 to 3	Kelli Marie Adams (Claimant's Mother)	to 12/08/2016	7
HO 7E	Disability Report - Appeals		to 01/31/2017	6
HO 8E	Disability Report - Field Office		to 01/31/2017	2
HO 9E	Exhibit List to Rep PH2E		to 03/10/2018	11
HO 10E	Report of Contact		to 07/26/2018	1
HO 11E	Representative Correspondence	Rep	08/29/2018 to	2
HO 12E	EVIDENCE SUMMARY	Rep	08/30/2018 to	19

Medical Records

Component No.	Description	Received	Source	Dates	Pages
HO 1F	Progress Notes		WIC Program	4 to 07/21/2015	4
HO 2F	Office Treatment Records		BLUEFIELD ORTHOPEDICS	5 to 09/28/2015	5
HO 3F	Outpatient Hospital Records		PRINCETON COMMUNITY HOSPITAL	12 to 11/18/2015	12
HO 4F	HIT MER		CARILION CLINIC	66 07/22/2015 to 02/04/2016	66
HO 5F	Unsuccessful Development Attempt to Secure Medical		CARILION RHEUMATOLO GY CTR	3 to 04/25/2016	3

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HO 6F	Unsuccessful Development Attempt to Secure Medical	DEPARTMENT OF HUMAN SERVICES LOGAN COUNTY	to 04/27/2016	1
HO 7F	Unsuccessful Development Attempt to Secure Medical	M Y KANAWATI MD	to 05/24/2016	1
HO 8F	CE Psychology	ELIZABETH A BODKIN MA	to 07/07/2016	5
HO 9F	Progress Notes	ROANOKE CLINICAL GENETICS	to 08/29/2016	4
HO 10F	Office Treatment Records	RURAL HEALTH CLINIC AT WELCH COMMUNITY HOSPITAL	07/21/2016 to 09/02/2016	7
HO 11F	Unsuccessful Development Attempt to Secure Medical	NEW RIVER GASTROENTEROLOGY ASSOCIATES		9
HO 12F	Unsuccessful Development Attempt to Secure Medical	WV DIVISION OF REHABILITATION	to 11/01/2016	1
HO 13F	Unsuccessful Development Attempt to Secure Medical	DEPARTMENT OF HUMAN SERVICES MCDOWELL COUNTY	to 11/07/2016	1
HO 14F	Office Treatment Records	CARILION CLINIC CARDIOLOGY	10/06/2015 to 11/18/2016	21
HO 15F	Unsuccessful Development Attempt to Secure Medical	DEPARTMENT OF HUMAN SERVICES MERCER COUNTY	to 12/12/2016	1
HO 16F	Outpatient Hospital Records	Bluefield Regional Medical Center	07/21/2015 to 02/23/2017	10

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HO 17F	Progress Notes	WV BIRTH TO THREE	12/30/2015 to 05/11/2017	78	
HO 18F	Emergency Department Records	CAMC	to 06/07/2017	32	
HO 19F	Office Treatment Records	GHAZALA O KHOKAR MD	07/21/2015 to 07/14/2017	8	
HO 20F	Office Treatment Records	INAS AL ATTAR MD	10/24/2016 to 07/14/2017	9	
HO 21F	Outpatient Hospital Records	WELCH COMMUNITY HOSPITAL	07/21/2015 to 08/29/2017	299	
HO 22F	Outpatient Hospital Records	SHRINERS HOSPITALS FOR CHILDREN	01/04/2017 to 11/27/2017	74	
HO 23F	Progress Notes	LOONEY EYECARE	to 02/06/2018	3	
HO 24F	Outpatient Hospital Records	Welch Community Hospital	12/11/2017 to 01/06/2018	63	
HO 25F	Outpatient Hospital Records	CAMC	06/07/2017 to 05/09/2018	11	
HO 26F	Inpatient Hospital Records	WVU Physicians of Charleston - WVUPC	05/09/2018 to 05/11/2018	9	
HO 27F	Inpatient Hospital Records	Shriners Hospital - Lexington	07/25/2018 to 07/27/2018	11	
HO 28F	Outpatient Hospital Records	Welch Community Hospital	05/08/2018 to 08/09/2018	101	
HO 29F	Progress Notes	Subsequent to hearing	Kids Care Clinic	07/22/2017 to 11/28/2017	2
HO 30F	Outpatient Hospital Records	Subsequent to hearing	Welch Community Hospital	08/28/2018 to 08/31/2018	42

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HO 31F	Office Treatment Records	Subsequen t to hearing	Mercer Medical Group ENT	09/24/2018 to 09/25/2018	6
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Disability Determination Explanation**EXHIBIT NO. B2A
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This Disability Determination Explanation is for the *DC* claim at the *Initial* level.

CLAIMANT INFORMATION**CLAIMANT INFORMATION****Name:** Nevaeh Hope Adams**SSN:** 794-01-8055**Phone Number:** 681-729-2017**Secondary Phone Number****Address:**

Mailing	Residence
PO BOX 46 BIG SANDY, WV 24816	250 MELVIN ST BIG SANDY, WV 24816

Claimant Gender: F**Self Reported Height:** 36 inches**Self Reported Weight:** 25.0 lbs**BMI:** 13.6**Special Indications:** None.**RELEVANT DATES****Below table represents the Relevant Dates**

Date of Birth	Current Age	AOD	Age at AOD	DFI	DLI	Age at DLI	Blind DLI
07/21/2015	3 years 9 months	(Younger person)	07/21/2015	(Younger person)	0 months		

Does the individual have an attorney /appointed representative? No**ALLEGATIONS OF IMPAIRMENTS**

The individual filed for Initial claim for disability on 11/20/2018 due to the following illnesses, injuries or conditions:

Turners syndrome, heart issues, hip problems, lazy eye, joint problems, vision problems,

developmental delays

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The individual alleges inability to function and/or work as of
07/21/2015

TECHNICAL ISSUES**Is the individual working?**

No

Is Presumptive Disability /Presumptive Blindness appropriate for this claim?

No

Prior Electronic Filings

Prior Electronic Filing	Claim Level	Claim Type	Status	Initial Application Filing Date	Protective Filing Date	Determination or Decision Date	AC Remand Date
1	Hearing	DC	Closed	03/24/2016		11/02/2018	
1	Reconsideration	DC	Closed	03/24/2016		01/04/2017	
1	Initial	DC	Closed	03/24/2016		10/17/2016	

Disclaimer: The Determination or Decision Date in the table above is propagated from the Decision Date field in eView, and may be later than the date on the Determination or Decision notice. A Determination or Decision (initial or revised) is final as of the date of the notice. Refer to DI 27501.001A for exceptions.

Alleged Onset Date:

07/21/2015

Has the individual performed work after the Alleged Onset Date(AOD)?

No

Has any period(s) of work been determined to be an unsuccessful work attempt, or involved subsidies/special conditions, impairment-related work expenses, or other technical issue(s)?

No

EVIDENCE OF RECORD**The following initial evidence has been received**

Source of Evidence	ELIZABETH BODKIN MA:MULLENS
EF Received	04/20/2019
Medical Opinion	No
Evidence Type	CE Rprt
Level	Initial

Source of Evidence	JAN DILS
EF Received	02/15/2019
Medical Opinion	No
Evidence Type	Atty/Rep Submit Evidnce

		EXHIBIT NO. B2A
Level	Initial	PAGE: 3 OF 14

Source of Evidence	Unknown Name
EF Received	02/15/2019
Medical Opinion	No
Evidence Type	5002 ROC
Level	Initial

Source of Evidence	LOGAN PEDIATRICS INC.
EF Received	02/14/2019
Medical Opinion	No
Evidence Type	CE Rprt
Level	Initial

Source of Evidence	LOGAN PEDIATRICS INC.
EF Received	02/14/2019
Medical Opinion	No
Evidence Type	CE Rprt
Level	Initial

Source of Evidence	PEDIATRIC CARDIOLOGY
EF Received	01/29/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	MERCER MEDICAL GROUP ENT
EF Received	01/19/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	WVU Medicine #2
EF Received	01/16/2019
Medical Opinion	No
Evidence Type	HIT MER
Level	Initial

Source of Evidence	PEDIATRIC CARDIOLOGY	EXHIBIT NO. B2A PAGE: 4 OF 14
EF Received	01/11/2019	
Medical Opinion	No	
Evidence Type	MER	
Level	Initial	

Source of Evidence	CAMC OUTPATIENT /CLINIC RECORDS
EF Received	01/11/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	SHRINERS HOSPITALS FOR CHILDREN
EF Received	01/08/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	RAU 7 BIRTH TO THREE
EF Received	01/08/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	WELCH COMM HOSP OUTPATIENT CLINIC
EF Received	01/08/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	PEDIATRIC CARDIOLOGY
EF Received	01/07/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	SHRINERS HOSPITALS FOR CHILDREN
---------------------------	---------------------------------

EF Received	01/07/2019	EXHIBIT NO. B2A PAGE: 5 OF 14
Medical Opinion	No	
Evidence Type	MER	
Level	Initial	

Source of Evidence	MCDOWELL COUNTY SCHOOLS
EF Received	01/03/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	LOONEY ENTERPRISES LLC
EF Received	01/02/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	Carilion Clinic
EF Received	12/20/2018
Medical Opinion	No
Evidence Type	HIT MER
Level	Initial

Source of Evidence	WVU Medicine
EF Received	12/20/2018
Medical Opinion	No
Evidence Type	HIT MER
Level	Initial

Source of Evidence	Unknown Name
EF Received	12/20/2018
Medical Opinion	No
Evidence Type	3377-Fnct Rprt-Chld/3-6
Level	Initial

Source of Evidence	University of Virginia Health System
EF Received	12/20/2018
Medical Opinion	No

	EXHIBIT NO. B2A PAGE: 6 OF 14
Evidence Type	HIT Response
Level	Initial

Source of Evidence	Unknown Name
EF Received	11/02/2018
Medical Opinion	Yes
Evidence Type	ALJ Dec
Level	Initial
Opinion	1 of 1
Source Name	ALJ
Medical Opinion Date	11/07/2018
Is the Medical Opinion from an Acceptable Medical Source	No

Document Medical Opinion

The claimant's developmental delay disorder is evaluated under Section 112.14 of the Listings. However, there is no evidence of a delay or deficit in the development of age-appropriate skills or a loss of previously acquired skilled with extreme limitation in one or marked limitation in o of the following developmental abilities: 1. plan and control motor movement, 2. learn and remember, 3. interact with others, and 4. regulate physiological functions, attention, emotion, and behavior as required by the Listing (Exhibits 8F and 17F).

After considering the evidence of record, the undersigned finds that the claimant's medically determinable impairments could reasonably be expected to produce the alleged symptoms; however, the statements concerning the intensity, persistence and limiting effects of these symptoms are not entirely consistent with the medical evidence and other evidence in the record for the reasons explained in this decision.

Source of Evidence	WV BIRTH TO THREE
EF Received	07/31/2017
Medical Opinion	No
Evidence Type	Progress Notes
Level	Initial

Source of Evidence	ELIZABETH A BODKIN MA
EF Received	07/12/2016
Medical Opinion	No
Evidence Type	CE Psycolg

Level Initial

EXHIBIT NO. B2A
PAGE: 7 OF 14**The following evidence has been requested:**

Source of Evidence	EF Request Date	Level
KELLI MARIE DANIELS	01/15/2019	Initial
PEDIATRIC CARDIOLOGY	01/15/2019	Initial
CAMC INPATIENT /ER RECORDS	12/21/2018	Initial

CLAIM COMMUNICATIONS

No general claim communications have been created.

CONSULTATIVE EXAMINATION(S) (CE)

This section has not been completed for this claim.

FINDINGS OF FACT AND ANALYSIS OF EVIDENCE**Analysis**

Case Type: DC PFD: 11/20/2018 ALJ: Y Prior: Y

Age: 3 Ed: N/A SpEd: N/A

ALLEGES: Turners syndrome, heart issues, hip problems, lazy eye, joint problems, vision problems, and developmental delays

DO/FO Comments: N/A

PHYSICAL

LOGAN PEDIATRICS - PCE Report (Dr. Okpani Nnachi)

2/12/2019 A: Turner Syndrome, Congenital insufficiency of Aortic valve, Other Congenital deformity of hip, Unspecified lack of expected nml physiological development in childhood, Esotropia unspecified, Short stature, Otitis medial bilat unspecified

BMI - 15.9 Active and playful girl with poor eye contact and unable to engage in any meaningful interaction. Can make sentences but mostly channeled toward what she wanted around the office - like toys - unable to engage.

MUSCLE STRENGTH - 4/5 Bilat UE/LE GRIP STRENGTH - 4/5 bilat

HIP ROM:

Forward Flex.....80° bilat

PEDIATRIC CARDIOLOGY

1/15/2019 A: Bicuspid aortic valve, Turner Syndrome, Congenital aortic valve stenosis

ECHO - 1. Bicuspid aortic valve with L/R cups fusion - peak velocity 1.8 m/s; no insufficiency 2. Mild dilation of the sinus valvosalva - AoV 1.5cm 3. No LV enlargement 4. No coarctation of the aorta
Agitated during BP eval - unable to obtain a measurement when she was calm. She is cleared for all activity

CARILION CLINIC

All MER in file is outside relevant time frame - this was assessed in prior filing.

WVU

1/2/2019 Dx: Turner syndrome karyotype 45 x, Estropia, Aortic valve insufficiency, Personal hx of congenital hip dysplasia

EXHIBIT NO. B2A
PAGE: 8 OF 14

10/4/2018 A: 3 y/o female w/Turner Syndrome, 45-XO and short stature
 BP - 135/78 BMI - 18.66 HT - 2' 10.76" HEENT - Pos esotropia

MERCER MEDICAL GROUP

9/25/2018 Hand written and difficult to read. Notes she has had 18 ear infections
 Notes developmental delays, Tinnitus R ear, Texture disorder - high palate

WELCH COMM HOSP

8/31/2018 cough, runny nose, fever - notes Turner's syndrome, Aortic leaky valve, Hip dysplasia
 6/6/2018 There for cough, congestion, watery matted eyes, runny nose, and tugging at L ear. Notes Turner Syndrome, Hip dysplasia, and Heart
 5/8/2018 there d/t pulling at R ear, runny nose, lack of appetite. Notes Turner Syndrome, Leaking aortic, Hip dysplasia
 5/8/2018 Med reconciliation form - Growth hormone
 12/12/2017 Discharge Dx: Acute R Otitis media, URI
 12/11/2017 CHEST XR - No evidence of pulmonary consolidation, cardiomegaly, or pulmonary vascular congestion

SHRINERS HOSPITAL

7/25/2018 A: 3 y/o female w/Turner syndrome, as well as bilat developmental dysplasia of the hips
 Notes hx of R open reduction and adductor tenotomy on 1/5/2017, L-sided open reduction and adductor tenotomy on 7/19/2017, she had repeat arthrogram on bilat hips as well as spica casting on 2/16/2018 - later had hip spica cast removed - doing well since that time, she is running and keeping up with her peers
 HIPS - Hip ROM is symmetric and painless. Forward flex is to 135°, IR to 60°, ER to 75°, and abduct to 60°
 PELVIS XR - Femoral heads are well seated under acetabulum. R side acetabular index measures 34° and on L 38°

CAMC (labs bookmarked in file)

5/9/2018 BONE AGE STUDY - Nmrl bone age

RAU 7 BIRTH TO THREE

12/29/2017 Multi-disciplinary Eval - Notes 40% delay in motor development, 25% delay in communication development, 40% delay in cognitive development, 25% delay in social emotional development, and 25% delay in adaptive development
 On Eval on 12/28 - reports no substantial/atypical issues in the areas of communication or social emotional development
 12/28/2017 Eval/Assessment Summary: 40% delay in motor development, 40% delay in cognitive development, 25% delay in adaptive development,

LOONEY ENTERPRISES

10/10/2017 I: Esotropia

EXTRAOCULAR MUSCLES - R Eye: Testing reveals convergent misalignment; Hirshburg testing shows misalignment temporally of light reflex OD

ADLS

Has lazy eye. Speech can be understood by people who know her well most of the time, can be understood by people who don't know her well some of the time. Does not ask a lot of questions, use complete sentences of more than 4 words, tell about things that happened in the past, tell a made up or familiar short story, answer questions about a short read-aloud children's story or TV, or deliver simple messages such as telephone messages. Does not know her age, ask what words mean, know her birthday, or know her phone number. Cannot define common words, read capital letters or understand jokes. Cannot catch a large ball, ride a big wheel/tricycle/bike, use a wind up toy, print some letters, copy first name, or use scissors fairly well. Does not enjoy being with other children the same age, does not play "pretend" with other children, does not play games. Notes she plays well with children for a short period of time, then goes off to be alone - prefers to be alone. Problems in all areas of personal needs. Can pay attention less than 15 min

**EXHIBIT NO. B2A
PAGE: 9 OF 14**

PSYCH

Eval Type: CE - Preschool Mental Profile

Date: 4/8/2019

Src: Elizabeth Bodkin M.A.

Dx: BIF

Mood: Euthymic

Affect: Broad

Con: WNL

SF: WNL

Other: Prognosis Fair

Testing: WPPSI: Visual Spatial 73, Fluid Reasoning 70, Working Memory 73, Processing Speed 70, Nonverbal Index 70, Block Design 7, Object Assembly 6, Matrix Reasoning 7, Picture Concepts 6, Picture Memory 7, Zoo location 6, Bug Search 7, Cancellation 6

Put forth good effort and attempted to answer all questions - Results are VALID

MCDOWELL COUNTY SCHOOLS

6/22/2018 IEP Impact Statement: Nevaeh's delays require specialized instruction in the general education setting to meet her needs

Sp Ed: 5 hours per week

5/31/2018 Battelle Developmental Inventory - Adaptive Domain: 80, Personal-Social Domain: 80, Communication Domain: 75, Motor Domain: 88, Cognitive Domain: 70 BDI-2 Total: 76

RAU 7 BIRTH TO THREE

12/29/2017 Multi-disciplinary Eval - Notes 40% delay in motor development, 25% delay in communication development, 40% delay in cognitive development, 25% delay in social emotional development, and 25% delay in adaptive development

On Eval on 12/28 - reports no substantial/atypical issues in the areas of communication or social emotional development

12/28/2017 Eval/Assessment Summary: 40% delay in motor development, 40% delay in cognitive development, 25% delay in adaptive development,

Eval Type: Prior CE - Infant/Toddler Mental Profile

Date: 7/7/2016

Src: Elizabeth Bodkin M.A.

Dx: Global Developmental delay

Mood: Euthymic

Affect: Broad

Con: WNL

SF: WNL

Testing: ELAP: Gross motor, Fine motor, and Cognition - 8mo

Language, Self-help, and Social-Emotional - 10mo

**MEDICALLY DETERMINABLE IMPAIRMENTS AND SEVERITY
(MDI)**
CHILD MEDICALLY DETERMINABLE IMPAIRMENTS (MDI)
Does the individual have one or more medically determinable impairments (MDIs)?

Yes

IMPAIRMENT**PRIORITY****SEVERITY**

3195 - Borderline Intellectual Functioning

Primary

Severe

7160 - Dysfunction - Major Joints	Secondary	Severe
7460 - Congenital Anomalies of the Heart	Other	Severe
		EXHIBIT NO. B2A PAGE: 10 OF 14

CHILD LISTINGS CONSIDERED

<u>Listing</u>	<u>Description</u>	<u>Subsection</u>
101.02	Dysfunction - Major Joints	
112.05	Intellectual Disorder	
104.06	Congenital Heart Disease	

CHILD MEDICAL DISPOSITION

Impairment Or Combination Of Impairments Is Severe, But Does Not Meet, Medically Equal, Or Functionally Equal The Listings Based On Example – Must consider functional equivalence of the listings by describing and evaluating the child's functioning in all domains on the childhood disability evaluation.

CHILDHOOD DISABILITY EVALUATION 1

Evaluation ID is: CDE1

This evaluation is for period: Current Evaluation

DOMAIN EVALUATIONS

1. Acquiring and Using Information

Rating: Less Than Marked

Evaluation(s):

Psychology: Psych CE (5/31/2018) - IQ scores in BIF range.

MCDOWELL COUNTY SCHOOLS IEP (6/22/2018) IEP Impact Statement:
Nevaeh's delays require specialized instruction in the general education setting to meet her needs, Sp Ed: 5 hours per week.

Battelle Developmental Inventory (5/31/2018) - Cognitive Domain: 70

RAU 7 BIRTH TO THREE (12/29/2017) Multi-disciplinary Eval - 40% delay in cognitive development

Pediatrics:

2. Attending and Completing Tasks

Rating: Less Than Marked

Evaluation(s):

Psychology: Psych CE (5/31/2018) - valid Working Memory Index 73, WNL for concentration on MSE.

Pediatrics:

3. Interacting and Relating With Others

Rating: Less Than Marked**Evaluation(s):**

Psychology: 5/31/2018 Battelle Developmental Inventory (5/31/2018) - Personal-Social Domain: 80, Communication Domain: 75.

Pediatrics:

4. Moving About and Manipulating Objects

Rating: Less Than Marked**Evaluation(s):**

Psychology: NA - per psych view.

Pediatrics: 3 years old child with known Turner's syndrome, start stature, on growth hormone therapy.
 She was born with Bicuspid aortic valve and Congenital aortic valve stenosis, no CHF and no meds, cleared for any age appropriate activities.
 H/O surgery on hips for dysplasia, gait is normal now.
 Esotropia is being f/u, visual acuity is okay.
 Over all mild limitations only.

5. Caring For Yourself

Rating: Less Than Marked**Evaluation(s):**

Psychology: Per parent report - child yet to eat with spoon, not potty trained.

Pediatrics:

6. Health and Physical Well-Being

Rating: Less Than Marked**Evaluation(s):**

Psychology: NA - per psych view.

Pediatrics: Mostly needs close medical f/u in various areas.

MEDICAL SIGNATURE(S)

G. David Allen, Ph.D. (038)

Psychology

04/24/2019

Uma Reddy, MD (032)

Pediatrics

04/26/2019

Assess the child's functioning based on the functional equivalence findings:

Does not functionally equal the listings - The child's medically determinable impairment or combination of impairments is severe, but does not meet, medically equal, or functionally equal the listings, as explained in: CDE1

ASSESSMENT OF POLICY ISSUES

SYMPTOMS EVALUATION**List the claimant's symptoms:**

Understanding and memory limitations
 Sustained concentration and persistence limitations
 Social interaction limitations
 Ability to adapt limitations
 Other

Turner's syndrome with congenital heart disease.

Can one or more of the individual's medically determinable impairment(s) (MDI(s)) reasonably be expected to produce the individual's pain or other symptoms?

Yes

Are the individual's statements about the intensity, persistence, and functionally limiting effects of the symptoms substantiated by the objective medical evidence alone?

Yes

EVALUATING MEDICAL OPINIONS

The following displays medical opinions from all sources:

Source of Evidence	Unknown Name
Source Name	ALJ
Level	Initial
Medical Opinion Date	11/07/2018
AMS	No
Document how you considered supportability and consistency	Generally find ALJ opinion persuasive for psych, though new testing does suggest moderate functional limitation.

RECONCILING MEDICAL OPINIONS

This section has not been completed for this claim.

DETERMINATION

Based on the documented findings, select the determination:

Not Disabled

Is there medical evidence of DAA?

There is no evidence of any substance abuse disorder/DAA issue

DC Claim/260209921

Indicate which of the following Acquiescence Rulings are applicable

AR apply

Albright v. Commissioner of the Social Security Administration (AR 00-1(4))

REGULATION BASIS CODE (RBC)**Regulation Basis Code:**

N43-20CFR416.924-CLAIMANT UNDER AGE 18

PERSONALIZED DISABILITY EXPLANATION (PDE)**PDE Text:**

See Iron Data

SIGNATURES

I affirm, that when I evaluated the child's functioning in deciding:

- If there is a severe impairment(s);
- If the impairment(s) meets or medically equals a listing (if the listing includes functioning in its criteria); and
- If the impairment(s) functionally equals the listings;

I considered the following factors and evidence.

FACTORS:

1. How the child's functioning compares to that of children the same age who do not have impairments; i.e., what the child is able to do, not able to do, or is limited or restricted in doing.
2. Combined effects of multiple impairments and the interactive and cumulative effects of an impairment(s) on the child's activities, considering that any activity may involve the integrated use of many abilities. So,
 - A single limitation may be the result of one or more impairments, and
 - A single impairment may have effects in more than one domain.
3. How well the child performs activities with respect to:

- Initiating, sustaining and completing activities independently (range of activities, prompting needed, pace of performance, effort needed and how long the child is able to sustain activities);
- Extra help needed (e.g., personal, equipment, medications);
- Adaptations (e.g., assistive devices, appliances);

- Structured or supportive settings (e.g., home, regular or special classroom), including comparison of functioning in and outside of setting, ongoing signs or symptoms despite setting, amount of support needed to function

EXHIBIT NO. B2A
PAGE: 14 OF 14

within regular setting.

4. Child's functioning in unusual settings, (e.g., one-to-one, a CE) vs. routine settings (e.g., home, childcare, school).
5. Early intervention and school programs (e.g., school records, comprehensive testing, IEPs, class placement, special education services, accommodations, attendance, participation).
6. Impact of chronic illness, characterized by episodes of exacerbation and remission, and how it interferes with the child's activities over time.
7. Effects of treatment, including adverse and beneficial effects of medications and other treatments, and if they interfere with the child's day-to-day functioning.

EVIDENCE:

For all dispositions, wherever appropriate, I have explained how I considered the medical, early intervention, school/pre-school, parent/caregiver and other relevant evidence that supports my findings, how I weighed medical opinion evidence, evaluated physical and mental symptoms, resolved any material inconsistencies and weighed evidence when material inconsistencies in the file could not be resolved. I have considered and explained test results in the context of all the other evidence.

Child MC /PC Signature

Uma Reddy, MD (032) 04/26/2019

Disability Adjudicator/Examiner Signature:

Lara Berry 04/29/2019

eCAT version: 10.6.21

SOCIAL SECURITY ADMINISTRATION

**EXHIBIT NO. B3A
PAGE: 1 OF 1****DISABILITY DETERMINATION AND TRANSMITTAL**

1. DESTINATION <input checked="" type="checkbox"/> DDS <input type="checkbox"/> ODO <input type="checkbox"/> DRS <input type="checkbox"/> DQB <input type="checkbox"/> INTPSC	2. DDS CODE S55	3. FILING DATE 11/20/2018	4. SSN 794-01-8055	5. BIC (if CDB or DWB CLAIM)
--	--------------------	------------------------------	-----------------------	------------------------------

5. NAME AND ADDRESS OF CLAIMANT (include ZIP Code) KELLI MARIE DANIELS FOR NEVAEH HOPE ADAMS PO BOX 46 BIG SANDY WV 24816	6. WE'S NAME (if CDB or DWB CLAIM)
---	------------------------------------

7. TYPE CLAIM (Title II) <input type="checkbox"/> DIB <input type="checkbox"/> FZ <input type="checkbox"/> DWB <input type="checkbox"/> CDB-R <input type="checkbox"/> CDB-D <input type="checkbox"/> RD-R <input type="checkbox"/> RD-D <input type="checkbox"/> RD <input type="checkbox"/> P-R <input type="checkbox"/> P-D <input type="checkbox"/> MQFE

8. TYPE CLAIM (Title XVI) <input type="checkbox"/> DI <input type="checkbox"/> DS <input type="checkbox"/> DC <input checked="" type="checkbox"/> BI <input type="checkbox"/> BS <input type="checkbox"/> BC <input type="checkbox"/>
--

9. DATE OF BIRTH 07/21/2015	10. PRIOR ACTION PD <input type="checkbox"/> PT <input type="checkbox"/>	11. REMARKS Clmt Phn: 681-729-2017 DDS Received 12/20/2018
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12. DISTRICT-BRANCH OFFICE ADDRESS (include ZIP Code) SOCIAL SECURITY ADMINISTRATION 22 CROSSROADS MALL MT. HOPE, WV 25880	DO-BO CODE 313
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13. DO-BO REPRESENTATIVE	14. DATE	11A. <input type="checkbox"/> Presumptive Disability _____	11B. <input type="checkbox"/> Impairment _____
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DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED

15. CLAIMANT DISABLED A. <input type="checkbox"/> Disability Began	16A. PRIMARY DIAGNOSIS BODY SYS. 12	CODE NO. 3195	16B. SECONDARY DIAGNOSIS	CODE NO. 7160
---	---	------------------	--------------------------	------------------

B. <input type="checkbox"/> Disability Ceased	BORDERLINE INTELLECTUAL FUNCTIONING			OTHER & UNSPECIFIED ARTHROPATHIES
---	-------------------------------------	--	--	-----------------------------------

17. DIARY TYPE	MO./YR.	REASON
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18. CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)/(216)(i)	19. CLAIMANT NOT DISABLED	
A. <input type="checkbox"/> Not Disab. for Cash Bene. Purp.	B. <input type="checkbox"/> Disab for Cash Benefit Purp. Beg	A. <input checked="" type="checkbox"/> Through Date of Current Determination B. <input type="checkbox"/> Through _____ C. <input type="checkbox"/> Before Age 22 (CDB only)

20. VOCATIONAL BACKGROUND	OCC YRS	EDYRS.	21. VR ACTION	SCIN	SC OUT	Prev Ref
---------------------------	---------	--------	---------------	------	--------	----------

22. REG-BASIS CODE N43	23. MED LIST NO.	24. MOB CODE	25. REVISED DET <input type="checkbox"/>	Initial <input checked="" type="checkbox"/>	Recon <input type="checkbox"/>	DHU <input type="checkbox"/>	ALJ Hearing <input type="checkbox"/>	Appeals Council <input type="checkbox"/>	U.S. District Court <input type="checkbox"/>
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26. LIST NO. 	A. <input type="checkbox"/>	B. <input type="checkbox"/>	C. <input type="checkbox"/>	D. <input type="checkbox"/>	E. <input type="checkbox"/>	F. <input type="checkbox"/>
--	-----------------------------	-----------------------------	-----------------------------	-----------------------------	-----------------------------	-----------------------------

27. RATIONALE <input checked="" type="checkbox"/> See Attached SSA-4268-U4/C4	<input type="checkbox"/> Check if Vocational Rule Met. Cite Rule 
--	--

28. A. <input type="checkbox"/> Period of Disability	B. <input type="checkbox"/> Disability Period	C. <input type="checkbox"/> Estab Beg _____	AND D. <input type="checkbox"/> Continues	E. <input type="checkbox"/> Term _____
--	---	---	---	--

29. LTR/PAR NO.	30. DISABILITY EXAMINER-DDS 09 Lara Berry	31. DATE 04/29/2019	32. PHYSICIAN OR MEDICAL SPEC. SIGNATURE See DDE dated 04/26/2019	33. DATE 04/26/2019
32A. PHYSICIAN OR MEDICAL SPEC. NAME (Stamp, Print or Type) Uma Reddy, MD (032)				32B. SPEC. CODE 32

34. REMARKS JAN DILS PO BOX 901 PARKERSBURG WV 26102	MULTIPLE IMPAIRMENTS CONSIDERED			
	34A. COMBINED MULTIPLE NO SEVERE-SEVERE			
	34B. COMBINED MULTIPLE NO SEVERE-II NO SEVERE			
35. BASIS CODE	36. REV. DET. CODES	37. SSA REPRESENTATIVE	SSA CODE	38. DATE

Disability Determination Explanation

**EXHIBIT NO. B4A
PAGE: 1 OF 13**

This Disability Determination Explanation is for the *DC* claim at the
Reconsideration level.

CLAIMANT INFORMATION

CLAIMANT INFORMATION

Name: Nevaeh Hope Adams

SSN: 794-01-8055

Phone Number: 681-729-2017

Secondary Phone Number

Address:

Mailing	Residence
C/O KELLI ADAMS PO BOX 46 BIG SANDY, WV 24816	250 MELVIN ST BIG SANDY, WV 24816

Claimant Gender: F

Self Reported Height: 36 inches

Self Reported Weight: 25.0 lbs

BMI: 13.6

Special Indications: None.

RELEVANT DATES

Below table represents the Relevant Dates

Date of Birth	Current Age	AOD	Age at AOD	DFI	DLI	Age at DLI	Blind DLI
07/21/2015	3 years 11 months	07/21/2015 (Younger person)	0 months (Younger person)				

Does the individual have an attorney/appointed representative? Yes

Representative's name, address and phone number:

Jan Denise Dils

PO Box 901

PARKERSBURG, WV 26101
EXHIBIT NO. B4A
 304-428-8900 **PAGE: 2 OF 13**
 304-428-4500

ALLEGATIONS OF IMPAIRMENTS

The individual filed for Initial claim for disability on **11/20/2018** due to the following illnesses, injuries, or conditions:

Turners syndrome, heart issues, hip problems, lazy eye, joint problems, vision problems, developmental delays

The individual alleges inability to function and/or work as of
07/21/2015

RECONSIDERATION ISSUES

Since you last told us about your medical conditions, has there been any CHANGE (for better or worse) in your physical or mental conditions?

Yes

Approximate date the change occurred: 12/1/2018

Claimant-supplied Information:

Increased diarrhea and hearing loss.

Since you last told us about your medical conditions, do you have any NEW physical or mental conditions?

No

Does the prior determination substantively and technically resolve all pertinent adjudicative issues?

No

Has the individual worked since last completing a disability report?

No

Prior Electronic Filings

Prior Electronic Filing	Claim Level	Claim Type	Status	Initial Application Filing Date	Protective Filing Date	Determination or Decision Date	AC Remand Date
1	Hearing	DC	Closed	03/24/2016		11/02/2018	
1	Reconsideration	DC	Closed	03/24/2016		01/04/2017	
1	Initial	DC	Closed	03/24/2016		10/17/2016	

Disclaimer: The Determination or Decision Date in the table above is propagated from the Decision Date field in eView, and may be later than the date on the Determination or Decision notice. A Determination or Decision (initial or revised) is final as of the date of the notice. Refer to DI 27501.001A for exceptions.

Alleged Onset Date:

07/21/2015

Has the individual performed work after the Alleged Onset Date(AOD)?

No

Has any period(s) of work been determined to be an unsuccessful work attempt, or involved

subsidies/special conditions, impairment-related work expenses, or other technical issues(s)?

No

**EXHIBIT NO. B4A
PAGE: 3 OF 13****EVIDENCE OF RECORD**

The following initial evidence has been received

Source of Evidence	ELIZABETH BODKIN MA:MULLENS
EF Received	04/20/2019
Medical Opinion	No
Evidence Type	CE Rprt
Level	Initial

Source of Evidence	JAN DILS
EF Received	02/15/2019
Medical Opinion	No
Evidence Type	Atty/Rep Submit Evidnce
Level	Initial

Source of Evidence	Unknown Name
EF Received	02/15/2019
Medical Opinion	No
Evidence Type	5002 ROC
Level	Initial

Source of Evidence	LOGAN PEDIATRICS INC.
EF Received	02/14/2019
Medical Opinion	No
Evidence Type	CE Rprt
Level	Initial

Source of Evidence	LOGAN PEDIATRICS INC.
EF Received	02/14/2019
Medical Opinion	No
Evidence Type	CE Rprt
Level	Initial

Source of Evidence	PEDIATRIC CARDIOLOGY
EF Received	01/29/2019

		EXHIBIT NO. B4A PAGE: 4 OF 13
Medical Opinion	No	
Evidence Type	MER	
Level	Initial	

Source of Evidence	MERCER MEDICAL GROUP ENT
EF Received	01/19/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	WVU Medicine #2
EF Received	01/16/2019
Medical Opinion	No
Evidence Type	HIT MER
Level	Initial

Source of Evidence	PEDIATRIC CARDIOLOGY
EF Received	01/11/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	CAMC OUTPATIENT /CLINIC RECORDS
EF Received	01/11/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	SHRINERS HOSPITALS FOR CHILDREN
EF Received	01/08/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	RAU 7 BIRTH TO THREE
EF Received	01/08/2019
Medical Opinion	No

	EXHIBIT NO. B4A PAGE: 5 OF 13
Evidence Type	MER
Level	Initial

Source of Evidence	WELCH COMM HOSP OUTPATIENT CLINIC
EF Received	01/08/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	PEDIATRIC CARDIOLOGY
EF Received	01/07/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	SHRINERS HOSPITALS FOR CHILDREN
EF Received	01/07/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	MCDOWELL COUNTY SCHOOLS
EF Received	01/03/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	LOONEY ENTERPRISES LLC
EF Received	01/02/2019
Medical Opinion	No
Evidence Type	MER
Level	Initial

Source of Evidence	Carilion Clinic
EF Received	12/20/2018
Medical Opinion	No

		EXHIBIT NO. B4A PAGE: 6 OF 13
Evidence Type	HIT MER	
Level	Initial	

Source of Evidence	WVU Medicine
EF Received	12/20/2018
Medical Opinion	No
Evidence Type	HIT MER
Level	Initial

Source of Evidence	Unknown Name
EF Received	12/20/2018
Medical Opinion	No
Evidence Type	3377-Fnct Rprt-Chld/3-6
Level	Initial

Source of Evidence	University of Virginia Health System
EF Received	12/20/2018
Medical Opinion	No
Evidence Type	HIT Response
Level	Initial

Source of Evidence	Unknown Name
EF Received	11/02/2018
Medical Opinion	Yes
Evidence Type	ALJ Dec
Level	Initial
Opinion	1 of 1
Source Name	ALJ
Medical Opinion Date	11/07/2018
Is the Medical Opinion from an Acceptable Medical Source	No

Document Medical Opinion

The claimant's developmental delay disorder is evaluated under Section 112.14 of the Listings. However, there is no evidence of a delay or deficit in the development of age-appropriate skills or a loss of previously acquired skilled with extreme limitation in one or marked limitation in 0 of the following developmental abilities: 1. plan and control motor movement, 2. learn and remember, 3.

EXHIBIT NO. B4A
PAGE: 7 OF 13

interact with others, and 4. regulate physiological functions, attention, emotion, and behavior as required by the Listing (Exhibits 8F and 17F).

After considering the evidence of record, the undersigned finds that the claimant's medically determinable impairments could reasonably be expected to produce the alleged symptoms; however, the statements concerning the intensity, persistence and limiting effects of these symptoms are not entirely consistent with the medical evidence and other evidence in the record for the reasons explained in this decision.

Source of Evidence	WV BIRTH TO THREE
EF Received	07/31/2017
Medical Opinion	No
Evidence Type	Progress Notes
Level	Initial

Source of Evidence	ELIZABETH A BODKIN MA
EF Received	07/12/2016
Medical Opinion	No
Evidence Type	CE Psycolg
Level	Initial

The following evidence has been requested:

Source of Evidence	EF Request Date	Level
KELLI MARIE DANIELS	01/15/2019	Initial
PEDIATRIC CARDIOLOGY	01/15/2019	Initial
CAMC INPATIENT /ER RECORDS	12/21/2018	Initial

CLAIM COMMUNICATIONS

No general claim communications have been created.

CONSULTATIVE EXAMINATION(S) (CE)

Is a CE(s) required?

No

FINDINGS OF FACT AND ANALYSIS OF EVIDENCE

Reconsideration Analysis

no new mer

MEDICALLY DETERMINABLE IMPAIRMENTS AND SEVERITY (MDI)

CHILD MEDICALLY DETERMINABLE IMPAIRMENTS (MDI)**Does the individual have one or more medically determinable impairments (MDIs)?**

Yes

<u>IMPAIRMENT</u>	<u>PRIORITY</u>	<u>SEVERITY</u>
3195 - Borderline Intellectual Functioning	Primary	Severe
7160 - Dysfunction - Major Joints	Secondary	Severe
7460 - Congenital Anomalies of the Heart	Other	Severe

CHILD LISTINGS CONSIDERED

<u>Listing</u>	<u>Description</u>	<u>Subsection</u>
101.02	Dysfunction - Major Joints	
112.05	Intellectual Disorder	
104.06	Congenital Heart Disease	

CHILD MEDICAL DISPOSITION

Impairment Or Combination Of Impairments Is Severe, But Does Not Meet, Medically Equal, Or Functionally Equal The Listings Based On Example – Must consider functional equivalence of the listings by describing and evaluating the child's functioning in all domains on the childhood disability evaluation.

CHILDHOOD DISABILITY EVALUATION 1**Evaluation ID is:** CDE1**This evaluation is for period:** Current Evaluation**DOMAIN EVALUATIONS**

1. Acquiring and Using Information

Rating: Less Than Marked**Evaluation(s):****Psychology:** Psych CE (5/31/2018) - IQ scores in BIF range.

MCDOWELL COUNTY SCHOOLS IEP (6/22/2018) IEP Impact Statement:
 Nevaeh's delays require specialized instruction in the general education setting to meet her needs, Sp Ed: 5 hours per week.

Battelle Developmental Inventory (5/31/2018) - Cognitive Domain: 70

RAU 7 BIRTH TO THREE (12/29/2017) Multi-disciplinary Eval - 40% delay in cognitive development

**EXHIBIT NO. B4A
PAGE: 9 OF 13****Pediatrics:**

2. Attending and Completing Tasks

Rating: Less Than Marked**Evaluation(s):**

Psychology: Psych CE (5/31/2018) - valid Working Memory Index 73, WNL for concentration on MSE.

Pediatrics:

3. Interacting and Relating With Others

Rating: Less Than Marked**Evaluation(s):**

Psychology: 5/31/2018 Battelle Developmental Inventory (5/31/2018) - Personal-Social Domain: 80, Communication Domain: 75.

Pediatrics:

4. Moving About and Manipulating Objects

Rating: Less Than Marked**Evaluation(s):**

Psychology: NA - per psych view.

Pediatrics: 3 years old child with known Turner's syndrome, start stature, on growth hormone therapy.

She was born with Bicuspid aortic valve and Congenital aortic valve stenosis, no CHF and no meds, cleared for any age appropriate activities.

H/O surgery on hips for dysplasia, gait is normal now.

Esotropia is being f/u, visual acuity is okay.

Over all mild limitations only.

5. Caring For Yourself

Rating: Less Than Marked**Evaluation(s):**

Psychology: Per parent report - child yet to eat with spoon, not potty trained.

Pediatrics:

6. Health and Physical Well-Being

Rating: Less Than Marked**Evaluation(s):**

Psychology: NA - per psych view.

Pediatrics: Mostly needs close medical f/u in various areas.

MEDICAL SIGNATURE(S)

James Binder, MD (037)

Psychology

06/21/2019

James Binder, MD (037)

Pediatrics

06/21/2019

**EXHIBIT NO. B4A
PAGE: 10 OF 13****Assess the child's functioning based on the functional equivalence findings:**

Does not functionally equal the listings – The child's medically determinable impairment or combination of impairments is severe, but does not meet, medically equal, or functionally equal the listings, as explained in: CDE1

Additional Explanation :

Initial assessment is consistent with current MER. JB

ASSESSMENT OF POLICY ISSUES**SYMPTOMS EVALUATION****List the claimant's symptoms:**

Understanding and memory limitations
Sustained concentration and persistence limitations
Social interaction limitations
Ability to adapt limitations
Other

Turner's syndrome with congenital heart disease.

Can one or more of the individual's medically determinable impairment(s) (MDI(s)) reasonably be expected to produce the individual's pain or other symptoms?

Yes

Are the individual's statements about the intensity, persistence, and functionally limiting effects of the symptoms substantiated by the objective medical evidence alone?

Yes

EVALUATING MEDICAL OPINIONS

The following displays medical opinions from all sources:

Source of Evidence	Unknown Name
Source Name	ALJ
Level	Initial
Medical Opinion Date	11/07/2018
AMS	No
Document how you considered supportability and consistency	Generally find ALJ opinion persuasive for psych, though new testing does suggest moderate functional limitation.

RECONCILING MEDICAL OPINIONS

Are there medical opinions about the individual's abilities and limitations that are more restrictive than your findings?

No

DETERMINATION

**Based on the documented findings, select the determination:
Not Disabled**

**EXHIBIT NO. B4A
PAGE: 11 OF 13**

Is there medical evidence of DAA?

There is no evidence of any substance abuse disorder /DAA issue

DC Claim/263133386

Indicate which of the following Acquiescence Rulings are applicable

AR apply

Albright v. Commissioner of the Social Security Administration (AR 00-1(4))

Effect of Prior Disability Findings on Adjudication of a Subsequent Disability Claim

REGULATION BASIS CODE (RBC)

Regulation Basis Code:

N43-20CFR416.924-CLAIMANT UNDER AGE 18

PERSONALIZED DISABILITY EXPLANATION (PDE)

PDE Text:

See Iron Data

SIGNATURES

I affirm, that when I evaluated the child's functioning in deciding:

- If there is a severe impairment(s);
- If the impairment(s) meets or medically equals a listing (if the listing includes functioning in its criteria); and
- If the impairment(s) functionally equals the listings;

I considered the following factors and evidence.

FACTORS:

1. How the child's functioning compares to that of children the same age who do not have impairments; i.e., what the child is able to do, not able to do, or is limited or restricted in doing.
2. Combined effects of multiple impairments and the interactive and cumulative effects of an impairment(s) on the child's activities, considering that any activity may involve the integrated use of many abilities. So,
 - A single limitation may be the result of one or more impairments and

- A single impairment may have effects in more

than one domain.

3. How well the child performs activities with respect to:

- Initiating, sustaining and completing activities independently (range of activities, prompting needed, pace of performance, effort needed and how long the child is able to sustain activities);
- Extra help needed (e.g., personal, equipment, medications);
- Adaptations (e.g., assistive devices, appliances);
- Structured or supportive settings (e.g., home, regular or special classroom), including comparison of functioning in and outside of setting, ongoing signs or symptoms despite setting, amount of support needed to function within regular setting.

4. Child's functioning in unusual settings, (e.g., one-to-one, a CE) vs. routine settings (e.g., home, childcare, school).
5. Early intervention and school programs (e.g., school records, comprehensive testing, IEPs, class placement, special education services, accommodations, attendance, participation).
6. Impact of chronic illness, characterized by episodes of exacerbation and remission, and how it interferes with the child's activities over time.
7. Effects of treatment, including adverse and beneficial effects of medications and other treatments, and if they interfere with the child's day-to-day functioning.

EVIDENCE:

For all dispositions, wherever appropriate, I have explained how I considered the medical, early intervention, school/pre-school, parent/caregiver and other relevant evidence that supports my findings, how I weighed medical opinion evidence, evaluated physical and mental symptoms, resolved any material inconsistencies and weighed evidence when material inconsistencies in the file could not be resolved. I have considered and explained test results in the context of all the other evidence.

Child MC/PC Signature

James Binder, MD (037) 06/21/2019

**EXHIBIT NO. B4A
PAGE: 12 OF 13**

This reconsideration file has been thoroughly reviewed to ensure that the total evidence of record is

sufficient and consistent to support the proposed determination.

**EXHIBIT NO. B4A
PAGE: 13 OF 13**

Disability Adjudicator/Examiner Signature:

David Hudkins 06/24/2019

eCAT version: 10.6.21

SOCIAL SECURITY ADMINISTRATION

**EXHIBIT NO. B5A
PAGE: 1 OF 1****DISABILITY DETERMINATION AND TRANSMITTAL**

1. DESTINATION <input checked="" type="checkbox"/> DDS <input type="checkbox"/> ODO <input type="checkbox"/> DRS <input type="checkbox"/> DQB <input type="checkbox"/> INTPSC					2. DDS CODE S55	3. FILING DATE 11/20/2018	4. SSN 794-01-8055	BIC (if CDB or DWB CLAIM)	
5. NAME AND ADDRESS OF CLAIMANT (include ZIP Code) KELLI DANIELS FOR NEVAEH HOPE ADAMS C/O KELLI ADAMS PO BOX 46 BIG SANDY WV 24816					6. WE'S NAME (if CDB or DWB CLAIM)				
					7. TYPE CLAIM (Title II) DIB <input type="checkbox"/> FZ <input type="checkbox"/> DWB <input type="checkbox"/> CDB-R <input type="checkbox"/> CDB-D <input type="checkbox"/> RD-R <input type="checkbox"/> RD-D <input type="checkbox"/> RD <input type="checkbox"/> P-R <input type="checkbox"/> P-D <input type="checkbox"/> MQFE				
					8. TYPE CLAIM (Title XVI) DI <input type="checkbox"/> DS <input type="checkbox"/> DC <input checked="" type="checkbox"/> BI <input type="checkbox"/> BS <input type="checkbox"/> BC <input type="checkbox"/>				
9. DATE OF BIRTH 07/21/2015		10. PRIOR ACTION PD <input checked="" type="checkbox"/> PT <input type="checkbox"/>			11. REMARKS Clmt Phn: 681-729-2017 Recon filed 06/14/2019 Recon received 06/18/2019				
12. DISTRICT-BRANCH OFFICE ADDRESS (include ZIP Code) SOCIAL SECURITY ADMINISTRATION 22 CROSSROADS MALL MT. HOPE, WV 25880					DO-BO CODE 313				
13. DO-BO REPRESENTATIVE					14. DATE	11A. <input type="checkbox"/> Presumptive Disability _____	11B. <input type="checkbox"/> Impairment _____		
DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED									
15. CLAIMANT DISABLED A. <input type="checkbox"/> Disability Began		16A. PRIMARY DIAGNOSIS BODY SYS. 12			CODE NO. 3195	16B. SECONDARY DIAGNOSIS	CODE NO. 7160		
B. <input type="checkbox"/> Disability Ceased					BORDERLINE INTELLECTUAL FUNCTIONING			OTHER & UNSPECIFIED ARTHROPATHIES	
17. DIARY TYPE		MO./YR.	REASON						
18. CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)/(216)(i)				19. CLAIMANT NOT DISABLED					
A. <input type="checkbox"/> Not Disab. for Cash Bene. Purp.		B. <input type="checkbox"/> Disab for Cash Benefit Purp. Beg		A. <input checked="" type="checkbox"/> Through Date of Current Determination B. <input type="checkbox"/> Through _____ C. <input type="checkbox"/> Before Age 22 (CDB only)					
20. VOCATIONAL BACKGROUND				OCC YRS	EDYRS.	21. VR ACTION	SCIN	SC OUT	Prev Ref
22. REG-BASIS CODE N43	23. MED LIST NO.	24. MOB CODE	25. REVISED DET <input checked="" type="checkbox"/>	A. <input type="checkbox"/> Initial	B. <input checked="" type="checkbox"/> Recon	C. <input type="checkbox"/> DHU	ALJ Hearing	Appeals Council	U.S. District Court
26. LIST NO. ► A. B. C. D. E. F.									
27. RATIONALE <input checked="" type="checkbox"/> See Attached SSA-4268-U4/C4 <input type="checkbox"/> Check if Vocational Rule Met. Cite Rule ►									
28. A. <input type="checkbox"/> Period of Disability B. <input type="checkbox"/> Disability Period C. <input type="checkbox"/> Estab Beg _____ AND D. <input type="checkbox"/> Continues E. <input type="checkbox"/> Term _____									
29. LTR/PAR NO.	30. DISABILITY EXAMINER-DDS 09 David Hudkins			31. DATE 06/24/2019	32. PHYSICIAN OR MEDICAL SPEC. SIGNATURE See DDE dated 06/21/2019			33. DATE 06/21/2019	
32A. PHYSICIAN OR MEDICAL SPEC. NAME (Stamp, Print or Type) James Binder, MD (037)								32B. SPEC. CODE 37	
34. REMARKS JAN DILS ATTORNEY AT LAW LC PO BOX 901 PARKERSBURG WV 26102 Recon Affirmation.								MULTIPLE IMPAIRMENTS CONSIDERED	
								34A. COMBINED MULTIPLE NO/SEVERE-SEVERE	
								34B. COMBINED MULTIPLE NO/SEVERE-II/NO/SEVERE	
35. BASIS CODE	36. REV. DET. CODES	37. SSA REPRESENTATIVE					SSA CODE	38. DATE	

From:

02/15/2019 12:24

#918 P.004/008

From: GFI FaxMaker

To: 13044364929

Page: 3/5

Date: 1/20/2019 12:24:18 PM

**EXHIBIT NO. B1B
PAGE: 1 OF 1**CONTINGENT FEE AGREEMENT

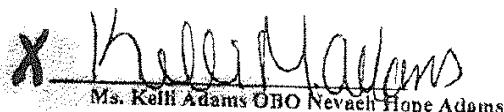
THIS AGREEMENT, Made and entered into on December 17, 2018 by and between **Ms. Kelli Adams OBO Nevaeh Hope Adams**, hereinafter referred to as "Client", and **Jan Dills, Attorney at Law**, hereinafter referred to as "Attorney";

WHEREAS Client desires to employ Attorney to represent him/her in connection with his claim for Disability Insurance Benefits (DIB) and/or Supplemental Security Income Disability benefits (SSID) from the Social Security Administration.

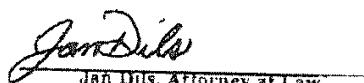
WITNESSETH that Client and Attorney agree as follows:

1. I agree that if the Social Security Administration (SSA) favorably decides my claim at any stage through the first hearing at the Administrative Law Judge (ALJ) level of appeal (with or without a hearing or supplemental hearing with no appeal to the Appeals Council), I will pay a maximum fee of the lower of (a) 25 percent of all past-due benefits accrued to client and/or auxiliary beneficiaries resulting from my claim, or (b) \$6,000.00 as established pursuant to section 206(a)(2)(A)(ii)(II) of the Social Security Act or such higher amount as the Commissioner of Social Security may prescribe pursuant to Section 206 (a)(2)(A) of the Social Security Act.
2. If my claim for Disability Insurance Benefits and/or Supplemental Security Income Disability is approved, the Social Security Administration should automatically withhold the Attorney fee pursuant to paragraph 1, and Attorney will collect attorney fee directly from the Social Security Administration. However, should the Social Security Administration fail to withhold the Attorney fee pursuant to paragraph 1, I will pay my attorney promptly from the back benefits that I receive and said money will be held in escrow pending approval of the fee amount by the Social Security Administration. However, in no event will any fee exceed the amount specified in paragraph 1.
3. I agree that if SSA favorably decides my claim at the Appeals Council (AC) level; or at the ALJ hearing level *after* a decision by the Appeals Council or Federal Court; or if a Federal Court favorably decides my case, the representative will request a fee through the fee petition process and, if the petition is approved by the judge, I will pay my attorney a fee equal to 25 percent of all past-due benefits in my Social Security and/or SSI disability claims for me and my family without the \$6,000.00 cap.
4. I further understand and agree that any costs incurred by Attorney in the course of this case, such as costs of copies of medical records and doctor reports, will be the responsibility of the Client.
5. I have not been promised that I will win my case. My attorneys hereby promise that they, as well as their staff, will do their utmost best to win disability benefits for me and any of my dependents which may qualify for dependents' benefits.

I accept and approve this agreement. My attorney and I have both received copies of this agreement.



Ms. Kelli Adams OBO Nevaeh Hope Adams



JAN DILLS, Attorney at Law

Social Security Administration
Supplemental Security Income
Important Information

Date: April 30, 2019

Claim Number: 794-01-8055

KELLI MARIE DANIELS FOR
NEVAEH HOPE ADAMS
PO BOX 46
BIG SANDY WV 24816

NOTICE OF DISAPPROVED CLAIM

IMPORTANT NOTICE – NEVAEH HOPE ADAMS IS NOT ELIGIBLE FOR SSI

We are writing about NEVAEH ADAMS' claim for Supplemental Security Income (SSI) payments. Based on a review of her medical condition, she does not qualify for SSI payments for this claim. This is because she is not disabled or blind under our rules.

We urge you to read this entire letter, including the information about appeal rights and the information about Medicaid eligibility.

The Decision on This Case

The medical evidence does not show that her loss of vision is severe enough to meet the blindness requirements for Supplemental Security income payments.

We have decided that her condition is not disabling under our rules. This is because her condition does not cause marked and severe functional limitations.

Evidence from the following sources was used to evaluate this claim:

CAMC OUTPATIENT/CLINIC RECORDS - report received 01/11/2019
PEDIATRIC CARDIOLOGY - report received 01/07/2019
MERCER MEDICAL GROUP ENT - report received 01/19/2019
WELCH COMM HOSP OUTPATIENT CLINIC - report received 01/08/2019
SHRINERS HOSPITALS FOR CHILDREN - report received 01/07/2019
LOONEY ENTERPRISES LLC - report received 01/02/2019
MCDOWELL COUNTY SCHOOLS - report received 01/03/2019
RAU 7 BIRTH TO THREE - report received 01/08/2019
PEDIATRIC CARDIOLOGY - report received 01/29/2019
LOGAN PEDIATRICS INC. - report received 02/14/2019
ELIZABETH BODKIN MA:MULLENS - report received 04/20/2019
ELIZABETH A BODKIN MA copied document
WVU MEDICINE #2 REPORT RECEIVED 01/16/2019.
XXX-XX-8055 ADAMS, NEVAEH HOPE

WVU MEDICINE REPORT RECEIVED 12/20/2018.
CARILION CLINIC REPORT RECEIVED 12/20/2018.

EXHIBIT NO. B3B
PAGE: 2 OF 9

You said that NEVAEH is disabled because of Turners syndrome, heart issues, hip problems, lazy eye, joint problems, vision problems, and developmental delays.

Her symptoms and their effect on her daily functioning have been considered in making this decision. While she may have difficulty with Turners syndrome, heart issues, hip problems, a lazy eye, vision problems, and developmental delays the evidence we considered does not show a condition that causes marked and severe functional limitations. Therefore, she cannot be found disabled.

If her condition gets worse, you should file a new application for supplemental security payments.

Although she is not eligible for Supplemental Security Income payments, she may be eligible for medical assistance (Medicaid). If you have any questions about her eligibility for Medicaid or need medical assistance, you should get in touch with the local Department of Health and Human Resources office.

About The Decision

Doctors and other trained staff looked at her case and made this decision. They work for your State but used our rules.

Please remember that there are many types of disability programs, both government and private, which use different rules. A person may be receiving benefits under another program and still not be entitled under our rules. This may be true in her case.

The Disability Rules

She must meet certain rules to qualify for SSI payments based on disability.

- She must have a medically established physical or mental condition that causes marked and severe functional limitations.
- That condition must last, or be expected to last, for at least 12 months in a row, or be expected to result in death.

Other Social Security Benefits

The application for SSI was also a claim for Social Security benefits. We looked into whether she qualifies for Social Security and found that she does not qualify (except for benefits she may already be receiving). If she disagrees, she has the right to appeal.

Information About Medicaid

Although she is not eligible for Supplemental Security Income payments, she may be eligible for medical assistance (Medicaid). If you have any questions about her eligibility for Medicaid, or need medical assistance, you should get in touch with the local Department of Health and Human Services office.

If She Disagrees With The Decision**EXHIBIT NO. B3B
PAGE: 3 OF 9**

If she disagrees with this decision, she has the right to appeal. We will review her case and consider any new facts. A person who did not make the first decision will decide the case.

- She has 60 days to ask for an appeal.
- The 60 days start the day after she gets this letter. We assume she got this letter 5 days after the date on it unless she shows us that she did not get it within the 5-day period.
- She must have a good reason for waiting more than 60 days to ask for an appeal.
- She has to ask for an appeal in writing. We will ask her to complete a form SSA-561-U2, called "Request for Reconsideration". Contact one of our offices or call 1-800-772-1213 to request this form. Or complete this form online at <http://www.socialsecurity.gov/disability/appeal>. Contact one of our offices if help is needed.
- In addition, complete a "Disability Report-Appeal" to tell us about her medical condition since she filed her claim. Contact one of our offices or call 1-800-772-1213 to request this form. Or, complete this report online after she completes the online Request for Reconsideration.

How The Appeal Works

You have a right to review the facts in her case. You can give us more facts to add to her file. Then we will decide her case again. You will not meet the person who will decide her case.

New Application

NEVAEH has the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If she disagrees with this decision and she files a new application instead of appealing:

- She might lose some benefits, or not qualify for any benefits, and
- We could deny the new application using this decision, if the facts and issues are the same.

So if she disagrees with this decision, she should file an appeal within 60 days.

If She Wants Help With Appeal

She can have a friend, lawyer or someone else help her. There are groups that can help find a lawyer or give free legal services if she qualifies. There are also lawyers who do not charge unless she wins the appeal. Your local Social Security office has a list of groups that can help her with her appeal.

If she gets someone to help her, please let us know. If she hires someone, we must approve the fee before he or she can collect it.

If You Have Any Questions

**EXHIBIT NO. B3B
PAGE: 4 OF 9**

If you have any questions, please call us toll free at 1-800-772-1213, or call your local Social Security Office. We can answer most questions over the phone. You can also write or visit any Social Security office. The office that serves your area is located at:

Social Security Administration
50 McDOWELL STREET
WELCH, WV 24801
866-273 -0399

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

Social Security Administration

LARA/ 0435960

CC: JAN DILS

XXX-XX-8055 ADAMS, NEVAEH HOPE

EXHIBIT NO. B3B
PAGE: 5 OF 9

JAN DILS
PO BOX 901
PARKERSBURG WV 26102

0435960 ADAMS, NEVAEH HOPE

XXX-XX-8055 ADAMS, NEVAEH HOPE

EXHIBIT NO. B3B
PAGE: 6 OF 9

Social Security Administration
Supplemental Security Income
Important Information

Date: April 30, 2019

Claim Number: 794-01-8055

KELLI MARIE DANIELS FOR
NEVAEH HOPE ADAMS
PO BOX 46
BIG SANDY WV 24816

NOTICE OF DISAPPROVED CLAIM

IMPORTANT NOTICE – NEVAEH HOPE ADAMS IS NOT ELIGIBLE FOR SSI

We are writing about NEVAEH ADAMS' claim for Supplemental Security Income (SSI) payments. Based on a review of her medical condition, she does not qualify for SSI payments for this claim. This is because she is not disabled or blind under our rules.

We urge you to read this entire letter, including the information about appeal rights and the information about Medicaid eligibility.

The Decision on This Case

The medical evidence does not show that her loss of vision is severe enough to meet the blindness requirements for Supplemental Security income payments.

We have decided that her condition is not disabling under our rules. This is because her condition does not cause marked and severe functional limitations.

Evidence from the following sources was used to evaluate this claim:

CAMC OUTPATIENT/CLINIC RECORDS - report received 01/11/2019
PEDIATRIC CARDIOLOGY - report received 01/07/2019
MERCER MEDICAL GROUP ENT - report received 01/19/2019
WELCH COMM HOSP OUTPATIENT CLINIC - report received 01/08/2019
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LOGAN PEDIATRICS INC. - report received 02/14/2019
ELIZABETH BODKIN MA:MULLENS - report received 04/20/2019
ELIZABETH A BODKIN MA copied document
WVU MEDICINE #2 REPORT RECEIVED 01/16/2019.
WVU MEDICINE REPORT RECEIVED 12/20/2018.
CARILION CLINIC REPORT RECEIVED 12/20/2018.

XXX-XX-8055 ADAMS, NEVAEH HOPE

You said that NEVAEH is disabled because of Turners syndrome, heart issues, hip problems, vision problems, and developmental delays.

EXHIBIT NO. B3B

PAGE: 7 OF 9

Her symptoms and their effect on her daily functioning have been considered in making this decision. While she may have difficulty with Turners syndrome, heart issues, hip problems, a lazy eye, vision problems, and developmental delays the evidence we considered does not show a condition that causes marked and severe functional limitations. Therefore, she cannot be found disabled.

If her condition gets worse, you should file a new application for supplemental security payments.

Although she is not eligible for Supplemental Security Income payments, she may be eligible for medical assistance (Medicaid). If you have any questions about her eligibility for Medicaid or need medical assistance, you should get in touch with the local Department of Health and Human Resources office.

About The Decision

Doctors and other trained staff looked at her case and made this decision. They work for your State but used our rules.

Please remember that there are many types of disability programs, both government and private, which use different rules. A person may be receiving benefits under another program and still not be entitled under our rules. This may be true in her case.

The Disability Rules

She must meet certain rules to qualify for SSI payments based on disability.

- She must have a medically established physical or mental condition that causes marked and severe functional limitations.
- That condition must last, or be expected to last, for at least 12 months in a row, or be expected to result in death.

Other Social Security Benefits

The application for SSI was also a claim for Social Security benefits. We looked into whether she qualifies for Social Security and found that she does not qualify (except for benefits she may already be receiving). If she disagrees, she has the right to appeal.

Information About Medicaid

Although she is not eligible for Supplemental Security Income payments, she may be eligible for medical assistance (Medicaid). If you have any questions about her eligibility for Medicaid, or need medical assistance, you should get in touch with the local Department of Health and Human Services office.

If She Disagrees With The Decision

XXX-XX-8055 ADAMS, NEVAEH HOPE

If she disagrees with this decision, she has the right to appeal. We will review her case at **EXHIBIT NO. B3B**
new facts. A person who did not make the first decision will decide the case. **PAGE: 8 OF 9**

- She has 60 days to ask for an appeal.
- The 60 days start the day after she gets this letter. We assume she got this letter 5 days after the date on it unless she shows us that she did not get it within the 5-day period.
- She must have a good reason for waiting more than 60 days to ask for an appeal.
- She has to ask for an appeal in writing. We will ask her to complete a form SSA-561-U2, called "Request for Reconsideration". Contact one of our offices or call 1-800-772-1213 to request this form. Or complete this form online at <http://www.socialsecurity.gov/disability/appeal>. Contact one of our offices if help is needed.
- In addition, complete a "Disability Report-Appeal" to tell us about her medical condition since she filed her claim. Contact one of our offices or call 1-800-772-1213 to request this form. Or, complete this report online after she completes the online Request for Reconsideration.

How The Appeal Works

You have a right to review the facts in her case. You can give us more facts to add to her file. Then we will decide her case again. You will not meet the person who will decide her case.

New Application

NEVAEH has the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If she disagrees with this decision and she files a new application instead of appealing:

- She might lose some benefits, or not qualify for any benefits, and
- We could deny the new application using this decision, if the facts and issues are the same.

So if she disagrees with this decision, she should file an appeal within 60 days.

If She Wants Help With Appeal

She can have a friend, lawyer or someone else help her. There are groups that can help find a lawyer or give free legal services if she qualifies. There are also lawyers who do not charge unless she wins the appeal. Your local Social Security office has a list of groups that can help her with her appeal.

If she gets someone to help her, please let us know. If she hires someone, we must approve the fee before he or she can collect it.

If You Have Any Questions

**EXHIBIT NO. B3B
PAGE: 9 OF 9**

If you have any questions, please call us toll free at 1-800-772-1213, or call your local Social Security Office. We can answer most questions over the phone. You can also write or visit any Social Security office. The office that serves your area is located at:

Social Security Administration
50 MCDOWELL STREET
WELCH, WV 24801
866-273 -0399

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Suspect Social Security Fraud?

If you suspect Social Security fraud, please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

Social Security Administration

LARA/ 0435960

XXX-XX-8055 ADAMS, NEVAEH HOPE

Social Security Administration Supplemental Security Income

SOCIAL SECURITY
SUITE A-8
5475 ROBERT C. BYRD DR
MOUNT HOPE WV 25880
Date: June 18, 2019
Claimant SSN: 794-01-8055

PO BOX 901
PARKERSBURG, WV 26102

Time: 8:27 AM ET
Unit: CR9

Request for Reconsideration Summary

On June 14, 2019, you, JAN DILS, provided the following information to support NEVAEH HOPE ADAMS' request for reconsideration. You understand that your responses to these questions are voluntary; but, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished. We have stored your request for a reconsideration, including your signature, electronically in our records.

Penalty of Perjury

You declared under penalty of perjury that all the information on this summary is true and correct to the best of your knowledge. Anyone who knowingly gives a false or misleading statement about a material fact in an appeal, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both.

What You Need To Do

- Review this summary to ensure we recorded your statements correctly.
- If you agree with all your statements, you should keep this summary for your records.
- If you disagree with any of your statements, you should contact us within 10 days after receiving this summary to let us know.

I disagree with the determination made on her claim for Supplemental Security Income benefits because THE DECISION IS CONTRARY TO MEDICAL EVIDENCE AND REGULATIONS.

See Next Page

794-01-8055
06/18/2019

EXHIBIT NO. B4B
PAGE: 2 OF 3
Page 2 of 3

She is represented by JAN DILS.

I have additional evidence to submit. I will submit this evidence by July 18, 2019.

If you have a question or something to report, call 866-964-2042 and ask for ANY CLAIMS REPRESENTATIVE. If you call or visit our office, please have this summary with you. For general information about Social Security, visit our web site at www.socialsecurity.gov on the Internet.

Your local Social Security office is located at:

SOCIAL SECURITY
SUITE A-8
5475 ROBERT C. BYRD DR
MOUNT HOPE WV 25880

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. subsection 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 8 minutes to read the instructions, gather the facts, and answer the questions. Send or bring the Completed Form to Your Local Social Security Office. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

794-01-8055
06/18/2019

Privacy Act Statement**Collection and Use of Personal Information**

Section 205(a), of the Social Security Act as amended, (42 U.S.C. 405(a)) and Title 20 C.F.R. 404.907 - 404.922 and 416.1407 - 416.1422 authorize us to collect this information. We will use the information you provide to help us determine your entitlement to benefits. The information you provide on this form is voluntary. However, we cannot reconsider the decision on your claim unless you furnish this information.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information for Social Security records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. Information from these matching agencies can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our System of Records Notice entitled Claims Folder System 60-0089. The notice, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any local Social Security office.

**Social Security Administration
Supplemental Security Income
Important Information**

Date: June 24, 2019

Claim Number: 794-01-8055

KELLI DANIELS FOR
NEVAEH HOPE ADAMS
C/O KELLI ADAMS
PO BOX 46
BIG SANDY WV 24816

Upon receipt of your request for reconsideration we had her claim independently reviewed by a physician and disability examiner in the State Agency which works with us in making disability determinations. The evidence in her case has been thoroughly evaluated; this includes the medical evidence and the additional information received since the original decision. We find that the previous determination denying her claim was proper under the law. Shown below is an explanation of the determination we made in her claim and how we arrived at it.

The determination on her claim was made by an agency of the State. It was not made by her own doctor or by other people writing reports about her. However, any evidence they gave us was used in making this determination. Doctors and other people in the State agency who are trained in disability evaluation reviewed the evidence and made the determination based on Social Security law and regulations.

The medical evidence does not show that her loss of vision is severe enough to meet the blindness requirements for Supplemental Security income.

In addition to the medical evidence already in file, evidence from the following sources was used to reconsider this claim:

ELIZABETH A BODKIN MA copied document

You said that NEVAEH is disabled because of Turners syndrome, heart issues, hip problems, lazy eye, joint problems, vision problems, developmental delays.

Although she has chest discomfort, the special studies of her heart show that the heartbeat and function are satisfactory.

Although she has discomfort, the evidence shows she is still able to move about and to use her arms, hands and legs in a satisfactory manner.

The evidence shows that she is able to see well enough to perform her usual daily activities.
The medical evidence does not show any other disabling condition.

XXX-XX-8055 ADAMS, NEVAEH HOPE

Our prior decision stated that while her condition causes some problems, it does not cause ~~functional limitations~~**EXHIBIT NO. B5B**. After careful review, we concluded that this decision is correct. ~~PAGE 2 OF 7~~

If you believe that the reconsideration determination is not correct, you may request a hearing before an administrative law judge of the Office of Disability Adjudication and Review. If you want a hearing, you must request it not later than 60 days from the date you receive this notice. You may make your request through any Social Security office or on the Internet at <http://www.socialsecurity.gov/disability/appeal>. As part of the appeal process, you also need to tell us about her medical condition. We provide a form for doing that, The Disability Report – Appeal. You may contact one of our offices or call 1-800-772-1213 to request this form. Or, you may complete the report online after you complete the online Request for Hearing by Administrative Law Judge. Read the enclosed leaflet and the rest of this letter for a full explanation of your right to appeal.

If at any time in the future you think she qualifies for payment, please contact us immediately about filing a new application. We cannot make payment for any month before the month in which you apply.

Please get in touch with Social Security if you believe this decision is wrong or you have any questions or need more information. Most questions can be handled by phoning or writing any Social Security office. If you visit a Social Security office, please bring this notice with you. If the decision in her case is based on incorrect information, we will be happy to make whatever change is necessary.

New Application

NEVAEH has the right to file a new application at any time, but filing a new application is not the same as appealing this decision. If she disagrees with this decision and she files a new application instead of appealing:

- She might lose some benefits, or not qualify for any benefits, and
- We could deny the new application using this decision, if the facts and issues are the same.

So if she disagrees with this decision, she should file an appeal within 60 days.

Your Right To Appeal

If you still are not satisfied with the decision, you may request a hearing of this decision by the Office of Hearings and Appeals. **YOU MUST REQUEST THE HEARING IN WRITING WITHIN 60 DAYS FROM THE DATE YOU RECEIVED THIS NOTICE.** If you cannot send us a written request for a hearing within 60 days, be sure to contact us by phone. If you wait longer than 60 days, we will not conduct a hearing of our decision unless you have a good reason for the delay.

If you request a hearing, the case will be assigned to an administrative law judge of the Office of Hearings and Appeals. The administrative law judge will let you know when and where the case will be heard. The hearing proceedings are informal. The administrative law judge will summarize the facts in your case, explain the law, and state what must be decided. Then you will have an opportunity to explain why you disagree with the decision made in your case, to present additional evidence and to have witnesses testify for you. You can also request the administrative law judge subpoena unwilling witnesses to appear for cross-examination and to bring with them any information about your case. If you decide not to appear at the hearing, you still have the right to submit additional evidence. The administrative law judge will base the decision on the evidence in the file plus any new evidence submitted.

If She Wants Help With Appeal

XXX-XX-8055 ADAMS, NEVAEH HOPE

She can have a friend, lawyer or someone else help her. There are groups that can help free legal services if she qualifies. There are also lawyers who do not charge unless she wins. Your local Social Security office has a list of groups that can help her with her appeal.

If she gets someone to help her, please let us know. If she hires someone, we must approve the fee before he or she can collect it.

If You Have Any Questions

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Social Security Administration
50 McDOWELL STREET
WELCH, WV 24801
866-273 -0399

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Suspect Social Security Fraud?

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Social Security Administration

224/ 0445824

CC: JAN DILS ATTORNEY AT LAW LC
Enclosure: SSA Pub. No. 70-10281

RECONDI

XXX-XX-8055 ADAMS, NEVAEH HOPE

EXHIBIT NO. B5B
PAGE: 4 OF 7

JAN DILS ATTORNEY AT LAW LC
PO BOX 901
PARKERSBURG WV 26102

0445824 ADAMS, NEVAEH HOPE

XXX-XX-8055 ADAMS, NEVAEH HOPE

EXHIBIT NO. B5B
PAGE: 5 OF 7

Social Security Administration
Supplemental Security Income
Important Information

Date: June 24, 2019

Claim Number: 794-01-8055

KELLI DANIELS FOR
NEVAEH HOPE ADAMS
C/O KELLI ADAMS
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BIG SANDY WV 24816

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Although she has discomfort, the evidence shows she is still able to move about and to use her arms, hands and legs in a satisfactory manner.

The evidence shows that she is able to see well enough to perform her usual daily activities.

The medical evidence does not show any other disabling condition.

Our prior decision stated that while her condition causes some problems, it does not cause marked and severe functional limitations. After careful review, we concluded that this decision is correct. Therefore, we cannot consider her disabled.

XXX-XX-8055 ADAMS, NEVAEH HOPE

EXHIBIT NO. B5B

If you believe that the reconsideration determination is not correct, you may request a hearing from the administrative law judge of the Office of Disability Adjudication and Review. If you want a hearing, you must request it not later than 60 days from the date you receive this notice. You may make your request through any Social Security office or on the Internet at <http://www.socialsecurity.gov/disability/appeal>. As part of the appeal process, you also need to tell us about her medical condition. We provide a form for doing that, The Disability Report – Appeal. You may contact one of our offices or call 1-800-772-1213 to request this form. Or, you may complete the report online after you complete the online Request for Hearing by Administrative Law Judge. Read the enclosed leaflet and the rest of this letter for a full explanation of your right to appeal.

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If you request a hearing, the case will be assigned to an administrative law judge of the Office of Hearings and Appeals. The administrative law judge will let you know when and where the case will be heard. The hearing proceedings are informal. The administrative law judge will summarize the facts in your case, explain the law, and state what must be decided. Then you will have an opportunity to explain why you disagree with the decision made in your case, to present additional evidence and to have witnesses testify for you. You can also request the administrative law judge subpoena unwilling witnesses to appear for cross-examination and to bring with them any information about your case. If you decide not to appear at the hearing, you still have the right to submit additional evidence. The administrative law judge will base the decision on the evidence in the file plus any new evidence submitted.

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Social Security Administration
50 McDOWELL STREET
WELCH, WV 24801
866-273 -0399

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Social Security Administration

224/ 0445824

Enclosure: SSA Pub. No. 70-10281

RECONDI

XXX-XX-8055 ADAMS, NEVAEH HOPE

Social Security Administration Supplemental Security Income

SOCIAL SECURITY
50 McDOWELL STREET
WELCH WV 24801

Date: August 20, 2019
Claimant SSN: 794-01-8055

JAN DILS
PO BOX 901
PARKERSBURG, WV 26102

Time: 3:29 PM ET
Unit: CR2

Request for Hearing by Administrative Law Judge Summary

On August 19, 2019, you, JAN DILS, provided the following information to support NEVAEH HOPE ADAMS' request for a hearing before an Administrative Law Judge. We have stored your request for a hearing, including your signature, electronically in our records.

Penalty of Perjury

You declared under penalty of perjury that all the information on this summary is true and correct to the best of your knowledge. Anyone who knowingly gives a false or misleading statement about a material fact in an appeal, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both.

What You Need To Do

- Review this summary to ensure we recorded your statements correctly.
- If you agree with all your statements, you should keep this summary for your records.
- If you disagree with any of your statements, you should contact us within 10 days after receiving this summary to let us know.

I disagree with the determination made on her claim for Supplemental Security Income benefits because THE DECISION IS CONTRARY TO MEDICAL EVIDENCE AND REGULATIONS.

She is represented by JAN DILS.

See Next Page

794-01-8055
08/20/2019

She understands that an Administrative Law Judge of the Office of Disability Adjudication and Review will be appointed to conduct the hearing or other proceedings in her case. She also understands that the Administrative Law Judge will send her notice of the time and place of a hearing at least 75 days before the date set for a hearing.

She has been advised of the right to appear in person before an Administrative Law Judge. She understands that her personal appearance before an Administrative Law Judge would provide her with the opportunity to present written evidence, her testimony and the testimony of other witnesses. She understands that this opportunity to be seen and heard could be helpful to the Administrative Law Judge in making a decision.

It could be especially useful in her case since the Administrative Law Judge would have an opportunity to hear an explanation as to how her impairments prevent her from working and restrict her activities.

She wishes to appear at the hearing.

I have additional evidence to submit. I will submit this evidence by September 19, 2019.

If you have a question or something to report, call 866-273-0399 and ask for ANY CLAIMS REPRESENTATIVE. If you call or visit our office, please have this summary with you. For general information about Social Security, visit our web site at www.socialsecurity.gov on the Internet.

Your local Social Security office is located at:

SOCIAL SECURITY
50 McDOWELL STREET
WELCH WV 24801

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. subsection 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 8 minutes to read the instructions, gather the facts, and answer the questions. Send or bring the Completed Form to Your Local Social Security Office. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

794-01-8055
08/20/2019

Privacy Act Statement**Collection and Use of Personal Information**

Sections 205(a) (42 U.S.C. 405 (a)), 702 (42 U.S.C. 902), 1631(e)(1)(A) and (B) (42 U.S.C. 1383(e)(1)(A) and (B)), 1839(i) (42 U.S.C. 1395r), and 1869(b)(1) and (c) (42 U.S.C. 1395ff) of the Social Security Act authorizes us to collect this information. We will use the information you provide to continue processing your claim. The information you provide on this form is voluntary. However, failure to provide all or part of the requested information could prevent us from making an accurate and timely decision on your claim.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information for Social Security records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded and administered benefit programs for repayment of payments or delinquent debts under these programs. The law allows us to do this even if you do not agree to it.

A complete list of routine uses for this information is available in our System of Records Notice entitled, Claims Folder System, 60-0089. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at any Social Security office.

**SOCIAL SECURITY ADMINISTRATION**
**EXHIBIT NO. B7B
PAGE: 1 OF 15**
Refer To:

Nevaeh Hope Adams

Office of Hearings Operations
 SSA OHO HEARING OFC
 CHARLESTON FED CENTER
 500 QUARRIER STREET
 SUITE 100
 CHARLESTON, WV 25301-2186
 Tel: 888-527-9325
 Fax: 304-344-3359

September 23, 2019

Kelli Adams on behalf of
 Nevaeh Hope Adams
 C/o Kelli Adams
 P.O. Box 46
 Big Sandy, WV 24816

Dear Kelli Adams:

Thank you for your request for a hearing before an administrative law judge (ALJ). This letter explains the hearing process and things that you should do now to get ready for your hearing. We will send you a notice after we schedule your hearing. We will notify you at least 75 days before the date of your hearing. The notice will provide you with the time and place of your hearing. We generally process requests for hearing by date order, with the oldest receiving priority. We will schedule your hearing as soon as we can, which may take several months.

Use of Video Teleconferencing (VTC) At Your Hearing

In certain situations, we hold your hearing by VTC rather than in person. We will let you know ahead of time if we schedule your hearing by VTC.

If we schedule your appearance by VTC, you and the ALJ will be at different locations during the hearing. A large, color monitor will enable you and the ALJ to see, hear, and speak to each other. The ALJ will also be able to see, hear, and speak to anyone who comes with you to the hearing. This may include your representative (if you have one), a friend, or a family member. We will provide someone at your location to run the equipment and provide any other help you may need.

You must let us know within 30 days after the date you receive this notice if you do not want to appear at your hearing by VTC. (We may extend the 30-day period if you show you had good cause for missing the deadline.) Please let us know by completing and returning the attached form in the envelope we sent your representative. We will arrange for you to appear in person.

If you move before we hold your hearing, we retain the right to decide how you will appear at your hearing, even if you objected to appearing by VTC. For us to consider your change of residence when we schedule your hearing, you must submit evidence proving your new residence.

The Hearing

Suspect Social Security Fraud? Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

Form HA-L2 (04-2015)

Representative

See Next Page

Nevaeh Hope Adams

**EXHIBIT NO. B7B
PAGE: 2 OF 15**

At your hearing, you may present your case to the ALJ who will make the decision on your claim(s). The ALJ will consider the issue(s) you raise, the evidence now in your file, and any additional evidence you provide. The ALJ may also consider other issues, including issues that were decided in your favor in the decision you appealed. The Notice of Hearing will list the issues the ALJ plans to consider at the hearing.

Your hearing is the time to explain why you believe the ALJ should decide the issues in your favor.

Your Right to An Interpreter At Your Hearing

You are not required to bring an interpreter. You **must** request an interpreter so we can provide an interpreter **free of charge**. When you request an interpreter, tell us what language you prefer (including ASL). An interpreter can be requested by calling our office or sending a letter.

Submitting Evidence

We need to make sure that your file has everything that the ALJ will need to decide your case. After the ALJ reviews the evidence in your file, he or she may request more evidence to consider at your hearing.

You are required to inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled. Your representative must help you inform us about or submit the evidence, unless the evidence falls under an exception. You must inform us about or give us evidence no later than five business days before the date of your hearing. The ALJ may choose to not consider the evidence if you fail to provide it timely.

We can help you get evidence. If you need help, contact our office, your local Social Security office, or your representative (if you appoint one) immediately.

If a physician, expert, or other person is not providing documents important to your case, you may ask the ALJ to issue a subpoena. A subpoena is a special document that requires a person to submit documents or to testify at your hearing. The ALJ will issue a subpoena only if he or she thinks the evidence is necessary to decide your case, and the evidence cannot be obtained another way. You must ask the ALJ to issue a subpoena at least 10 days before your hearing date. Send your request in writing to the address at the top of the first page of this letter.

You May See The Evidence in Your File

If you wish to see the evidence in your file, you can see it on or before the date of your hearing. If you wish to see your file before the date of your hearing, please call us as soon as you reasonably can at the number at the top of the first page of this letter.

If You Have Any Questions or Your Address Changes

If you have any questions, please call or write us. You must tell us if you change your address. For your convenience, we gave you our telephone number and address on the first page of this letter.

See Next Page

Form HA-L2 (04-2015)

Representative

Nevaeh Hope Adams

EXHIBIT NO. B7B
Page No. 3
PAGE: 3 OF 15

Sincerely yours,

Kathy A. Lytton
Hearing Office Director

Enclosures:

HA-55 (Objection to Appearing by Video Teleconferencing)
Form SSA-L1697-U3 (Acknowledgement of Representation)
HA-L4 (What Happens Next)
SSA Publication No. 70-067 (Why You Should Have Your Hearing By Video)
HA-827 (Medical Release Notice)
SSA-827 (Authorization to Disclose Information to SSA)
Form HA-L32 (Electronic Disability Claims Processing Insert)
Barcode Sheet

cc: Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

Form HA-L2 (04-2015)
Representative

**SOCIAL SECURITY ADMINISTRATION****Refer To:**

Nevaeh Hope Adams

Office of Hearings Operations
 SSA OHO HEARING OFC
 CHARLESTON FED CENTER
 500 QUARRIER STREET
 SUITE 100
 CHARLESTON, WV 25301-2186
 Tel: 888-527-9325
 Fax: 304-344-3359

September 23, 2019

Kelli Adams on behalf of
 Nevaeh Hope Adams
 C/o Kelli Adams
 P.O. Box 46
 Big Sandy, WV 24816

Dear Kelli Adams:

Thank you for your request for a hearing before an administrative law judge (ALJ). This letter explains the hearing process and things that you should do now to get ready for your hearing. We will send you a notice after we schedule your hearing. We will notify you at least 75 days before the date of your hearing. The notice will provide you with the time and place of your hearing. We generally process requests for hearing by date order, with the oldest receiving priority. We will schedule your hearing as soon as we can, which may take several months.

Use of Video Teleconferencing (VTC) At Your Hearing

In certain situations, we hold your hearing by VTC rather than in person. We will let you know ahead of time if we schedule your hearing by VTC.

If we schedule your appearance by VTC, you and the ALJ will be at different locations during the hearing. A large, color monitor will enable you and the ALJ to see, hear, and speak to each other. The ALJ will also be able to see, hear, and speak to anyone who comes with you to the hearing. This may include your representative (if you have one), a friend, or a family member. We will provide someone at your location to run the equipment and provide any other help you may need.

You must let us know within 30 days after the date you receive this notice if you do not want to appear at your hearing by VTC. (We may extend the 30-day period if you show you had good cause for missing the deadline.) Please let us know by completing and returning the attached form in the envelope we sent your representative. We will arrange for you to appear in person.

If you move before we hold your hearing, we retain the right to decide how you will appear at your hearing, even if you objected to appearing by VTC. For us to consider your change of residence when we schedule your hearing, you must submit evidence proving your new residence.

The Hearing

Suspect Social Security Fraud? Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

Form HA-L2 (04-2015)

Claimant

See Next Page

Nevaeh Hope Adams

**EXHIBIT NO. B7B
PAGE: 5 OF 15**

At your hearing, you may present your case to the ALJ who will make the decision on your claim(s). The ALJ will consider the issue(s) you raise, the evidence now in your file, and any additional evidence you provide. The ALJ may also consider other issues, including issues that were decided in your favor in the decision you appealed. The Notice of Hearing will list the issues the ALJ plans to consider at the hearing.

Your hearing is the time to explain why you believe the ALJ should decide the issues in your favor.

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You are not required to bring an interpreter. You **must** request an interpreter so we can provide an interpreter **free of charge**. When you request an interpreter, tell us what language you prefer (including ASL). An interpreter can be requested by calling our office or sending a letter.

Submitting Evidence

We need to make sure that your file has everything that the ALJ will need to decide your case. After the ALJ reviews the evidence in your file, he or she may request more evidence to consider at your hearing.

You are required to inform us about or submit all evidence known to you that relates to whether or not you are blind or disabled. Your representative must help you inform us about or submit the evidence, unless the evidence falls under an exception. You must inform us about or give us evidence no later than five business days before the date of your hearing. The ALJ may choose to not consider the evidence if you fail to provide it timely.

We can help you get evidence. If you need help, contact our office, your local Social Security office, or your representative (if you appoint one) immediately.

If a physician, expert, or other person is not providing documents important to your case, you may ask the ALJ to issue a subpoena. A subpoena is a special document that requires a person to submit documents or to testify at your hearing. The ALJ will issue a subpoena only if he or she thinks the evidence is necessary to decide your case, and the evidence cannot be obtained another way. You must ask the ALJ to issue a subpoena at least 10 days before your hearing date. Send your request in writing to the address at the top of the first page of this letter.

You May See The Evidence in Your File

If you wish to see the evidence in your file, you can see it on or before the date of your hearing. If you wish to see your file before the date of your hearing, please call us as soon as you reasonably can at the number at the top of the first page of this letter.

If You Have Any Questions or Your Address Changes

If you have any questions, please call or write us. You must tell us if you change your address. For your convenience, we gave you our telephone number and address on the first page of this letter.

Nevaeh Hope Adams

EXHIBIT NO. B7B
Page No. 3
PAGE: 6 OF 15

Sincerely yours,

Kathy A. Lytton
Hearing Office Director

Enclosures:

- HA-55 (Objection to Appearing by Video Teleconferencing)
- HA-L4 (What Happens Next)
- SSA Publication No. 70-067 (Why You Should Have Your Hearing By Video)
- HA-827 (Medical Release Notice)
- SSA-827 (Authorization to Disclose Information to SSA)

cc: Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

Form HA-L2 (04-2015)
Claimant

Social Security Administration

EXHIBIT NO. B7B
PAGE: 7 OF 15
 Form Approved
 OMB No. 0960-0671

OBJECTION TO APPEARING BY VIDEO TELECONFERENCING

Name: Nevaeh Hope Adams

Social Security Number: 794-01-8055

Wage Earner:

Hearing Office: Charleston Wv



RQID:00000000000000000264076713 SITE:Y09 DR:S
 SSN:794018055 DOCTYPE:3267 RF:D CS:71bd

[] **I do not want to appear at my hearing by video teleconference. Please schedule my hearing so that I may appear in person.**

Please return this form only if you object to a hearing by video teleconference.

Additional Comments: _____

Signature: _____

Date: _____

Area Code and Telephone Number: _____

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(b)(1), 205(d) and 1631(c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to acknowledge you are opting-out of an appearance via video teleconferencing. Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled Claims Folder System. Additional information about this and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

**SOCIAL SECURITY HEARING PROCESS
WHAT HAPPENS NEXT?**

- * Your hearing request and your file are now at the Office of Hearings Operations (OHO).
- * We may look at your case to see if we can make a decision in your favor without a hearing. If we do not make a decision this way, we will prepare your case for an administrative law judge (ALJ). We prepare cases in the order we get them.
- * An ALJ will review your file after we prepare it. We will then schedule a hearing for your case. You will get a notice informing you when and where we will hold your hearing. We will send you the notice at least 75 days before the date of your hearing. If you have a representative, we will also send the notice to that person.
- * You will come to your hearing and talk to the ALJ. Other people, such as witnesses or your representative, can also come to your hearing. If the ALJ wants any more evidence, or if you ask for more time to give us more evidence, the ALJ will tell you how long we will wait for that evidence.
- * The ALJ will make a decision after your hearing if he or she has all of the evidence. Otherwise, the ALJ will make a decision when he or she gets the evidence needed to make a decision.
- * You can expect to wait another 3 months after the hearing until you receive your written decision in the mail.
- * We cannot talk to you about the outcome of your case before we mail you the written decision.
- * Remember: In order to make your case go as quickly as possible, please be sure to send us all of your medical and other evidence as soon as possible. Your representative, if you have one, may also send evidence to us. Having the evidence sooner could help the ALJ decide your case sooner.

Why You Should Have Your Hearing By Video Teleconference

If you are participating in a hearing before an administrative law judge, Social Security can make the process more convenient for you, through video teleconferencing (VTC) technology.

What is VTC?

VTC allows you and other hearing participants to see and hear each other clearly on color monitors. The judge remains in his or her office, and you go to a site that may be more convenient to where you live. A technician is there to make sure the teleconferencing equipment is connected and working properly.

How is a hearing by VTC different?

Except for the equipment, a hearing by VTC is no different from a hearing at which you appear in person. The judge can see and speak with you and anyone who comes to the hearing with you, such as your representative or witnesses. You can see the judge and anyone who is with the judge, or anyone at another video hearing site, such as a medical or vocational expert. Transmission of the hearing is secure, and your privacy is protected. We do not videotape hearings, but we do make audio recordings, as we do for all hearings.

What are the advantages of a hearing by VTC?

Often an appearance by VTC can be scheduled faster than an in-person appearance. That means less waiting time. In addition, a VTC location may be closer to your home. That might make it easier for you to have witnesses or other people accompany you.

www.socialsecurity.gov

How is a hearing by VTC scheduled?

Prior to scheduling your hearing, we will notify you that we may schedule you to appear by VTC, and provide you the opportunity to object to appearing by video. If you have questions after you receive acknowledgment of your request for a hearing, please contact your hearing office.



Social Security Administration
 SSA Publication No. 70-067
 ICN 443300
 Unit of Issue – HD (one hundred)
 October 2014 (April 2008 edition may be used)

**NOTICE TO REPRESENTATIVE OF CLAIMANT BEFORE
THE SOCIAL SECURITY ADMINISTRATION****TOE 420**

Jan Denise Dils
 P. O. Box 901
 Parkersburg, WV 26102

Date: September 18, 2019
 Claimant: Nevaeh Hope Adams
 Wage Earner:
 Social Security Number: 794-01-8055

We have received written notice that the claimant has appointed you to act as the representative in connection with this claim(s) under the Social Security Act (the Act). We will, therefore, be dealing directly with you on matters pertaining to this claim(s).

Generally, to charge a fee for services, you must use one of two, mutually exclusive fee approval processes. You must file either a fee petition or a fee agreement with us. In either case, you cannot charge more than the fee amount we approve.

Fee Petition Process

You may ask for approval of a fee by giving us a fee petition when you have completed your services to the claimant. This written request must describe in detail the amount of time you spent on each service provided and the amount of fee you are requesting.

Fee Agreement Process

If you and the claimant have a written fee agreement, that you have not already submitted, either of you must give it to us before we decide the claim(s). We usually will approve the agreement if you both sign it; the fee you agreed on is no more than 25 percent of the past-due benefits, or \$6,000 (or a higher amount we set and announce in the Federal Register), whichever is less; we approve the claim(s); and the claim results in past-due benefits.

If you do not file a fee agreement, you must use form **SSA-1560-U5 (PETITION TO OBTAIN APPROVAL OF A FEE FOR
REPRESENTING A CLAIMANT BEFORE THE SOCIAL SECURITY ADMINISTRATION)** to petition for approval of the fee you wish to charge. File the SSA-1560-U5 when the proceedings are complete and your services have ended. If you are an attorney or a non-attorney whom SSA has found eligible to receive direct payment and you seek direct payment from the claimant's title II or title XVI past-due benefits, you must file the SSA-1560-U5, or a notice of intent to petition for a fee within 60 days of the notice of the favorable determination. Further information and instructions for completion are given on the form itself.

After we approve a fee, you must look to the claimant for payment, except when you are an attorney or non-attorney who is eligible to receive direct payment and there are past-due benefits payable under title II or title XVI of the Act as a result of a favorable determination on the claim. In such cases, we will pay up to 25 percent of such past-due benefits directly to you toward payment of the approved fee and charge you the assessment required by section 206(d) and 1631(2)(2)(c) of the Social Security Act. You cannot charge or collect this expense from the claimant.

If you wish to waive either a fee or direct payment of a fee and you have not already done so, you should sign and date the appropriate box below or send us a letter with an appropriate statement. Early filing of the waiver will enable us to prevent the automatic withholding of past-due benefits for a possible direct payment.

- **WAIVER OF FEE** - I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligation, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Signature (Representative)	Date
----------------------------	------

- **WAIVER OF DIRECT PAYMENT BY ATTORNEY OR NON-ATTORNEY ELIGIBLE TO RECEIVE DIRECT PAYMENT** - I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or supplemental security income benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Signature (Representative)	Date
----------------------------	------

Electronic Disability Claims Processing

Social Security is changing from a paper to an electronic disability claims process in order to improve the quality and timeliness of our decisions. Your client's disability claim file is being processed electronically. Your claimant's rights under the Social Security Act remain the same.

Your client's case is available to be viewed electronically using the Appointed Representative Services (ARS). If you do not already have access to ARS, please contact your local hearing office to initiate the registration process. Once you have access, your client's case will be viewable at <https://secure.ssa.gov/acu/LoginWeb/>.

NOTE: If you are requesting direct payment of the authorized fee, you must access your clients' files electronically using ARS.

Additional evidence should be submitted within the timeframes for the submission of evidence discussed in the notice. **The preferred way to submit evidence to the electronic folder is by using one of the following three methods:**

- o Send the evidence using the Eletronic Records Express (ERE) website. If you have not registered to use the ERE website, contact your local hearing office.
- o Fax the evidence using this fax number -- (877)871-1882. Remember that the enclosed barcode must be the first page for each document being faxed.
- o Send the evidence to the contract scanner listed below. The barcode must be the first page of each document. **DO NOT SEND ORIGINAL DOCUMENTS. DOCUMENTS ARE NOT RETURNED.**

**CHARLESTON, WV OHO
P. O. BOX 8775
LONDON, KY 40742-8775**

You may also send the evidence by mail or deliver it to the hearing office but there may be a delay in associating the evidence with the electronic file.

NOTE: The attached barcode pertains to your client's disability claim file only. Please keep the original barcode sheet for submitting all documents on this case. Bar codes may be used more than once when faxing evidence into the electronic file.

**SOCIAL SECURITY ADMINISTRATION****Refer To:**

Nevaeh Hope Adams

Office of Hearings Operations
 SSA OHO HEARING OFC
 CHARLESTON FED CENTER
 500 QUARRIER STREET
 SUITE 100
 CHARLESTON, WV 25301-2186
 Tel: 888-527-9325
 Fax: 304-344-3359

September 23, 2019

Kelli Adams on behalf of
 Nevaeh Hope Adams
 C/o Kelli Adams
 P.O. Box 46
 Big Sandy, WV 24816

Dear Kelli Adams:

In order to obtain records to update your file we need a current Authorization to Release Information. Please sign the enclosed form(s) and return it to our office within ten (10) days. A return envelope is enclosed for your convenience.

Sincerely yours,

Kathy A. Lytton
 Hearing Office Director

cc: Jan Denise Dils
 P. O. Box 901
 Parkersburg, WV 26102

Enclosure (SSA-827)

**EXHIBIT NO. B7B
PAGE: 13 OF 15**

WHOSE Records to be Disclosed	
NAME (<i>First, Middle, Last, Suffix</i>) Nevaeh Hope Adams	
SSN 794-01-8055	Birthday (<i>mm/dd/yy</i>) 07/21/2015

**AUTHORIZATION TO DISCLOSE INFORMATION TO
THE SOCIAL SECURITY ADMINISTRATION (SSA)**

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT *All my medical records; also education records and other information related to my ability to perform tasks.*
This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:

- Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
- Drug abuse, alcoholism, or other substance abuse
- Sickle cell anemia
- Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
- Gene-related impairments (including genetic test results)

2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.

3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.

4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM

The Social Security Administration and to the State agency authorized to process my case (usually called "disability determination services"), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE

Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be rediscovered to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY
INDIVIDUAL authorizing disclosure

IF not signed by subject of disclosure, specify basis for authority to sign
 Parent of minor Guardian Other personal representative (explain)

SIGN >>

(Parent/guardian/personal representative sign here if two signatures required by State law) >>

Date Signed	Street Address C/o Kelli Adams, P.O. Box 46		
Phone Number (with area code) 304-656-7434	City Big Sandy	State WV	ZIP 24816

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN >>

IF needed, second witness sign here (e.g., if signed with "X" above)
SIGN >>

Phone Number (or Address)

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

EXHIBIT NO. B7B
PAGE: 14 OF 15

**Explanation of Form SSA-827,
 "Authorization to Disclose Information to the Social Security Administration (SSA)"**

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

**Privacy Act Statement
 Collection and Use of Personal Information**

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(l) and 1631(e)(l)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(d)(l) and 1383(e)(l)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090; Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 60-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory **or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.**

EXHIBIT NO. B7B
PAGE: 15 OF 15



INSERT THIS END FIRST



**Please include this barcode cover sheet as the first page
of each set of documents returned.**

Fax the evidence to this fax number:

877-871-1882



RQID:0000000000000000264076712 SITE:Y09 DR:S
SSN:794018055 DOCTYPE:5032 RF:D CS:8164

Claimant: Nevaeh Hope Adams

SSN: 794-01-8055

**SOCIAL SECURITY ADMINISTRATION**
**EXHIBIT NO. B8B
PAGE: 1 OF 6**

Refer To:
Nevaeh Hope Adams

Office of Hearings Operations
Charleston Fed Center
500 Quarrier Street
Suite 100
Charleston, WV 25301-2186
Tel: (888)527-9325 / Fax: (833)574-0712
Date: July 21, 2020

COVID-19 Public Health Emergency Hearing Changes

Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

Due to the COVID-19 national public health emergency, we are currently conducting hearings only by telephone, with the claimant's consent. To determine whether a claimant consents to a telephone hearing, we have been calling the claimant's representative pursuant to our COVID Enhanced Outreach process. However, we are updating our outreach process for cases in which the claimant is represented. We will now provide the enclosed COVID-19 Telephone Hearing Agreement Form to the representative instead of calling the representative. The claimant or representative will indicate on the form if the claimant agrees to a hearing by telephone, and if so, to provide phone numbers for the hearing. If the claimant is unable to sign the form due to COVID-19 precautions, the representative may sign in lieu of the claimant. We will not schedule, or proceed with a hearing by telephone until we receive the claimant's consent. We also will accept a verbal agreement to appear by telephone. To provide a verbal agreement, please call us at the number in the heading of this notice. If the claimant does not consent to appear by telephone, we will not schedule the hearing at this time, or if already scheduled, we will postpone the hearing until we can offer another option, such as a hearing by video teleconferencing or in person, as appropriate.

Waiver of Timely Mailed Notice of Hearing

We generally must mail a notice of hearing at least 75 days, or an amended notice of hearing at least 20 days, before the date of the hearing. If circumstances prevent us from mailing this notice timely, we cannot proceed with the hearing unless the claimant waives his or her right to a timely mailed notice of hearing or amended notice of hearing. As applicable, we will mail a Waiver of Timely Written Notice of Hearing form for completion.

How to Submit Documents to Us

In our efforts to maintain service during the COVID-19 national public health emergency, we are emphasizing electronic options for doing business with us when possible to make it more convenient to the public and to reduce paper mail and faxes in our hearing offices. Registered representatives with a recognized notice of appointment in a case should continue to use the

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Nevaeh Hope Adams

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“Upload New File” function available when viewing a claimant’s electronic folder in Appointed Representative Services (ARS) to upload documents, including the COVID-19 Telephone Hearing Agreement Form or the Waiver of Timely Written Notice of Hearing form. This process does not require a barcode. Alternatively, representatives can also submit documents with a barcode using the “Send Individual Response” function in ARS and Electronic Records Express (ERE). Registered representatives should use these methods to submit any documents to us electronically, whenever possible.

If a representative is not registered, he or she can use a physical **fax machine or his or her own e-fax** solution to send documents, including the completed COVID-19 Telephone Hearing Agreement Form or the Waiver of Timely Written Notice of Hearing form. Due to our modernization efforts, sending documents to us via fax will now deliver a secure, electronic copy and route it to the specific hearing office’s designated email inbox. To submit documents electronically via fax, simply use the toll-free fax number with area code “833” assigned to the servicing hearing office, included in the header of this notice. For a specific hearing office’s designated fax number, visit https://www.ssa.gov/appeals/ho_locator.html.

For appointed representatives who do not have direct access to the electronic file, we can provide an encrypted copy of the electronic file by email. Please call us at the number in the heading of this notice to provide an email address for receipt of the electronic file.

Submitting the Notice of Appointment Electronically

Representatives who are not yet appointed to a case but are registered through ARS can use the “Contact OHO Office” function to send a one-way communication, including non-case information or the written notice of appointment, such as the SSA-1696, to a designated email box for the servicing hearing office. We highly recommend that any representative who will appear at a claimant’s hearing but is not yet appointed in the case submit appointment documentation before the hearing.

For an appointment of representative to be valid, the claim(s) file must contain a completed and properly signed notice of appointment, which can be on form SSA-1696, Claimant’s Appointment of Representative, or another written document that meets the requirements of 20 CFR 404.1707 and 416.1507. Form SSA-1696 is accessible on the Social Security website at <https://www.ssa.gov/forms/ssa-1696.pdf>. Additional information about use of the “Contact OHO Office” tool can be found at <https://www.ssa.gov/ar>.

During the COVID-19 public health emergency, we are temporarily permitting claimant signatures on a notice of appointment that do not meet the standards listed in GN 03910.040 (e.g., signatures that appear to be electronic or a digitized image of a handwritten signature) with additional verbal confirmation by the claimant about his or her intent to appoint the representative and electronic signature. A fee agreement with a claimant signature identical to the one on the written notice of appointment may be accepted if it is submitted simultaneously with notice of appointment.

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Nevaeh Hope Adams

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If You Have Any Questions

If you have any questions, please contact your servicing hearing office via the contact information in the heading of this notice.

Social Security Administration

cc: Kelli Adams on behalf of
Nevaeh Hope Adams
C/O Kelli Adams
P.O. Box 46
Big Sandy, WV 24816

Enclosure:
Telephone Hearing Agreement Form

Social Security Administration

OMB Control No. 0960-0671

COVID-19 Telephone Hearing Agreement Form

Claimant's Name:	
Social Security Number:	
Wage Earner:	
Representative's Name:	

Due to the coronavirus 2019 (COVID-19) national public health emergency, we are conducting hearings only by telephone at this time. We will not conduct the hearing by telephone unless the claimant (hereinafter "you") voluntarily agrees to appear in that manner. If you, the claimant, agree to appear at your hearing by telephone, the administrative law judge (ALJ) assigned to your case will conduct the hearing from his or her personal residence.

Please check one of the boxes below to tell us whether you voluntarily agree to appear at your hearing by telephone. If you agree to appear by telephone, please be sure to provide the telephone number where we can reach you at the time of your hearing. If you do not agree to appear by telephone, we will wait to schedule your hearing until we resume standard operations and can schedule you to appear at a hearing by video teleconferencing or in person, as appropriate. If we have already scheduled your hearing and you do not agree to appear by telephone, we will postpone your hearing.

I agree to a telephone hearing. On the day of the hearing, I can be contacted at:

My contact number: _____

My representative's contact number: _____

I do not agree to a telephone hearing. I understand that by selecting this option, my hearing will be delayed.

If your contact information changes or if you have questions, please call the Hearing Office at the telephone number on the COVID-19 Public Health Emergency Hearing Changes notice associated with this request.

Additional Comments: _____

[] **I am the claimant whose name appears above, and the selection on this form accurately represents my voluntary determinations.**

Claimant Signature:	Date:
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---- Or ----

[] **I represent the claimant whose name appears above and who presently is unable to sign this form due to COVID-19 precautions. As the authorized representative, I have consulted with the claimant, and the selection on this form accurately represents his or her voluntary determinations.**

Representative Signature:	Date:
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Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a) and 1631(d)(1) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed.

We will use the information to schedule your hearing. We may also share your information for the following purposes, called routine uses:

- To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting SSA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs. We contemplate disclosing information under this routine use only in situations in which SSA may enter a contractual or similar agreement with a third party to assist in accomplishing an agency function relating to this system of records.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0320, entitled Electronic Disability Claim File, as published in the Federal Register (FR) on December 22, 2003, at 68 FR 71210. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy/.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

**SOCIAL SECURITY ADMINISTRATION**
**EXHIBIT NO. B9B
PAGE: 1 OF 22**

Refer To:
Nevaeh Hope Adams

Office of Hearings Operations
Charleston Fed Center
500 Quarrier Street
Suite 100
Charleston, WV 25301-2186
Tel: (888)527-9325 / Fax: (833)574-0712

September 16, 2020

Kelli Adams on behalf of
Nevaeh Hope Adams
C/O Kelli Adams
P.O. Box 46
Big Sandy, WV 24816

NOTICE OF HEARING

I have scheduled your hearing for:

Day: Thursday **Date: December 3, 2020** **Time: 12:30 PM**
Eastern (ET)

I will conduct your hearing by telephone because it is not possible for you to attend in person or by video teleconferencing, or other extraordinary circumstances prevent you from attending in person or by video teleconferencing. On the date and at the time listed above, I will call you at the telephone number in our file. The number is (304)656-7434. If this is not the correct telephone number, please call this office immediately.

It Is Important That You, and Your Child, Attend Your Hearing

I have set aside this time for you to tell me about your case. If you do not attend the hearing and I do not find that you have a good reason, I may **dismiss** your request for hearing. I may do so without giving you further notice.

Please bring someone to care for your child, since your child may not need to be present for the entire hearing.

Form HA-83 (04-2015)
Representative

Suspect Social Security Fraud?

**Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline
at 1-800-269-0271 (TTY 1-866-501-2101).**

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Nevaeh Hope Adams (794-01-8055)

EXHIBIT NO. B9B
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Complete the Enclosed Form

Please complete and return the enclosed acknowledgement form at the earliest possible opportunity. Please use the enclosed envelope to return the form to us. We sent your representative a copy of the acknowledgment form. Your representative also should return his or her copy of the form.

If You Cannot Attend Your Scheduled Hearing

If you are not able to attend your hearing at the time we have set, please call this office immediately.

If you wish to change the time of your hearing, you must ask for a change. Your request must be in writing to tell me why you need the change and the time you would like the hearing held.

You must ask for this change before the earlier of the two dates described below. The first date is 30 days after you receive this notice. The second date is 5 days before the date of your hearing. We assume you received this notice 5 days after the date on it unless you show us that you did not get it within the 5-day period. If you delay in asking for a change, I will also decide whether you have a good reason for the delay. I will rule on your request based on our standards for deciding if there is a good reason for changing the time and place of your hearing.

I will decide whether you have a good reason for requesting the change. If I find you have a good reason for your request, we will set a new time for your hearing. We will also send another notice giving you the new time of your hearing. We will send this notice at least 20 days before the date of the new hearing.

Submitting More Evidence and Reviewing Your File

You are required to inform us about or submit all evidence known to you that relates whether or not you are blind or disabled. Your representative must help you inform us about or submit the evidence, unless the evidence falls under an exception. **If you are aware of or have more evidence, such as recent records, reports, or evaluations, you must inform me about it or give it to me no later than 5 business days before the date of your hearing. If you do not comply with this requirement, I may decline to consider the evidence unless the late submission falls within a limited exception.**

If you missed the deadline to inform us about or submit evidence, I will accept the evidence if I have not yet issued a decision and you did not inform us about or submit the evidence before the deadline because:

1. Our action misled you;
2. You had a physical, mental, educational, or linguistic limitation(s) that prevented you from informing us about or submitting the evidence earlier, or;

Form HA-83 (04-2015)
 Representative

See Next Page

Nevaeh Hope Adams (794-01-8055)

EXHIBIT NO. B9B**PAGE: 3 OF 22**

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3. Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing us about or submitting the evidence earlier.

If you want to see your file before the date of your hearing, please call this office and make arrangements. If your file is electronic, you may ask for a copy on a compact disc.

Issues I Will Consider

The hearing concerns your application of December 14, 2018, for Supplemental Security Income (SSI). I will consider whether you are disabled under section 1614(a)(3)(C) of the Social Security Act (the Act).

Under the Act, I will find you disabled if you have a physical or mental condition(s) and:

- You are not working;
- You have a condition(s) that causes marked and severe functional limitations; **and**
- Your condition(s) has lasted 12 straight months, can be expected to last 12 straight months, or can be expected to result in death.

I will follow a step-by-step process to decide if you are disabled. I will stop the process at the first step I can make a decision. The steps in this process look at:

- Any work you have may have done after your condition(s) began;
- The severity of your condition(s); and
- Whether your condition(s) meets or medically equals the requirements of a listed impairment in Appendix 1 of Subpart P of our regulations or functionally equals the listings.

Our regulations explain the rules for deciding whether you are disabled and, if so, when you became disabled. These rules are in the Code of Federal Regulations, Title 20, Chapter III, Part 416, Subpart I.

The child should be present at this hearing so I can consider the case fully.

More About the Issues

If I find that you have been disabled, I will also consider whether your disability continues through the date of the decision or whether your condition(s) has improved.

Form HA-83 (04-2015)
Representative

See Next Page

Nevaeh Hope Adams (794-01-8055)

EXHIBIT NO. B9B**PAGE: 4 OF 22**

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If You Object to the Issues

If you object to the issues or remarks listed above, you must tell me in writing why you object. You must tell me as soon as possible before the hearing, but not later than 5 business days before the date of the hearing. You must state the reason(s) for your objection.

Your Right To Request a Subpoena

I may issue a subpoena that requires a person to submit documents or testify at your hearing. I will do this if the person has evidence or information that you reasonably need to present your case fully.

If you want me to issue a subpoena, you must write to me as soon as possible. I must receive your request no later than 10 days before your hearing. In your request, please tell me:

- What documents you need and/or who the witnesses are;
- The location of the documents or witnesses;
- The important facts you expect the document or witness to prove; and
- Why you cannot prove these facts without a subpoena.

What Happens At the Hearing?

- I will ask you and any other witnesses to take an oath or to affirm that the testimony is true.
- You will have a chance to testify and tell me about your case.
- You and your representative (if you have one) may submit documents, present and question witnesses, state your case, and give written statements about the facts and law. You must provide your written statements no later than 5 business days before the date of your hearing.
- I will ask you and any other witnesses questions that will help me make a decision in your case.
- We will make an audio recording of the hearing.

The Decision

After the hearing, I will issue a written decision and mail it to you. The decision will explain my findings of fact and conclusions of law. I will base my decision given all the evidence of record, including the testimony at your hearing.

Form HA-83 (04-2015)
Representative

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Nevaeh Hope Adams (794-01-8055)

**EXHIBIT NO. B9B
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If You Have Any Questions

If you have any questions, please call, **(888)527-9325**, or write this office. For your convenience, our address is on the first page of this notice.

Sincerely,

Francine A Serafin
Administrative Law Judge

Enclosures:

Form HA-L32 (Electronic Disability Claims Processing Insert)
Form HA-504-OP1 (09-2003) ef (03-2015)
Form HA-4631 (Claimant's Recent Medical Treatment)
Form HA-4632 (Claimant's Medications)
Form HA-4633 (Claimant's Work Background)
Barcode Sheet

cc: Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

Form HA-83 (04-2015)
Representative

**SOCIAL SECURITY ADMINISTRATION**
**EXHIBIT NO. B9B
PAGE: 6 OF 22**

Refer To:
Nevaeh Hope Adams

Office of Hearings Operations
Charleston Fed Center
500 Quarrier Street
Suite 100
Charleston, WV 25301-2186
Tel: (888)527-9325 / Fax: (833)574-0712

September 16, 2020

Kelli Adams on behalf of
Nevaeh Hope Adams
C/O Kelli Adams
P.O. Box 46
Big Sandy, WV 24816

NOTICE OF HEARING

I have scheduled your hearing for:

Day: Thursday **Date: December 3, 2020** **Time: 12:30 PM**
Eastern (ET)

I will conduct your hearing by telephone because it is not possible for you to attend in person or by video teleconferencing, or other extraordinary circumstances prevent you from attending in person or by video teleconferencing. On the date and at the time listed above, I will call you at the telephone number in our file. The number is (304)656-7434. If this is not the correct telephone number, please call this office immediately.

It Is Important That You, and Your Child, Attend Your Hearing

I have set aside this time for you to tell me about your case. If you do not attend the hearing and I do not find that you have a good reason, I may **dismiss** your request for hearing. I may do so without giving you further notice.

Please bring someone to care for your child, since your child may not need to be present for the entire hearing.

Form HA-83 (04-2015)
Claimant

Suspect Social Security Fraud?

**Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline
at 1-800-269-0271 (TTY 1-866-501-2101).**

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Nevaeh Hope Adams (794-01-8055)

EXHIBIT NO. B9B
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Complete the Enclosed Form

Please complete and return the enclosed acknowledgement form at the earliest possible opportunity. Please use the enclosed envelope to return the form to us. We sent your representative a copy of the acknowledgment form. Your representative also should return his or her copy of the form.

If You Cannot Attend Your Scheduled Hearing

If you are not able to attend your hearing at the time we have set, please call this office immediately.

If you wish to change the time of your hearing, you must ask for a change. Your request must be in writing to tell me why you need the change and the time you would like the hearing held.

You must ask for this change before the earlier of the two dates described below. The first date is 30 days after you receive this notice. The second date is 5 days before the date of your hearing. We assume you received this notice 5 days after the date on it unless you show us that you did not get it within the 5-day period. If you delay in asking for a change, I will also decide whether you have a good reason for the delay. I will rule on your request based on our standards for deciding if there is a good reason for changing the time and place of your hearing.

I will decide whether you have a good reason for requesting the change. If I find you have a good reason for your request, we will set a new time for your hearing. We will also send another notice giving you the new time of your hearing. We will send this notice at least 20 days before the date of the new hearing.

Submitting More Evidence and Reviewing Your File

You are required to inform us about or submit all evidence known to you that relates whether or not you are blind or disabled. Your representative must help you inform us about or submit the evidence, unless the evidence falls under an exception. **If you are aware of or have more evidence, such as recent records, reports, or evaluations, you must inform me about it or give it to me no later than 5 business days before the date of your hearing. If you do not comply with this requirement, I may decline to consider the evidence unless the late submission falls within a limited exception.**

If you missed the deadline to inform us about or submit evidence, I will accept the evidence if I have not yet issued a decision and you did not inform us about or submit the evidence before the deadline because:

1. Our action misled you;
2. You had a physical, mental, educational, or linguistic limitation(s) that prevented you from informing us about or submitting the evidence earlier, or;

Form HA-83 (04-2015)
 Claimant

See Next Page

Nevaeh Hope Adams (794-01-8055)

**EXHIBIT NO. B9B
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3. Some other unusual, unexpected, or unavoidable circumstance beyond your control prevented you from informing us about or submitting the evidence earlier.

If you want to see your file before the date of your hearing, please call this office and make arrangements. If your file is electronic, you may ask for a copy on a compact disc.

Issues I Will Consider

The hearing concerns your application of December 14, 2018, for Supplemental Security Income (SSI). I will consider whether you are disabled under section 1614(a)(3)(C) of the Social Security Act (the Act).

Under the Act, I will find you disabled if you have a physical or mental condition(s) and:

- You are not working;
- You have a condition(s) that causes marked and severe functional limitations; **and**
- Your condition(s) has lasted 12 straight months, can be expected to last 12 straight months, or can be expected to result in death.

I will follow a step-by-step process to decide if you are disabled. I will stop the process at the first step I can make a decision. The steps in this process look at:

- Any work you have may have done after your condition(s) began;
- The severity of your condition(s); and
- Whether your condition(s) meets or medically equals the requirements of a listed impairment in Appendix 1 of Subpart P of our regulations or functionally equals the listings.

Our regulations explain the rules for deciding whether you are disabled and, if so, when you became disabled. These rules are in the Code of Federal Regulations, Title 20, Chapter III, Part 416, Subpart I.

The child should be present at this hearing so I can consider the case fully.

More About the Issues

If I find that you have been disabled, I will also consider whether your disability continues through the date of the decision or whether your condition(s) has improved.

Form HA-83 (04-2015)
Claimant

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Nevaeh Hope Adams (794-01-8055)

EXHIBIT NO. B9B**PAGE: 9 OF 22**

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If You Object to the Issues

If you object to the issues or remarks listed above, you must tell me in writing why you object. You must tell me as soon as possible before the hearing, but not later than 5 business days before the date of the hearing. You must state the reason(s) for your objection.

Your Right To Request a Subpoena

I may issue a subpoena that requires a person to submit documents or testify at your hearing. I will do this if the person has evidence or information that you reasonably need to present your case fully.

If you want me to issue a subpoena, you must write to me as soon as possible. I must receive your request no later than 10 days before your hearing. In your request, please tell me:

- What documents you need and/or who the witnesses are;
- The location of the documents or witnesses;
- The important facts you expect the document or witness to prove; and
- Why you cannot prove these facts without a subpoena.

What Happens At the Hearing?

- I will ask you and any other witnesses to take an oath or to affirm that the testimony is true.
- You will have a chance to testify and tell me about your case.
- You and your representative (if you have one) may submit documents, present and question witnesses, state your case, and give written statements about the facts and law. You must provide your written statements no later than 5 business days before the date of your hearing.
- I will ask you and any other witnesses questions that will help me make a decision in your case.
- We will make an audio recording of the hearing.

The Decision

After the hearing, I will issue a written decision and mail it to you. The decision will explain my findings of fact and conclusions of law. I will base my decision given all the evidence of record, including the testimony at your hearing.

Form HA-83 (04-2015)
Claimant

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Nevaeh Hope Adams (794-01-8055)

**EXHIBIT NO. B9B
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Page 5 of 5

If You Have Any Questions

If you have any questions, please call, **(888)527-9325**, or write this office. For your convenience, our address is on the first page of this notice.

Sincerely,

Francine A Serafin
Administrative Law Judge

Enclosures:
Form HA-504-OP1 (09-2003) ef (03-2015)

cc: Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

Form HA-83 (04-2015)
Claimant

Electronic Disability Claims Processing

Social Security is changing from a paper to an electronic disability claims process in order to improve the quality and timeliness of our decisions. Your client's disability claim file is being processed electronically. Your claimant's rights under the Social Security Act remain the same.

Your client's case is available to be viewed electronically using the Appointed Representative Services (ARS). If you do not already have access to ARS, please contact your local hearing office to initiate the registration process. Once you have access, your client's case will be viewable at <http://ssa.gov/ar/>.

NOTE: If you are requesting direct payment of the authorized fee, you must access your clients' files electronically using ARS. We will continue to provide you a CD copy of the file on the day of the hearing at this time.

Additional evidence should be submitted within the timeframes for the submission of evidence discussed in the notice. **The preferred way to submit evidence to the electronic folder is by using one of the following three methods:**

- **Send the evidence using the Electronic Records Express (ERE) website. If you have not registered to use the ERE website, contact your local hearing office.**
- **Fax the evidence using this fax number -- (877)871-1882. Remember that the enclosed barcode must be the first page for each document being faxed.**
- **Send the evidence to the contract scanner listed below. The barcode must be the first page of each document. DO NOT SEND ORIGINAL DOCUMENTS. DOCUMENTS ARE NOT RETURNED.**

**Charleston, WV OHO
P. O. Box 8775
London, KY 40742-8775**

You may also send the evidence by mail or deliver it to the hearing office but there may be a delay in associating the evidence with the electronic file.

NOTE: The attached barcode pertains to your client's disability claim file only. Please keep the original barcode sheet for submitting all documents on this case. Barcodes may be used more than once when faxing evidence into the electronic file.

**EXHIBIT NO. B9B
PAGE: 12 OF 22**

 Form Approved
 OMB NO. 0960-0671

ACKNOWLEDGEMENT OF RECEIPT (NOTICE OF HEARING)

(COMPLETE THIS FORM AND RETURN IT AT ONCE IN THE ENVELOPE PROVIDED. NO POSTAGE IS NECESSARY)

Claimant: Nevaeh Hope Adams	Social Security Number: 794-01-8055
Wage Earner:	Administrative Law Judge: Francine A Serafin
Hearing Scheduled: Thursday, December 3, 2020 at 12:30 PM Eastern (ET)	Hearing Office: Charleston Wv
Location of Hearing: 1103 George Kostas Dr Logan, WV 25601	 RQID:0000000000000000282517139 SITE:Y09 DR:S SSN:794018055 DOCTYPE:3005 RF:D CS:cba3

(Check only one)

I will be available by phone at the time shown on the Notice of Hearing. If an emergency arises after I mail this form and I am not available, I will immediately notify you at the telephone number shown on the Notice of Hearing.

I cannot be present at the time shown on the Notice of Hearing. I request that you reschedule my hearing because:

NOTE: YOUR REQUEST FOR HEARING MAY BE DISMISSED IF YOU DO NOT ATTEND THE HEARING AND CANNOT GIVE A GOOD REASON FOR NOT ATTENDING. THE TIME OR PLACE OF THE HEARING WILL BE CHANGED IF YOU HAVE A GOOD REASON FOR YOUR REQUEST.

Signature:	Date:	Area Code and Telephone Number:
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I have recently moved. My new address is:

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(b)(1), 205(d) and 1631(c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to acknowledge you will appear at your hearing with an Administrative Law Judge.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans' Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled Claims Folder System. Additional information about this and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

**EXHIBIT NO. B9B
PAGE: 14 OF 22**

Form Approved
OMB NO. 0960-0671

ACKNOWLEDGEMENT OF RECEIPT (NOTICE OF HEARING)

(COMPLETE THIS FORM AND RETURN IT AT ONCE IN THE ENVELOPE PROVIDED. NO POSTAGE IS NECESSARY)

Claimant: Nevaeh Hope Adams	Social Security Number: 794-01-8055
Wage Earner:	Administrative Law Judge: Francine A Serafin
Hearing Scheduled: Thursday, December 3, 2020 at 12:30 PM Eastern (ET)	Hearing Office: Charleston Wv
Location of Hearing: 1103 George Kostas Dr Logan, WV 25601	

(Check only one)

I will be available by phone at the time shown on the Notice of Hearing. If an emergency arises after I mail this form and I am not available, I will immediately notify you at the telephone number shown on the Notice of Hearing.

I cannot be present at the time shown on the Notice of Hearing. I request that you reschedule my hearing because:

NOTE: YOUR REQUEST FOR HEARING MAY BE DISMISSED IF YOU DO NOT ATTEND THE HEARING AND CANNOT GIVE A GOOD REASON FOR NOT ATTENDING. THE TIME OR PLACE OF THE HEARING WILL BE CHANGED IF YOU HAVE A GOOD REASON FOR YOUR REQUEST.

Signature:	Date:	Area Code and Telephone Number:
------------	-------	---------------------------------

I have recently moved. My new address is:

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(b)(1), 205(d) and 1631(c) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to acknowledge you will appear at your hearing with an Administrative Law Judge.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information may prevent an accurate and timely decision on any claim filed.

We rarely use the information you supply us for any purpose other than to make a determination regarding benefits eligibility. However, we may use the information for the administration of our programs including sharing information:

3. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans' Affairs); and,
4. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A complete list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notice 60-0089, entitled Claims Folder System. Additional information about this and other system of records notices and our programs are available online at www.socialsecurity.gov or at your local Social Security office.

We may share the information you provide to other health agencies through computer matching programs. Matching programs compare our records with records kept by other Federal, State or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. We estimate that it will take about 30 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

**EXHIBIT NO. B9B
PAGE: 16 OF 22**

Social Security Administration

 Form Approved
 OMB No.0960-0292
CLAIMANT'S RECENT MEDICAL TREATMENT**A. To be completed by hearing office**
 (Claimant and Social Security Number)
 Nevaeh Hope Adams
 794-01-8055

 (Wage Earner and Social Security Number)
 (Leave blank if same as claimant)

 The last time we brought your
 case up-to-date was:
 September 18, 2019
B. To be completed by claimant**PLEASE PRINT****Please Answer the Following Questions:**

- (1) Have you been treated or examined by a doctor (other than a doctor at a hospital) since the above date? Yes No

(If yes, please list the name, addresses and telephone numbers of doctors who have treated or examined you since the above date. Also list dates of treatment or examination. If possible, send updated reports from these doctors to the Administrative Law Judge prior to the date of your hearing.)

DOCTORS' NAME(S)	ADDRESS(ES) & TELEPHONE NO.(S)	DATE(S)

- (2) What have these doctors told you about your condition?
-
-
-
-

- (3) Have you been hospitalized since the above date? Yes No
- (If yes, please list the name and address of the hospital. Also explain why you were hospitalized and what treatment you received.)*

Name of Hospital	Address of Hospital (Include ZIP Code)
------------------	--

Reason for hospitalization:

Treatment received:

 Form **HA-4631** (8-1996) ef (9-2012)
 Issue Old Stock

 If more space is needed,
 use additional sheets.

 RQID:0000000000000000282517143 SITE:Y09 DR:S
 SSN:794018055 DOCTYPE:3040 RF:D CS:1083

Privacy Act Statement**Collection and Use of Personal Information**

Sections 205(a), 702, 1631(e)(1)(A) and (B), and 1869(b)(1) and (C) of the Social Security Act, as amended, allows us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed or could result in denial of the claim.

We will use the information to determine eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his or her affairs or his or her eligibility for or entitlement to benefits under the Social Security program when the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns his or her eligibility for benefits under the Social Security program; and
2. To specified business and other community members and Federal, State, and local agencies for verification of eligibility for benefits under section 1631(e) of the Act

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, and 60-0320, entitled Electronic Disability (eDIB) Claim File. Additional information and a full listing of all our SORNs are available on our website at www.ssa.gov/privacy/sorn.html.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

Form **HA-4631** (8-1996) ef (9-2012)

EXHIBIT NO. B9B
PAGE: 18 OF 22

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No.0960-0289

CLAIMANT'S MEDICATIONS

A. To be completed by Hearing Office

(Claimant and Social Security Number)

(Wage Earner and Social Security Number)
(Leave blank if same as claimant)

The last time we brought your case up-to-date was:
September 18, 2019

B. To be completed by the claimant

PLEASE PRINT

PLEASE LIST BELOW THE PRESCRIPTION MEDICATION WHICH YOU ARE PRESENTLY TAKING. IF THE NAME OF THE MEDICATION IS NOT SHOWN ON THE PRESCRIPTION CONTAINER, YOU MAY VERIFY THE NAME WITH YOUR PHARMACIST.

NAME OF YOUR PHYSICIAN:				
NAME OF MEDICATION & DOSAGE	DATE FIRST PRESCRIBED	DAILY AMOUNT TAKEN	REASONS FOR MEDICATION	NAME OF PHYSICIAN

PLEASE LIST BELOW THE NONPRESCRIPTION MEDICATION YOU ARE TAKING AND THE REASONS YOU TAKE THEM.

A standard linear barcode is located at the bottom left of the page.

Form HA-4632 (2-1994) ef (10-2012)
Use Until Stock Is Exhausted

If more space is needed,
use additional sheets.

RQID:0000000000000000282517144 SITE:Y09 DR:S
SSN:794018055 DOCTYPE:3045 RF:D CS:4d1

Privacy Act Statement**Collection and Use of Personal Information**

Sections 205, 223, 702, 1614, 1631, and 1869 of the Social Security Act, as amended allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from re-evaluating the decision on your claim.

We will use the information to determine your eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To representative payees, when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting the Social Security Administration in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and
2. To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting SSA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits. Additional information and a full listing of all our SORNs are available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

Form **HA-4632** (2-1994) ef (10-2012)

SOCIAL SECURITY ADMINISTRATION

EXHIBIT NO. B9B
PAGE: 20 OF 22
Form Approved
OMB No.0960-0300

CLAIMANT'S WORK BACKGROUND**A. To be completed by Hearing Office**

(Claimant and Social Security Number)

Nevaeh Hope Adams
794-01-8055(Wage Earner and Social Security Number)
(Leave blank if same as claimant)The last time we brought your case
up-to-date was:
September 18, 2019**B. To be completed by the claimant****PLEASE PRINT**

Start with your most recent job, and list that and any work performed within the past 15 years.

DATE OF EMPLOYMENT (APPROXIMATELY)	NAME OF EMPLOYER AND LOCATION OF EMPLOYMENT	DUTIES PERFORMED
FROM		
TO		
FROM		
TO		
FROM		
TO		

Form HA-4633 (2-1994) ef (10-2012)
Issue Old StockIf more space is needed,
use additional sheets.RQID:0000000000000000282517145 SITE:Y09 DR:
SSN:794018055 DOCTYPE:3050 RF:D CS:4a1e

Privacy Act Statement**Collection and Use of Personal Information**

Sections 205(a), 702, 1631 (e) and 1869(b)(1)(C) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failure to provide all or part of the information may prevent us from making an accurate and timely decision on your eligibility for disability benefits.

We will use this information to determine your eligibility for receiving disability benefits. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his/her affairs or his/her eligibility for or entitlement to benefits under the Social Security program when the individual is unable to provide information being sought. An individual is considered to be unable to provide certain types of information when: he/she is incapable or of questionable mental capability; he/she cannot read or write; he/she cannot afford the cost of obtaining the information; he/she has a hearing impairment, and is contacting SSA by telephone through a telecommunications relay system operator; a language barrier exists; or the custodian of the information will not, as a matter of policy, provide it to the individual; or the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual; and it concerns one or more of the following: his/her eligibility for benefits under the Social Security program; the amount of his/her benefit payment; or any case in which the evidence is being reviewed as a result of suspected abuse or fraud, concern for program integrity, or for quality appraisal or evaluation and measurement activities.
2. To specified business and other community members and Federal, State, and local agencies for verification of eligibility for benefits under section 1631(e) of the Act.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System; and 60-0320, entitled Electronic Disability Claim File. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form**

Form **HA-4633** (2-1994) ef (10-2012)



INSERT THIS END FIRST



**Please include this barcode cover sheet as the first page
of each set of documents returned.**

Fax the evidence to this fax number:

877-871-1882



RQID:0000000000000000282517146 SITE:Y09_DR:S
SSN:794018055 DOCTYPE:5032 RF:D CS:a1d5

**Claimant: Nevaeh Adams
SSN: 794-01-8055**

EXHIBIT NO. B10B
PAGE: 1 OF 1



October 21, 2020

The Honorable Judge Serafin
SSA Office of Hearings Operations
500 Quarrier Street
Suite 100
Charleston, WV 25301

**RE: Ms. Nevaeh Hope Adams
SSN: 794-01-8055**

Dear Honorable Judge Serafin:

Ms. Adams has advised us that she does wish to have her hearing conducted by telephone on December 3, 2020 and waives the 20-day notice.

The attorney and claimant telephone contact information are provided below:

Attorney Miles Cary - (304) 584-1239
Ms. Nevaeh Hope Adams - (304) 938-6159

Sincerely,

A handwritten signature in black ink that reads "Miles C. Cary".

Miles Cary, Attorney
Jan Dils, Attorneys at Law LC

MC/MDW

| MAIN OFFICE |

963 Market Street Parkersburg, WV 26101
P: 304.428.8900 F: 304.428.4500

PARKERSBURG | BECKLEY | CHARLESTON | HUNTINGTON | LOGAN | CHARLOTTE
1-877-JANDILS | JANDILS.COM



ADMINISTRACIÓN DEL SEGURO SOCIAL

EXHIBIT NO. B11B
PAGE: 1 OF 6

Referente a:
Nevaeh Hope Adams

Oficina de Operaciones de Audiencias
Charleston Fed Center
500 Quarrier Street
Suite 100
Charleston, WV 25301-2186
Teléfono: (888)527-9325 / Número de Fax:
(833)574-0712

Fecha: 9 de noviembre del 2020

Kelli Adams para
Nevaeh Hope Adams
C/O Kelli Adams
P.O. Box 46
Big Sandy, WV 24816

AVISO DE AUDIENCIA – RECORDATORIO IMPORTANTE

Recientemente le enviamos por correo el aviso indicando la hora de la audiencia que solicitó. Adjunto con su aviso, le enviamos un formulario de acuse de recibo, el cual le pedimos que llenara y devolviera. Si aún no ha devuelto el formulario de acuse de recibo, llame al número que aparece en la parte superior de este aviso para informarnos si comparecerá a su audiencia. Si no puede comparecer a su audiencia, infórmenos por qué no puede hacerlo.

Esperamos que esté presente en la audiencia señalada para:

Día: jueves **Fecha:** 3 de diciembre del 2020 **Hora:** 12:30 PM
Eastern (ET)

NO SE PRESENTE EN PERSONA EN UNA OFICINA DEL SEGURO SOCIAL PARA SU AUDIENCIA.

Si no comparece a esta audiencia, y no puede justificar su ausencia, el juez de derecho administrativo puede **desestimar** su solicitud de audiencia sin ningún otro aviso. Si el juez desestima su solicitud de audiencia, la decisión anterior se convertirá en la decisión final del Comisionado con respecto a su solicitud.

Si no entiende este aviso, su información de contacto ha cambiado, o si surge algún problema inesperado, por favor llame a esta oficina de audiencias al número de teléfono que aparece en la parte superior de este aviso.

Form HA-L503 (04-2013)
Claimant

See Next Page

EXHIBIT NO. B11B
PAGE: 2 OF 6
Page 2 of 2

Nevaeh Hope Adams

Cordialmente,
Social Security Administration

cc: Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

**SOCIAL SECURITY ADMINISTRATION**
**EXHIBIT NO. B11B
PAGE: 3 OF 6**

Refer To:
Nevaeh Hope Adams

Office of Hearings Operations
Charleston Fed Center
500 Quarrier Street
Suite 100
Charleston, WV 25301-2186
Tel: (888)527-9325 / Fax: (833)574-0712

November 9, 2020

Kelli Adams on behalf of
Nevaeh Hope Adams
C/O Kelli Adams
P.O. Box 46
Big Sandy, WV 24816

NOTICE OF HEARING-IMPORTANT REMINDER

We recently mailed you a Notice stating the time of the hearing you requested. We enclosed with your Notice an Acknowledgement Form, which we asked you to complete and return. If you have not yet returned the Acknowledgement Form, please call the number listed above and tell us if you plan to attend your hearing. If you do not plan to attend your hearing, please tell us why you cannot attend.

We expect you to attend the hearing scheduled for:

Day: Thursday **Date:** December 3, 2020 **Time:** 12:30 PM
Eastern (ET)

DO NOT COME IN PERSON TO A SOCIAL SECURITY OFFICE FOR YOUR HEARING.

If you do not appear at this hearing, and do not provide a good reason why you did not appear, the administrative law judge (ALJ) may **dismiss** your request for hearing without further notice. If the ALJ dismisses your request for hearing, the prior decision will become the final decision of the Commissioner on your application.

If you do not understand this notice, if your contact information has changed, or if some unexpected problem arises, please call this hearing office at the phone number listed above.

Sincerely,
Social Security Administration

cc: Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102



ADMINISTRACIÓN DEL SEGURO SOCIAL

EXHIBIT NO. B11B
PAGE: 4 OF 6

Referente a:
Nevaeh Hope Adams

Oficina de Operaciones de Audiencias
Charleston Fed Center
500 Quarier Street
Suite 100
Charleston, WV 25301-2186
Teléfono: (888)527-9325 / Número de Fax:
(833)574-0712

Fecha: 9 de noviembre del 2020

Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

AVISO DE AUDIENCIA – RECORDATORIO IMPORTANTE

Recientemente le enviamos por correo el aviso indicando la hora de la audiencia que solicitó. Adjunto con su aviso, le enviamos un formulario de acuse de recibo, el cual le pedimos que llenara y devolviera. Si aún **no** ha devuelto el formulario de acuse de recibo, llame al número que aparece en la parte superior de este aviso para informarnos si comparecerá a su audiencia. Si no puede comparecer a su audiencia, infórmenos por qué no puede hacerlo.

Esperamos que esté presente en la audiencia señalada para:

Día: jueves **Fecha:** 3 de diciembre del 2020 **Hora:** 12:30 PM
Eastern (ET)

NO SE PRESENTE EN PERSONA EN UNA OFICINA DEL SEGURO SOCIAL PARA SU AUDIENCIA.

Si no comparece a esta audiencia, y no puede justificar su ausencia, el juez de derecho administrativo puede **desestimar** su solicitud de audiencia sin ningún otro aviso. Si el juez desestima su solicitud de audiencia, la decisión anterior se convertirá en la decisión final del Comisionado con respecto a su solicitud.

Si no entiende este aviso, su información de contacto ha cambiado, o si surge algún problema inesperado, por favor llame a esta oficina de audiencias al número de teléfono que aparece en la parte superior de este aviso.

Form HA-L503 (04-2013)
Representative

See Next Page

EXHIBIT NO. B11B
PAGE: 5 OF 6
Page 2 of 2

Nevaeh Hope Adams

Cordialmente,
Social Security Administration

cc: Kelli Adams on behalf of
Nevaeh Hope Adams
C/O Kelli Adams
P.O. Box 46
Big Sandy, WV 24816

Form HA-L503 (04-2013)
Representative

**SOCIAL SECURITY ADMINISTRATION**

Refer To:
Nevaeh Hope Adams

**EXHIBIT NO. B11B
PAGE: 6 OF 6**

Office of Hearings Operations
Charleston Fed Center
500 Quarrier Street
Suite 100
Charleston, WV 25301-2186
Tel: (888)527-9325 / Fax: (833)574-0712

November 9, 2020

Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

NOTICE OF HEARING-IMPORTANT REMINDER

We recently mailed you a Notice stating the time of the hearing you requested. We enclosed with your Notice an Acknowledgement Form, which we asked you to complete and return. If you have not yet returned the Acknowledgement Form, please call the number listed above and tell us if you plan to attend your hearing. If you do not plan to attend your hearing, please tell us why you cannot attend.

We expect you to attend the hearing scheduled for:

Day: Thursday Date: December 3, 2020 Time: 12:30 PM
Eastern (ET)

DO NOT COME IN PERSON TO A SOCIAL SECURITY OFFICE FOR YOUR HEARING.

If you do not appear at this hearing, and do not provide a good reason why you did not appear, the administrative law judge (ALJ) may **dismiss** your request for hearing without further notice. If the ALJ dismisses your request for hearing, the prior decision will become the final decision of the Commissioner on your application.

If you do not understand this notice, if your contact information has changed, or if some unexpected problem arises, please call this hearing office at the phone number listed above.

Sincerely,
Social Security Administration

cc: Kelli Adams on behalf of
Nevaeh Hope Adams
C/O Kelli Adams
P.O. Box 46
Big Sandy, WV 24816

Form HA-L503 (04-2013)
Representative



SOCIAL SECURITY ADMINISTRATION

Refer To:
Nevaeh Hope Adams

**EXHIBIT NO. B12B
PAGE: 1 OF 2**

Office of Hearings Operations
Charleston Fed Center
500 Quarrier Street
Suite 100
Charleston, WV 25301-2186
Tel: (888)527-9325 / Fax: (833)574-0712

November 18, 2020

Kelli Adams on behalf of
Nevaeh Hope Adams
C/O Kelli Adams
P.O. Box 46
Big Sandy, WV 24816

NOTICE OF HEARING-IMPORTANT REMINDER

We recently mailed you a Notice stating the time of the hearing you requested. We enclosed with your Notice an Acknowledgement Form, which we asked you to complete and return. If you have not yet returned the Acknowledgement Form, please call the number listed above and tell us if you plan to attend your hearing. If you do not plan to attend your hearing, please tell us why you cannot attend.

We expect you to attend the hearing scheduled for:

Day: Thursday **Date:** December 3, 2020 **Time:** 12:30 PM
Eastern (ET)

DO NOT COME IN PERSON TO A SOCIAL SECURITY OFFICE FOR YOUR HEARING.

If you do not appear at this hearing, and do not provide a good reason why you did not appear, the administrative law judge (ALJ) may **dismiss** your request for hearing without further notice. If the ALJ dismisses your request for hearing, the prior decision will become the final decision of the Commissioner on your application.

If you do not understand this notice, if your contact information has changed, or if some unexpected problem arises, please call this hearing office at the phone number listed above.

Sincerely,
Social Security Administration

cc: Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

**SOCIAL SECURITY ADMINISTRATION**

Refer To:
Nevaeh Hope Adams

**EXHIBIT NO. B12B
PAGE: 2 OF 2**

Office of Hearings Operations
Charleston Fed Center
500 Quarrier Street
Suite 100
Charleston, WV 25301-2186
Tel: (888)527-9325 / Fax: (833)574-0712

November 18, 2020

Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

NOTICE OF HEARING-IMPORTANT REMINDER

We recently mailed you a Notice stating the time of the hearing you requested. We enclosed with your Notice an Acknowledgement Form, which we asked you to complete and return. If you have not yet returned the Acknowledgement Form, please call the number listed above and tell us if you plan to attend your hearing. If you do not plan to attend your hearing, please tell us why you cannot attend.

We expect you to attend the hearing scheduled for:

Day: Thursday Date: December 3, 2020 Time: 12:30 PM
Eastern (ET)

DO NOT COME IN PERSON TO A SOCIAL SECURITY OFFICE FOR YOUR HEARING.

If you do not appear at this hearing, and do not provide a good reason why you did not appear, the administrative law judge (ALJ) may **dismiss** your request for hearing without further notice. If the ALJ dismisses your request for hearing, the prior decision will become the final decision of the Commissioner on your application.

If you do not understand this notice, if your contact information has changed, or if some unexpected problem arises, please call this hearing office at the phone number listed above.

Sincerely,
Social Security Administration

cc: Kelli Adams on behalf of
Nevaeh Hope Adams
C/O Kelli Adams
P.O. Box 46
Big Sandy, WV 24816

Form HA-L503 (04-2013)
Representative

3046567430

04:38:14 p.m. 12-14-2020

8 / 8

2/14/2020 13:59 T-05:00 TO: +13046567902 FROM: 3044284500

**EXHIBIT NO. B13B
PAGE: 1 OF 1****CONTINGENT FEE AGREEMENT**

THIS AGREEMENT, Made and entered into on September 29, 2020 by and between **Ms. Kelli Adams OBO Ms. Nevaeh Hope Adams**, hereinafter referred to as "Client", and **Jan Dils and Miles Cary, Attorneys at Law**, hereinafter referred to as "Attorney";

WHEREAS Client desires to employ Attorney to represent him/her in connection with his claim for Disability Insurance Benefits (DIB) and/or Supplemental Security Income Disability benefits (SSID) from the Social Security Administration.

WITNESSETH that Client and Attorney agree as follows:

1. I agree that if the Social Security Administration (SSA) favorably decides my claim at any stage through the first hearing at the Administrative Law Judge (ALJ) level of appeal (with or without a hearing or supplemental hearing with no appeal to the Appeals Council), I will pay a maximum fee of the lower of (a) 25 percent of all past-due benefits accrued to client and/or auxiliary beneficiaries resulting from my claim, or (b) \$6,000.00 as established pursuant to section 206(a)(2)(A)(ii)(II) of the Social Security Act or such higher amount as the Commissioner of Social Security may prescribe pursuant to Section 206 (a)(2)(A) of the Social Security Act.
2. If my claim for Disability Insurance Benefits and/or Supplemental Security Income Disability is approved, the Social Security Administration should automatically withhold the Attorney fee pursuant to paragraph 1, and Attorney will collect attorney fee directly from the Social Security Administration. However, should the Social Security Administration fail to withhold the Attorney fee pursuant to paragraph 1, I will pay my attorney promptly from the back benefits that I receive and said money will be held in escrow pending approval of the fee amount by the Social Security Administration. However, in no event will any fee exceed the amount specified in paragraph 1.
3. I agree that if SSA favorably decides my claim at the Appeals Council (AC) level; or at the ALJ hearing level *after* a decision by the Appeals Council or Federal Court; or if a Federal Court favorably decides my case, the representative will request a fee through the fee petition process and, if the petition is approved by the judge, I will pay my attorney a fee equal to 25 percent of all past-due benefits in my Social Security and/or SSI disability claims for me and my family without the \$6,000.00 cap.
4. I have not been promised that I will win my case. My attorneys hereby promise that they, as well as their staff, will do their utmost best to win disability benefits for me and any of my dependents which may qualify for dependents' benefits.

I accept and approve this agreement. My attorney and I have both received copies of this agreement.

Kelli Adams OBO
Ms. Nevaeh Hope Adams

Jan Dils, Attorney
Miles Cary, Attorney

3046567430

04:32:09 p.m. 12-14-2020

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**EXHIBIT NO. B14B
PAGE: 1 OF 4**

2/14/2020, 13:59, T-05:00 TO: +13046567902 FROM: 3044284500

Discontinue Prior Editions
Social Security AdministrationPage 3 of 6
OMB No. 0960-0527

Claimant's Social Security Number	Appointed Representative's Rep ID
7 9 4 - 0 1 - 8 0 5 5	4 C D J 3 L H C Y 3

Claimant's Appointment of a Representative**Section 1 - Claimant's Information****Social Security Number**

7 9 4 - 0 1 - 8 0 5 5

First Name Nevaeh Initial Last Name Adams

Mailing AddressC/O Kelli Adams
PO Box 46

City Big Sandy	State WV	ZIP/Postal Code 24816	Country - if outside the U.S.
-------------------	-------------	--------------------------	-------------------------------

Phone Number **Alternate Phone Number (Optional)**

(304) 938-6159 Country/Area Code	Phone Number	Country/Area Code	Phone Number
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Number Holder's Information (Complete when applicable)

My claim is based on another person's work or earnings (e.g., spouse or parent). This person's information is different from mine.

Number Holder's Social Security Number

Kelli Adams	M	
First Name	Initial	Last Name

Section 2 - Disclosure (Claimant Only)

By selecting this box, I, the claimant listed in Section 1, whose signature appears in Section 8, authorize SSA to release information in relation to my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g., clerks, assistants), partners, or parties under contractual arrangements for or with my representative. (The appointed representative's partners, associates, delegates, and designees must be prepared to provide information in order to be authenticated.)

Section 3 - Principal Representative (Claimant only - Complete when applicable)

I have appointed before, or appoint now, more than one representative. I ask SSA to make contacts or send notices to this individual. My principal representative is:

Name **JAN DILS**

3046567430

04:36:22 p.m. 12-14-2020

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**EXHIBIT NO. B14B
PAGE: 2 OF 4**

2/14/2020 13:59 T-05:00 TO: +13046567902 FROM: 3044284500

Form SSA-1696 (09-2019) UF

Page 4 of 6

Claimant's Social Security Number

Appointed Representative's Rep ID

7	9	4	-	0	1	8	0	5	5	4	C	D	J	3	L	H	C	Y	3
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

Section 4 - Representative's Information (Claimant and Representative)

Representatives who are eligible and seek direct payment of their fee must register and receive a Rep ID before the appointment. For more information about registration visit us on-line at www.socialsecurity.gov/ar, contact us at 1-800-772-1213 (TTY 1-800-325-0778), or visit your local Social Security office.

Representatives Rep ID

4	C	D	J	3	L	H	C	Y	3
---	---	---	---	---	---	---	---	---	---

First Name Miles	Initial 	Last Name Cary
---------------------	-------------	-------------------

Mailing Address

Jan Dils, Attorneys at Law, LC
PO Box 901

City Parkersburg	State WV	ZIP/Postal Code 26102	Country - if outside the U.S.
---------------------	-------------	--------------------------	-----------------------------------

Phone Number (304) Country/Area Code	Alternate Phone Number (Optional) 428-8900 Phone Number	(877) Country/Area Code	526-3457 Phone Number
--	---	----------------------------	--------------------------

Section 5 - Representative's Status, Affiliations, and Certifications (Representative Only)

Representative's Status Part A - Type of Representative (Representatives have a duty to keep their information current)

- I am an attorney (SSA regulation states that an attorney is someone in good standing who has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States.)
- I am a non-attorney eligible for direct payment (SSA law requires that non-attorneys meet certain criteria to qualify for direct payment. Refer to our website at www.ssa.gov/representation for criteria).
- I am a non-attorney not eligible for direct payment.

Representative's Status Part B - Disqualification

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice law.

Yes No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency.

Yes No

3046567430

04:35:22 p.m. 12-14-2020

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EXHIBIT NO. B14B
PAGE: 3 OF 4

2/14/2020 13:59 T-05:00 TO: +13046567902 FROM: 3044284500

Form SSA-1696 (09-2019) UF

Page 5 of 6

Claimant's Social Security Number	Appointed Representative's Rep ID
7 9 4 - 0 1 - 8 0 5 5	4 C D J 3 L H C Y 3

Section 5 - Continued (Representative Only)**Affiliation Information**

If you are representing the claimant(s) as a partner or employee of a business entity, firm or other organization you may provide your Employer Identification Number (EIN) here, if one exists for tax purposes. This number is not your Social Security Number (SSN). This is your employer's tax identification number. (*Do not complete this section if you do not qualify for direct payment.*)

EIN	2 6 -- 0 0 0 4 1 1 0
-----	----------------------

Organization's Name (Enter the full name of the business, entity, firm or organization with which you want to be affiliated while representing this claim)

Jan Dils, Attorneys at Law, LC

Representative's Business Address (if different than mailing address)

963 Market Street

City	State	ZIP/Postal Code
Parkersburg	WV	26102

Country - if outside the U.S.

Representative's Certification

I accept this appointment and certify the following:

- I understand and agree that I will comply with SSA's laws and rules on the representation of parties, including the Rules of Conduct and Standards of Responsibility for Representatives; I will not charge, collect, or retain a fee for representational services that SSA has not approved or that is more than SSA approved unless a regulatory exclusion applies.
- I understand that if I fail to comply with any of SSA's laws and rules I may be suspended or disqualified as a representative before SSA.
- I will not disclose any information to any unauthorized party without the claimant's specific written consent.
- I am not currently suspended or prohibited, for any reason, from practicing before the Social Security Administration.
- I am not disqualified from representing the claimant as a current or former officer or employee of the United States.
- I accept appointment as the representative for the claimant named in Section 2 of this form in connection with the claims and asserted rights described in Section 6 of this form.
- I agree that a copy of this signed form SSA-1696 will have the same force and effect as the original.
- I declare under penalty of perjury that I have examined all of the information on this form and on all accompanying statements or forms, including any information, attestations and certifications provided to SSA in registration, and that they are all currently true and correct to the best of my knowledge.

If I intend to seek direct payment of the authorized fee on this claim -

- I have registered for and obtained a Rep ID, and my registration information is up-to-date.
- I have provided up-to-date information on my registration concerning whether I have been suspended or prohibited from practice before SSA or any other Federal program or agency, disbarred or suspended by a court or bar, and convicted of a violation under Section 206 or 1631(d) of the Social Security Act.

I CERTIFY TO ALL OF THE ABOVE

MC

(Representative's Initials)

3046567430

04:33:51 p.m. 12-14-2020

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**EXHIBIT NO. B14B
PAGE: 4 OF 4**

2/14/2020 13:59 T-05:00 TO: +13046567902 FROM: 3044284500

Form SSA-1696 (09-2019) UF

Page 6 of 6

Claimant's Social Security Number	Appointed Representative's Rep ID
7 9 4 - 0 1 - 8 0 5 5	4 C D J 3 L H C Y 3

Section 6 - Claim Type (Claimant or Representative)

I appoint the individual named in Section 4 to act as my representative in connection with my claim(s) or asserted right(s) under Title 2 (RSDI), Title 16 (SSI), Title 18 (Medicare Coverage), and Title 8 (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: *(Check all that apply)*

- Claim/Appeal for Title 2 Disability Benefits
- Claim/Appeal for Title 16
- Concurrent Title 2 and Title 16
- Claim/Appeal for Retirement Benefits
- Claim/Appeal for Title 18 (Medicare), 8 (Special Veteran's Benefits)
- Continuing Disability Review (CDR)
- Post-Entitlement Issue (a new issue you raise after eligibility for other benefits)

(E.g., benefit amount, month of entitlement, representative payee, suspension, termination, overpayment)

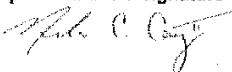
Section 7 - Fee Arrangement (Representative Only)

Check one box below:

- I will request a fee and direct payment of this fee. Select this box if you are eligible for direct payment and want us to withhold a portion of the past-due benefits to pay you the fee we may authorize. *(We must authorize the fee.)*
- I will request a fee but not direct payment. Select this box if you are not eligible for direct payment from the past-due benefits, or if you do not want direct payment. You must collect any fee we may authorize on your own. *(We must authorize the fee.)*
- I waive the right to receive a fee from the claimant, any auxiliary beneficiaries or any other individual. Select this box if you certify that an entity, or a Federal, state, county, or city government agency will pay the fee and any expenses from its funds. The claimant, auxiliary beneficiaries, or other individuals must not be liable for the fee, directly or indirectly, in whole or in part, or any expenses. *(We do not need to authorize the fee if all regulatory conditions apply.)*
- I waive the right to a fee.

Section 8 - Signatures (Claimant and Representative)

Representative's Signature



Date

September 29, 2020

Claimant's Signature



Date

September 29, 2020

EXHIBIT NO. B1D
PAGE: 1 OF 1

MSSICS DEVELOPMENT WORKSHEET PAGE 1 OF DW01
 794-01-8055 NEVAE ADAMS TRANSFER TO:
 UNIT: CR4 FO: 313
 APPLICANT NAME: KELLI MARIE DANIELS
 CLAIMANT NAME: NEVAEH HOPE ADAMS
 SSN: 794-01-8055
 ADDRESS: PO BOX 46

CITY: BIG SANDY STATE: WV ZIP: 24816
 PHONE: 681 729 2017 INFO:

MISC:

ISSUE:	SCREEN:	REQUEST:	F/UP:	F/UP:	TICKLE:	RECEIVED:	REMARKS:
DEFER APP	ACLM		121418			121418	
ATTEST			121418			121418	BARNES,N
PRTFL112018	ACLM					112018	
T16CO	ACLM					112018	
DDSDEC	ADIB	121418	032619			043019	
PRINT APP	DPRN	122018				122018	

MORE ISSUES:
 REMARKS (Y):

FIELDS ARE PROTECTED - PF3 TO TERMINATE - PRESS ENTER TO ADVANCE

EXHIBIT NO. B2D

PAGE: 1 OF 6

December 20, 2018, 12:40

PAGE 1

CLAIMANT: 794-01-8055 NEVAEH HOPE ADAMS

KELLI MARIE DANIELS
PO BOX 46
BIG SANDY, WV 24816

APPLICATION SUMMARY FOR SUPPLEMENTAL SECURITY INCOME

On December 14, 2018, you, KELLI MARIE DANIELS, applied on behalf of NEVAEH HOPE ADAMS for Supplemental Security Income and any federally administered State supplementation under title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under title XIX of the Social Security Act. We have stored your application electronically in our records.

What You Need To Do

- o Review this summary to ensure we recorded your statements correctly.
 - o If you agree with all your statements, you should keep this summary for your records.
 - o If you disagree with any of your statements, you should contact us within 10 days after receiving this summary to let us know.
- o IDENTIFICATION

The claimant's name is NEVAEH HOPE ADAMS. Her social security number is 794-01-8055.

Her date of birth is July 21, 2015.

She has not used any other social security number(s).

She is not blind.

She is disabled. Her disability began on July 21, 2015.

She is a United States citizen by birth.

She never lived outside the United States.

She never was married.

o FUGITIVE FELON INFORMATION

The following statements describe NEVAEH HOPE ADAMS' fugitive felon status as of November 20, 2018.

EXHIBIT NO. B2D**PAGE: 2 OF 6**

December 20, 2018, 12:40

PAGE 2

CLAIMANT: 794-01-8055 NEVAEH HOPE ADAMS

She has not been accused or convicted of a felony or an attempt to commit a felony.

- LIVING ARRANGEMENTS

The following statements describe NEVAEH HOPE ADAMS' living arrangements as of November 1, 2018.

She began living at 250 MELVIN ST, BIG SANDY, WV 24816 on November 1, 2018.

She lives in a house/apartment/mobile home/houseboat.

She does not expect these arrangements to change.

- RESOURCES

This report of resources is valid for any and all SSI claims in which she is involved.

She does not own any type of resource.

- INCOME

This report of income is valid for any and all SSI claims in which she is involved.

She does not receive any type of income.

- ELIGIBILITY FOR OTHER BENEFITS FOR NEVAEH HOPE ADAMS

She currently gets Supplemental Nutrition Assistance Program (SNAP) benefits.

- MEDICAID

She may be eligible for Medicaid. However, she must help her State identify other sources that may pay for medical care. Also, she must give information to help the State get medical support for any child(ren) who are her legal responsibility. This includes information to help the State determine who a child's father is.

If she wants Medicaid, she must agree to allow her State to seek payments from sources, such as insurance companies, that are available to pay for her medical care. This includes payments for medical care for her or any person who receives Medicaid and is her legal responsibility. The State cannot provide her Medicaid if she does not agree to this Medicaid requirement. If she needs further information, she may contact her Medicaid agency.

- MEDICAL ASSISTANCE

I agree that any payments from sources responsible for paying for medical care will go to the State if Medicaid already has paid for this care.

She does not have any private, group or government health insurance that pays the cost of her medical care.

EXHIBIT NO. B2D

PAGE: 3 OF 6

December 20, 2018, 12:40

PAGE 3

CLAIMANT: 794-01-8055 NEVAEH HOPE ADAMS

APPLICANT

My relationship to the claimant is natural/adoptive parent with custody.

PERMISSION TO CONTACT FINANCIAL INSTITUTIONS FOR NEVAEH HOPE ADAMS

We have asked you for permission to obtain, from any financial institution, any financial record about NEVAEH HOPE ADAMS that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if she is eligible or if she continues to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you notify us in writing that you are canceling her permission, (2) her application for SSI is denied in a final decision, or (3) her eligibility for SSI terminates. If you do not give or cancel her permission she will not be eligible for SSI and we will deny her claim or stop her payments.

I, KELLI MARIE DANIELS, give SSA permission to contact any financial institution and request any financial records that financial institution may have about her.

AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION TO OBTAIN PERSONAL INFORMATION FOR NEVAEH HOPE ADAMS. DATED April 22, 2016.

We ask authorization for any public or private custodian of records to disclose any information to the Social Security Administration when we think it is needed for Social Security benefits. Once authorized, our permission to receive this information remains in effect until one of the following occurs: (1) you notify us in writing that the authorization is revoked, (2) all Social Security applications are denied in a final decision or are withdrawn, or (3) eligibility for all Social Security benefits terminates.

I, KELLI ADAMS, the parent of NEVAEH HOPE ADAMS, authorize any public or private custodian of records to disclose to the Social Security Administration any records or information about NEVAEH HOPE ADAMS.

IMPORTANT REMINDER

Penalty of Perjury

You declared under penalty of perjury that all the information on this summary is true and correct to the best of your knowledge. Anyone who knowingly gives a false or misleading statement about a material fact in an application, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both.

IMPORTANT INFORMATION--PLEASE READ CAREFULLY

We will check your statements and compare our records with records from other State and Federal agencies, including the Internal Revenue Service to make sure the claimant is paid the correct amount.

EXHIBIT NO. B2D

PAGE: 4 OF 6

December 20, 2018, 12:40

PAGE 4

CLAIMANT: 794-01-8055 NEVAEH HOPE ADAMS

If you have a question or something to report, call 866-964-2042 Ext 13906 and ask for NANCY BARNES. If you call or visit our office, please have this summary with you. For general information about Social Security, visit our web site at www.socialsecurity.gov on the Internet.

You may visit or write to the Social Security Office at:

SOCIAL SECURITY
SUITE A-8
5475 ROBERT C. BYRD DR
MOUNT HOPE WV 25880

We will process this application for Supplemental Security Income as quickly as possible. You should hear from us within 90 to 120 days. If you do not hear from us by then, please get in touch with us.

We will let you know if we need more information to decide if the claimant is eligible for SSI payments. In the meantime, if the claimant moves or changes her/his mailing address, the claimant--or someone for the claimant-- should report the change to the office shown.

Also, the claimant (or someone for the claimant) must let us know if the claimant is admitted to a hospital or other medical facility. The claimant could lose some SSI payments if the claimant does not let us know right away.

Always give the Social Security number when writing or telephoning about this claim. If you have any questions about this claim, we will be glad to help you.

HELPFUL HEALTH CARE WEBSITES

Health Information

The U.S. Department of Health and Human Services provides information on many health topics at www.healthfinder.gov on the Internet. You may wish to visit that site to review that information, which may be helpful to her.

Prescription Drug Assistance Programs

She may be able to get help paying for prescription drugs. To find out what programs are offered by drug companies, state and local governments, and local organizations, please visit www.healthfinder.gov/rxdrug on the Internet.

EXHIBIT NO. B2D**PAGE: 5 OF 6**

December 20, 2018, 12:40

PAGE 5

CLAIMANT: 794-01-8055 NEVAEH HOPE ADAMS

PRIVACY ACT STATEMENT**Collection and Use of Personal Information**

Section 1631(e) of the Social Security Act, as amended, authorizes us to collect this information. The information you provide us will be used to enable the Social Security Administration to determine if you are eligible for Supplemental Security Income (SSI) payments.

The information you furnish on this form is voluntary. However, failure to provide the requested information may keep us from making an accurate and timely decision on your claim, which in turn may result in loss of some payments.

We rarely use the information you supply for any purpose other than for determining eligibility for SSI. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal Laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Complete lists of routine uses for this information are available in System of Records Notice 60-0103, Supplemental Security Income Record and Special Veterans Benefits, and also in System of Records Notice 60-0089, Claims Folder Systems. The Notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at your local Social Security office.

EXHIBIT NO. B2D

PAGE: 6 OF 6

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PAGE 6

CLAIMANT: 794-01-8055 NEVAEH HOPE ADAMS

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 18-19 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

The following response was returned from the NDNH service call:

No NDNH data found associated with the queried SSN. These results have been saved to the EF.

EXHIBIT NO. B3D
PAGE: 1 OF 1

QRY DATE: 10/15/19 AN: 794-01-8055 DOC: Y09 UNIT: EDEQY PG: 001 DEQR
INPUT: YRS REQ: 2015-2019; COVERED DETAILS; NON-COVERED DETAILS; PENSION;
SPECIAL WAGE PAYMENT; EMPLOYER ADDRESS
MEF: NA: N H ADAMS DB: 07/2015 SX: F AK:

EXHIBIT NO. B4D
PAGE: 1 OF 1

DETAIL COVERED FICA EARNINGS AND EMPLOYER NAME AND ADDRESS FOR YEARS REQUESTED

NO COVERED FICA EARNINGS POSTED FOR YEARS REQUESTED

DETAIL NON-COVERED EARNINGS AND W-2 PENSION DATA AND EMPLOYER NAME AND ADDRESS FOR YEARS REQUESTED

NO NON-COVERED EARNINGS AND W-2 PENSION DATA POSTED FOR YEARS REQUESTED

REMARKS

CLAIMS ACTIVITY--SEE SSR

QRY DATE: 10/15/19 AN: 794-01-8055 DOC: Y09 UNIT: EDEQY PG: 001 DEQR
INPUT: YRS REQ: 2015-2019; COVERED DETAILS; NON-COVERED DETAILS; PENSION;
SPECIAL WAGE PAYMENT; EMPLOYER ADDRESS
MEF: NA: N H ADAMS DB: 07/2015 SX: F AK:

EXHIBIT NO. B5D
PAGE: 1 OF 1

DETAIL COVERED FICA EARNINGS AND EMPLOYER NAME AND ADDRESS FOR YEARS REQUESTED

NO COVERED FICA EARNINGS POSTED FOR YEARS REQUESTED

DETAIL NON-COVERED EARNINGS AND W-2 PENSION DATA AND EMPLOYER NAME AND ADDRESS FOR YEARS REQUESTED

NO NON-COVERED EARNINGS AND W-2 PENSION DATA POSTED FOR YEARS REQUESTED

REMARKS

CLAIMS ACTIVITY--SEE SSR

The following response was returned from the NDNH service call:

EXHIBIT NO. B6D

PAGE: 1 OF 1

No NDNH data found associated with the queried SSN. These results have been saved to the EF.

From:

12/20/2018 13:08

#899 P.005/012

**EXHIBIT NO. B1E
PAGE: 1 OF 10**

Form **SSA-3377-BK** (10-2017) UF
 Discontinue Prior Editions
 Social Security Administration

Page 3 of 10
 OMB No. 0960-0542
**FUNCTION REPORT -
 CHILD AGE 3 TO 6th BIRTHDAY**

SECTION 1 - IDENTIFYING INFORMATION

1. A. Print NAME OF CHILD:

FIRST

MIDDLE

LAST

B. Child's SOCIAL SECURITY NUMBER:

Month/Day/Year

C. Child's DATE OF BIRTH:

D. PERSON COMPLETING FORM

NAME:

RELATIONSHIP TO CHILD:

DATE FORM COMPLETED:

Month/Day/Year

DAYTIME TELEPHONE NUMBER (*including Area Code*) :

MAILING ADDRESS (Number and Street, Apt. No. (if any), P.O. Box, or Rural Route):

CITY

STATE

ZIP CODE

From:

12/20/2018 13:09

#899 P.006/012

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Form SSA-3377-BK (10-2017) UF

Page 4 of 10

SECTION 2 - FUNCTION DETAILS

<p>2. A. Does the child have problems seeing?</p> <p><input checked="" type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.B.)</p>	<p>If "yes," please mark every statement below that is generally true about the child:</p> <p><input type="checkbox"/> Child uses glasses or contact lenses. If the child has problems seeing even with glasses or contact lenses, please explain:</p> <p><input type="checkbox"/> Child cannot be fitted for glasses or contact lenses. Explain:</p> <p><input type="checkbox"/> Child has other seeing problems. If so, please describe: <i>lazy eye.</i></p>
<p>B. Does the child have problems hearing?</p> <p><input checked="" type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.C.)</p>	<p>If "yes," please mark every statement below that is generally true about the child:</p> <p>Child uses hearing aid(s). If the child has problems hearing even with a hearing aid(s) OR has trouble using a hearing aid, please explain:</p> <p><input type="checkbox"/> Child cannot be fitted for hearing aid(s).</p> <p><input checked="" type="checkbox"/> Child has other hearing problems. If so, please describe: <i>Referrals are being made for hearing tests</i></p> <p><input type="checkbox"/> Child uses American Sign Language.</p> <p><input type="checkbox"/> Child reads lips.</p>

From:

12/20/2018 13:09

#899 P.007/012

EXHIBIT NO. B1E**PAGE: 3 OF 10**

Page 5 of 10

Form SSA-3377-BK (10-2017) UF

<p>2. C. Is the child totally unable to talk?</p> <p><input type="checkbox"/> YES (Go to 2.D.)</p> <p><input checked="" type="checkbox"/> NO (Continue)</p>	<p>Does the child have problems talking clearly?</p> <p><input checked="" type="checkbox"/> Yes (answer questions below)</p> <p><input type="checkbox"/> No (continue to question 2.D.)</p> <p>If "yes," please mark the block that best describes the child in each of the two statements below, and then describe any other speech problems:</p> <p>Speech can be understood by people who know the child well:</p> <p><input checked="" type="checkbox"/> Most of the time, or</p> <p><input type="checkbox"/> Some of the time, or</p> <p><input type="checkbox"/> Hardly ever.</p> <p>Speech can be understood by people who don't know the child well:</p> <p><input type="checkbox"/> Most of the time, or</p> <p><input checked="" type="checkbox"/> Some of the time, or</p> <p><input type="checkbox"/> Hardly ever.</p> <p>If the child has other problems talking, please explain:</p> <hr/>
---	--

From:

12/20/2018 13:10

#899 P.008/012

EXHIBIT NO. B1E**PAGE: 4 OF 10**

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Form SSA-3377-BK (10-2017) UF

<p>2. D. Is the child's ability to communicate limited?</p> <p><input checked="" type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.E.)</p> <p><input type="checkbox"/> NOT SURE (Continue)</p>	<p>If "yes," or "not sure," please tell us what the child does or can do by checking "yes" or "no" for each of the following:</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Asks a lot of what, why, and where questions</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Uses complete sentences of more than 4 words most of the time</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Talks about what he or she is doing</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Takes part in conversations with other children</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Asks for what he or she wants</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tells about things and activities that happened in the past</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Can tell a made up or familiar short story</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Can answer questions about a short read-aloud children's story or TV story like "Little Red Ridinghood"</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Can deliver simple messages such as telephone messages</p> <p>If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to communicate:</p>
--	---

From:

12/20/2018 13:10

#899 P.009/012

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<p>2. E. Does the child's impairment(s) limit his or her progress in understanding and using what he or she has learned?</p> <p><input type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.F.)</p> <p><input type="checkbox"/> NOT SURE (Continue)</p>	<p>If "yes," or "not sure," please tell us what the child does or can do by checking "yes" or "no" for each of the following:</p> <table> <tbody> <tr> <td><input checked="" type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Recite numbers to 3</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Count three objects (like blocks, cars or dolls)</td> </tr> <tr> <td><input checked="" type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Recite numbers to 10</td> </tr> <tr> <td><input checked="" type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td>Identify most colors, such as purple, and shapes, such as a star</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input checked="" type="checkbox"/> No</td> <td>Knows his or her age</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input checked="" type="checkbox"/> No</td> <td>Asks what words mean</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input checked="" type="checkbox"/> No</td> <td>Knows his or her birthday</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input checked="" type="checkbox"/> No</td> <td>Knows his or her telephone number</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input checked="" type="checkbox"/> No</td> <td>Can define common words</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input checked="" type="checkbox"/> No</td> <td>Can read capital letters of the alphabet</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input checked="" type="checkbox"/> No</td> <td>Understands a joke</td> </tr> </tbody> </table> <p>If necessary, please explain. In addition, please tell us anything else you think we should know about the child's progress in understanding and using what he or she has learned:</p>	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Recite numbers to 3	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Count three objects (like blocks, cars or dolls)	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Recite numbers to 10	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Identify most colors, such as purple, and shapes, such as a star	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Knows his or her age	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Asks what words mean	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Knows his or her birthday	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Knows his or her telephone number	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Can define common words	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Can read capital letters of the alphabet	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Understands a joke
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Recite numbers to 3																																
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Count three objects (like blocks, cars or dolls)																																
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Recite numbers to 10																																
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Identify most colors, such as purple, and shapes, such as a star																																
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Knows his or her age																																
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Asks what words mean																																
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<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Can read capital letters of the alphabet																																
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Understands a joke																																

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<p>2. F. Are the child's physical abilities limited?</p> <p><input checked="" type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.G.)</p> <p><input type="checkbox"/> NOT SURE (Continue)</p>	<p>If "yes," or "not sure," please tell us what the child does or can do by checking "yes" or "no" for each of the following:</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Catch a large ball, like a beach ball</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Ride a big wheel, tricycle, or bike with training wheels</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Wind up a toy</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Print at least some letters</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Copy first name</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Use scissors fairly well</p> <p>If necessary, please explain. In addition, please tell us anything else you think we should know about the child's physical abilities:</p>
<p>G. Does the child's impairment(s) affect his or her behavior with other people?</p> <p><input checked="" type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.H.)</p> <p><input type="checkbox"/> NOT SURE (Continue)</p>	<p>If "yes," or "not sure," please tell us what the child does or can do by checking "yes" or "no" for each of the following:</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Enjoys being with other children the same age</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Shows affection towards other children</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Is affectionate towards parents</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Shares toys</p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Takes turns</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Plays "pretend" with other children</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Plays games like tag, hide-and-seek</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Plays board games (like checkers or Candyland)</p> <p>If necessary, please explain. In addition, please tell us anything else you think we should know about the child's behavior around other people:</p> <p><i>She plays well with children for a short period of time, then goes off to be alone. She prefers to be alone</i></p>

From:

12/20/2018 13:11

#899 P.011/012

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<p>2. H. Does the child's impairment(s) affect his or her habits and ability to take care of personal needs?</p> <p><input checked="" type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.I.)</p> <p><input type="checkbox"/> NOT SURE (Continue)</p>	<p>If "yes," or "not sure," please tell us what the child does or can do by checking "yes" or "no" for each of the following. Check "yes" if it is something the child used to do but doesn't do any more just because he or she is older. For example, if the child used to dress with help but now dresses without help, check "yes" for both.</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Usually controls bowels and bladder during the day</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Eats using a fork and spoon by self</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Dresses self with help</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Dresses self without help (except tying shoes)</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Washes or bathes without help</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Brushes teeth with help</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Brushes teeth without help</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Puts toys away</p> <p>If necessary, please explain. In addition, please tell us anything else you think we should know about the child's habits and ability to take care of personal needs:</p>
<p>I. Is the child's ability to pay attention and stick with a task limited?</p> <p><input checked="" type="checkbox"/> YES (Continue)</p> <p><input type="checkbox"/> NO (Go to 2.J.)</p> <p><input type="checkbox"/> NOT SURE (Continue)</p>	<p>If "yes," or "not sure," how long can the child pay attention to TV, music, reading aloud or games?</p> <p><input checked="" type="checkbox"/> 15 minutes <input type="checkbox"/> 30 minutes</p> <p>If necessary, please explain. In addition, please tell us anything else you think we should know about the child's ability to pay attention and stick with a task:</p> <p><i>less than .</i></p>

From:

12/20/2018 13:12

#899 P.012/012

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2. J. Please tell us anything else about the child that you think we should know.

SECTION 3 - REMARKS

From:

12/20/2018 13:07

#899 P.003/012

EXHIBIT NO. B1E
PAGE: 9 OF 10

Form SSA-3377-BK (10-2017) UF
Discontinue Prior Editions
Social Security Administration

Page 1 of 10
OMB No. 0960-0542

Function Report Child Age 3 to 6th Birthday

Filling out the Function Report

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, CONTACT YOUR SOCIAL SECURITY OFFICE. WE WILL HELP YOU.

The information that you give us on this form will be used by the office that makes the disability decision on the child's claim. You can help them by completing as much of the form as you can.

- Print or type.
- Do not ask a doctor or hospital to complete this form.
- Be sure to explain your answer if an explanation is requested or needed.
- If more space is needed to answer any of the questions, please use the "REMARKS" section and show the number of the question being answered.

The information we ask for on this form tells us how you think the child's illnesses or injuries affect the way he or she does many of his or her usual activities.

**PLEASE REMOVE THIS SHEET BEFORE
RETURNING THE COMPLETED FORM.**

Continued on the Reverse

From:

12/20/2018 13:07

#899 P.004/012

**EXHIBIT NO. B1E
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Form SSA-3377-BK (10-2017) UF

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Privacy Act Statement**Collection and Use of Personal Information**

Sections 205(a), 223(d), and 1631(e)(1), of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide on behalf of the minor child to determine his or her benefit eligibility.

Furnishing us the information is voluntary. However, failing to provide us with all or part of the requested information may prevent us from making an accurate and timely decision on the claim.

We rarely use the information for any purpose other than for making a decision regarding entitlements to benefits. However, we may use it for the administration and integrity of our programs. We may also disclose the information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to our benefits and coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g. to the Government Accountability Office and Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, and investigatory activities necessary to assure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for federally funded and administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of this information is available in our Privacy Act System of Records Notices entitled, Claims Folders Systems, 60-0089. Additional information about this and other system of records notices and our programs are available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE**. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Boulevard, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**

DISABILITY REPORT - FIELD OFFICE - Form SSA-3367
EXHIBIT NO. B2E
PAGE: 1 OF 2

(3367) ID/Prior Filings**Identifying Information**

1. Name of person(s) on whose Social Security record(s) this claim is being filed:

Nevaeh Hope Adams

His or Her Social Security Number(s): **794-01-8055**

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Female**

Date of Birth: **07/21/2015**

2. Claimant's Alleged Onset Date: **07/21/2015**

3. Potential Onset Date:

4. Reason for Potential Onset Date:

5. Explanation for Potential Onset Date, when applicable:

Miscellaneous Information

6. Protective Filing Date:

Non-Blind Date Last Insured (DIB/Freeze case):

Blind Date Last Insured (DIB/Freeze case):

Closed Period Case: **No**

Prior Filing Information

7. Prior Filing(s): **Yes**

If "Yes" and you are not sending the prior folder, enter the following:

Type of prior claim(s):	DC
SSN(s) of prior claim(s):	794-01-8055 dc
Date and level of last decision: 11/02/2018 Hearing	
Last Decision:	Denial
Location of prior folder:	cef
Prior folder requested:	No
Date requested:	

(3367) Presumptive

The Presumptive Disability page details are not being displayed here because there is no PD on this case.

(3367) Observations

9. Observations/Perceptions:

How was the Interview Conducted? **No contact with claimant**

Observations: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

(3367) Development

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? **No**

12. Is DDS capability development needed? **No**

Remarks:

Name of Interviewer: **N. Barnes**

Phone Number: **866-964-2042**

Name of Person Completing Form: **N. Barnes**

Date: **12/20/2018**

(3820) Section 1 - Information About the Child

A. Child's Name: **Nevaeh Hope Adams**

B. Child's Social Security Number: **794-01-8055**

C. Your Name: **Kelli Marie Daniels**

Your Mailing Address: **PO BOX 46
BIG SANDY, WV 24816**

D. Your Daytime Telephone Number: **681-729-2017 Your number - Voice**

E. What is your relationship to the child? **NATURAL OR ADOPTIVE PARENT WITH CUSTODY**

F. Can you speak and understand English? **Yes**

If "NO", what is your preferred language?

NOTE: If you cannot speak and understand English, we will provide an interpreter free of charge.

If you cannot speak and understand English, give us the name of someone we may contact who speaks and understands English and will give you messages.

Can you read and understand English? **Yes**

G. Does the child live with you? **Yes**

If "NO", with whom does the child live?

H. Can the child speak and understand English? **Yes**

If "NO", what languages can the child speak?

If the child understands any other languages, list them here:

I. What is the child's height (without shoes)? **36"**

What is the child's weight (without shoes)? **25 lbs.**

J. Does the child have a medical assistance card? **No**

If "YES", show the number here:

(3820) Section 2 - Contact Information

A. Does the child have a legal guardian or custodian other than you? **No**

B. Is there another adult who helps care for the child and can help us get information about the child if necessary? **No**

(3820) Section 3 - The Child's Illnesses, Injuries, or Conditions and How They Affect Him/Her**EXHIBIT NO. B3E****PAGE: 2 OF 6**

A. What are the child's disabling illnesses, injuries, or conditions?

Turners syndrome, heart issues, hip problems, lazy eye, joint problems, vision problems, developmental delaysB. When did the child become disabled? **07/21/2015**C. Do the child's illnesses, injuries, or conditions cause pain or other symptoms? **Yes****(3820) Section 4 - Information About the Child's Medical Records**

A. Has the child been seen by a doctor/hospital/clinic or anyone else for the illnesses, injuries, or conditions?

Yes

B. Has the child been seen by a doctor/hospital/clinic or anyone else for emotional or mental problems?

No

C. List each Doctor/HMO/Therapist/Other. Include the child's next appointment:

Name:	CAMC WOMENS & CHILDRENS HOSPITAL		
Address:	800 PENNSYLVANIA AVE CHARLESTON, WV 25302	Date First Visit:	05/2018
Phone:	Chart/HMO# :	Date Last Visit:	11/2018
		Next Appointment:	01/07/2019

Reasons for Visits:

endocrinology, gastrointestinal,

What treatment was received?

evaluations and testing

Name:	CARILION CLINICCLINICAL GENETICS		
Address:	MEDICAL RECORDS 102 HIGHLAND AVE SE STE 104 ROANOKE, VA 24013	Date First Visit:	07/2015
Phone:	540-985-8454	Chart/HMO# :	Date Last Visit: 2016
			Next Appointment: -

Reasons for Visits:

genetic issues

What treatment was received?

testing

Name:	MERCER MEDICAL GROUP ENT		
Address:	MEDICAL RECORDS 122 TWELFTH STREET 3RD FLR STE A PRINCETON, WV 24740	Date First Visit:	09/19/2018
		Date Last Visit:	09/19/2018

Phone:	304-487-3407	Chart/HMO# :	Next Appointment:	-
Reasons for Visits: hearing evaluation				
What treatment was received? evaluation				

**EXHIBIT NO. B3E
PAGE: 3 OF 6**

Name:	PEDIATRIC CARDIOLOGY		
Address:	MEDICAL RECORDS 102 HIGHLAND AVE SW STE 404 ROANOKE, VA 24013		Date First Visit: 07/23/15
Phone:	540-224-4545	Chart/HMO# :	Date Last Visit: 2016
Reasons for Visits: heart issues			
What treatment was received? evaluations			

Name:	WELCH COMM HOSP OUTPATIENT CLINIC		
Address:	MEDICAL RECORDS 454 McDOWELL STREET WELCH, WV 24801		Date First Visit: 2015
Phone:	304-436-8674	Chart/HMO# :	Date Last Visit: 11/2018
Reasons for Visits: pediatrician			
What treatment was received? well visits, sick visits			

D. List each Hospital/Clinic. Include the child's next appointment:

E. Does anyone else have medical records or information about the child's illnesses, injuries or conditions (foster parents, social workers, counselors, tutors, school nurses, detention centers, attorneys, insurance companies, workers' compensation), or is the child scheduled to see anyone else?

Yes

Name:	MCDOWELL COUNTY SCHOOLS		
Address:	SPECIAL EDUCATION RECORDS 30 CENTRAL AVENUE WELCH, WV 24801-2099		Date First Visit: 06/2018
Phone:	304-436-8441		Date Last Visit: 06/2018
Claim Number:			
Reasons for Visits:			
Tanya Cook evaluated her and determined that she will have to be special needs when she starts school.			

(3820) Section 5 - Medications

Does the child currently take any medications for illnesses, injuries, or conditions? **No**

If "YES," tell us the following: (Look at the child's medicine containers, if necessary.)

Name of Medicine	Prescribed By (Name of Doctor)	Reason For Medicine	Side Effects The Child Has

(3820) Section 6 - Tests

Has the child had, or will he/she have, any medical tests for illnesses, injuries, or conditions?

No

If "YES," tell us the following (give us approximate dates, if necessary).

Kind of Test	When Was/Will Test Be Done (Month, day, year)	Where Done (Name of Facility)	Who Sent The Child For This Test

(3820) Section 7 - Additional Information

A. Has the child been tested or examined by any of the following?

Headstart (Title V): **No**

Public or Community Health Department: **No**

Child Welfare or Social Service Agency: **No**

Women, Infants and Children (WIC) Program: **No**

Program for Children with Special Health Care Needs: **No**

Mental Health/Mental Retardation Center: **No**

Vocational Rehabilitation: **No**

If "NO" and the child is over age 15, do you want the child to be referred to Vocational Rehabilitation? **No**

B. Has the child received Vocational Rehabilitation or other employment support services to help him or her go to work? **No**

If you answered 'YES,' to any of the above in A. or B., please complete C. below:

C.

Additional Sources

Vocational Rehabilitation Sources

(3820) Section 8 - Education

A. Is the child currently enrolled in any school?

No, too young.

B. Other reason the child is not enrolled in school.

C. List the name of the school the child is currently attending and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

D. List the name of all other schools attended in the last 12 months and give dates attended.

E. Is the child attending Daycare/Preschool? **No**

If "YES," complete the following:

(3820) Section 9 - Work History

Questions A & B. Has the child ever worked (including sheltered work)? **No**

If "YES", complete the following:

(3820) Section 10 - Remarks

Use this section for any additional information about the child.

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN EXHIBIT NO. B5E TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.
PAGE: 6 OF 6

Signature of claimant or person filing on claimant's behalf (parent, guardian)

Date (Month, day, year)

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and street, city, state and ZIP code)	Address (Number and street, city, state and ZIP code)

Form SSA-3820 EDCS

(3441) Section 1 - Information About the Disabled Person

1.A. Name (First, Middle Initial, Last, Suffix): **Nevaeh Hope Adams**

1.B. Social Security Number: **794-01-8055**

1.C. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada:
681-729-2017

Check this box if you do not have a phone or number where we can leave a message

1.D. Alternate Phone Number - another number where we may reach you, if any:

1.E. Email Address (Optional):

(3441) Section 2 - Contacts

Give the name of someone (**other than your doctors**) we can contact who knows about your medical conditions, and can help you with your claim. (e.g., friend or relative)

2.A. Name (First, Middle, Last)

2.B. Relationship to Disabled Person

2.C. Mailing Address (Street or PO Box)

Include apartment number or unit if applicable.

City, State/Province, ZIP/Postal Code,

Country (if not U.S.)

2.D. Daytime Phone Number, including area code

(include IDD and country codes if outside
the U.S. or Canada)

2.E. Can this person speak and understand English?

If no, what language does the contact person prefer?

2.F. Who is completing this form? **Someone else (Please complete the information below).**

2.G. Name (First, Middle, Last)

Jan Dils

2.H. Relationship to Disabled Person

Appointed Representative(Attorney/Staff)

2.I. Mailing Address (Street or PO Box)

Include apartment number or unit if applicable. **PO Box 901**

City, State/Province, ZIP/Postal Code,

Parkersburg, WV 26102

Country (if not U.S.)

2.J. Daytime Phone Number, including area code

(include IDD and country codes if outside
the U.S. or Canada)

EXHIBIT NO. B4E

PAGE: 2 OF 6

(3441) Section 3 - Medical Conditions

Date of Last disability report: **12/20/2018**

3.A. Since you last told us about your medical conditions, has there been any CHANGE (for better or worse) in your physical or mental conditions?

Yes

Approximate date change occurred:

12/1/2018

If "Yes", please describe in detail:

Increased diarrhea and hearing loss.

3.B. Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? **No**

Approximate date of new conditions:

If "Yes", please describe in detail:

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 4 - Medical Treatment

4.A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name or nickname.

No

If yes, please list the other names used here:

4.B. Since you last told us about your medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or **do you have a future appointment scheduled?**

EXHIBIT NO. B4E
PAGE: 3 OF 6

No

4.C. What type(s) of condition(s) were you treated for, or will you be seen for?

If you answered "Yes" to 4.B., please tell us who may have **NEW** medical records about any of your **physical or mental** conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. **Complete one page for each provider.** If you have more than three providers, list them in SECTION 10 - REMARKS on the last page.

Please include:

- doctors' offices
- hospitals (including emergency room visits)
- clinics
- mental health center
- other health care facilities.

Only list the providers you have seen since you last told us about your medical treatment.

If you have been treated by more providers, use SECTION 10 - REMARKS on the last page.

(3441) Section 5 - Other Medical Information

5. Since you last told us about your other medical information, does anyone else have **medical information** about any of your **physical or mental** conditions (including emotional and learning problems) or are you scheduled to see anyone else?

This may include:

- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

No (Go to SECTION 6 - MEDICINES)

If you need to list more people or organizations, use SECTION 10 - REMARKS on the last page.

(3441) Section 6 - Medicines

EXHIBIT NO. B4E
PAGE: 4 OF 6

6. Are you currently taking any medicines (prescription or non-prescription)? No

No (Go to SECTION 7 - ACTIVITIES)

(3441) Section 7 - Activities

7. Since you last told us about your activities, has there been any **change** (for better or worse) in your daily activities due to your **physical or mental** conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.)

No

If yes, please describe in detail:

If you need more space, use SECTION 10- REMARKS on the last page.

(3441) Section 8 - Work and Education

8.A. Since you last told us about your work, have you worked or has your work changed?

If yes, you will be asked to provide additional information.

No

8.B. Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school?

No

If yes, what type?

Date(s) attended:

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 9 - Vocational Rehabilitation, Employment, or Other Support Services

EXHIBIT NO. B4E

PAGE: 5 OF 6

9. Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program?
- an individualized plan for employment with a vocational rehabilitation agency or any other organization?
- a Plan to Achieve Self-Support (PASS)?
- an individualized education program (IEP) through an educational institution (if a student age 18-21)?
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

No (Go to SECTION 10 - REMARKS)

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 10 - Remarks

Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.).

EXHIBIT NO. B4E**PAGE: 6 OF 6**

I DECLARE UNDER PENALTY OF PERJURY THAT I HAVE EXAMINED ALL THE INFORMATION ON THE ACCOMPANYING STATEMENTS OR FORMS, AND IT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANYONE WHO KNOWINGLY GIVES A FALSE OR MISLEADING STATEMENT ABOUT A MATERIAL FACT IN THIS INFORMATION, OR CAUSES SOMEONE ELSE TO DO SO, COMMITS A CRIME AND MAY BE SENT TO PRISON, OR MAY FACE OTHER PENALTIES, OR BOTH.

Signature of claimant or person filing on claimant's behalf (parent, guardian)

Date (Month, day, year)

Address (Number and street, city, state and ZIP code)

e-mail Address (optional)

C/O KELLI ADAMS
PO BOX 46
BIG SANDY, WV 24816

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness

2. Signature of Witness

Address (Number and street, city, state and ZIP code)

Address (Number and street, city, state and ZIP code)

Form SSA-3441 EDCS

DISABILITY REPORT - FIELD OFFICE - Form SSA-3367
EXHIBIT NO. B5E
PAGE: 1 OF 2

(3367) ID/Prior Filings

Identifying Information

1. Name of person(s) on whose Social Security record(s) this claim is being filed:

Nevaeh Hope Adams

His or Her Social Security Number(s): **794-01-8055**

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Female**

Date of Birth: **07/21/2015**

2. Claimant's Alleged Onset Date: **07/21/2015**

3. Potential Onset Date:

4. Reason for Potential Onset Date:

5. Explanation for Potential Onset Date, when applicable:

Miscellaneous Information

6. Protective Filing Date:

Non-Blind Date Last Insured (DIB/Freeze case):

Blind Date Last Insured (DIB/Freeze case):

Closed Period Case:

Prior Filing Information

7. Prior Filing(s):

If "Yes" and you are not sending the prior folder, enter the following:

(3367) Presumptive

The Presumptive Disability page details are not being displayed here because there is no initial level SSI claim on this case.

(3367) Observations

9. Observations/Perceptions:

How was the Interview Conducted? **No contact with claimant**

**EXHIBIT NO. B5E
PAGE: 2 OF 2**

Observations: Describe the claimant's behavior, appearance, grooming, degree of limitations, etc.

(3367) Development

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? **No**

12. Is DDS capability development needed? **No**

Remarks:

Name of Interviewer: **B. Burgess**

Phone Number: **866-964-2042**

Name of Person Completing Form: **B. Burgess**

Date: **06/18/2019**

Form SSA-3367 EDCS

DISABILITY REPORT - FIELD OFFICE - Form SSA-3367
EXHIBIT NO. B6E
PAGE: 1 OF 2

(3367) ID/Prior Filings

Identifying Information

1. Name of person(s) on whose Social Security record(s) this claim is being filed:

Nevaeh Hope Adams

His or Her Social Security Number(s): **794-01-8055**

Name of Claimant (if different from above):

SSN (if different from above):

Gender: **Female**

Date of Birth: **07/21/2015**

2. Claimant's Alleged Onset Date: **07/21/2015**

3. Potential Onset Date:

4. Reason for Potential Onset Date:

5. Explanation for Potential Onset Date, when applicable:

Miscellaneous Information

6. Protective Filing Date:

Non-Blind Date Last Insured (DIB/Freeze case):

Blind Date Last Insured (DIB/Freeze case):

Closed Period Case:

Prior Filing Information

7. Prior Filing(s):

If "Yes" and you are not sending the prior folder, enter the following:

(3367) Presumptive

The Presumptive Disability page details are not being displayed here because there is no initial level SSI claim on this case.

(3367) Observations

9. Observations/Perceptions:

(3367) Development

10. Development Initiated by FO:

A. Medical:

B. Other:

C. Forms to be completed by applicant and sent to the DDS:

SSA-3371:

SSA-3369:

Other:

11. Was medical evidence brought in to the FO by the claimant? **No**

12. Is DDS capability development needed? **No**

Remarks:

Name of Interviewer: **K. Blankenship**

Phone Number: **866-273-0399**

Name of Person Completing Form:

Date:

Form SSA-3367 EDCS

(3441) Section 1 - Information About the Disabled Person

1.A. Name (First, Middle Initial, Last, Suffix): **Nevaeh Hope Adams**

1.B. Social Security Number: **794-01-8055**

1.C. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada:
681-729-2017

Check this box if you do not have a phone or number where we can leave a message

1.D. Alternate Phone Number - another number where we may reach you, if any:

1.E. Email Address (Optional):

(3441) Section 2 - Contacts

Give the name of someone (**other than your doctors**) we can contact who knows about your medical conditions, and can help you with your claim. (e.g., friend or relative)

2.A. Name (First, Middle, Last)

2.B. Relationship to Disabled Person

2.C. Mailing Address (Street or PO Box)

Include apartment number or unit if applicable.

City, State/Province, ZIP/Postal Code,

Country (if not U.S.)

2.D. Daytime Phone Number, including area code

(include IDD and country codes if outside
the U.S. or Canada)

2.E. Can this person speak and understand English?

If no, what language does the contact person prefer?

2.F. Who is completing this form? **Someone else (Please complete the information below).**

2.G. Name (First, Middle, Last)

Jan Dils

2.H. Relationship to Disabled Person

Appointed Representative(Attorney/Staff)

2.I. Mailing Address (Street or PO Box)

Include apartment number or unit if applicable. **PO Box 901**

City, State/Province, ZIP/Postal Code,

Parkersburg, WV 26102

Country (if not U.S.)

2.J. Daytime Phone Number, including area code

(include IDD and country codes if outside
the U.S. or Canada)

EXHIBIT NO. B7E

PAGE: 2 OF 6

(3441) Section 3 - Medical Conditions

Date of Last disability report: **06/18/2019**

3.A. Since you last told us about your medical conditions, has there been any CHANGE (for better or worse) in your physical or mental conditions?

No

Approximate date change occurred:

If "Yes", please describe in detail:

3.B. Since you last told us about your medical conditions, do you have any NEW physical or mental conditions? **No**

Approximate date of new conditions:

If "Yes", please describe in detail:

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 4 - Medical Treatment

4.A. Have you used any other names on your medical or educational records? Examples are maiden name, other married name or nickname.

No

If yes, please list the other names used here:

4.B. Since you last told us about your medical treatment, have you seen a doctor or other health care provider, received treatment at a hospital or clinic, or **do you have a future appointment scheduled?**

EXHIBIT NO. B7E
PAGE: 3 OF 6

No

4.C. What type(s) of condition(s) were you treated for, or will you be seen for?

If you answered "Yes" to 4.B., please tell us who may have NEW medical records about any of your **physical or mental** conditions (including emotional or learning problems).

Use the following pages to provide information for up to three (3) providers. **Complete one page for each provider.** If you have more than three providers, list them in SECTION 10 - REMARKS on the last page.

Please include:

- doctors' offices
- hospitals (including emergency room visits)
- clinics
- mental health center
- other health care facilities.

Only list the providers you have seen since you last told us about your medical treatment.

If you have been treated by more providers, use SECTION 10 - REMARKS on the last page.

(3441) Section 5 - Other Medical Information

5. Since you last told us about your other medical information, does anyone else have **medical information** about any of your **physical or mental** conditions (including emotional and learning problems) or are you scheduled to see anyone else?

This may include:

- workers' compensation
- vocational rehabilitation services
- insurance companies who have paid you disability benefits
- prisons and correctional facilities
- attorneys
- social service agencies
- welfare agencies
- school/education records

No (Go to SECTION 6 - MEDICINES)

If you need to list more people or organizations, use SECTION 10 - REMARKS on the last page.

(3441) Section 6 - Medicines

EXHIBIT NO. B7E
PAGE: 4 OF 6

6. Are you currently taking any medicines (prescription or non-prescription)? No

No (Go to SECTION 7 - ACTIVITIES)

(3441) Section 7 - Activities

7. Since you last told us about your activities, has there been any **change** (for better or worse) in your daily activities due to your **physical or mental** conditions? (Examples of daily activities are household tasks, personal care, getting around, hobbies and interests, social activities, etc.)

No

If yes, please describe in detail:

If you need more space, use SECTION 10- REMARKS on the last page.

(3441) Section 8 - Work and Education

8.A. Since you last told us about your work, have you worked or has your work changed?

If yes, you will be asked to provide additional information.

No

8.B. Since you last told us about your education, have you completed or are you enrolled in any type of specialized job training, trade school, or vocational school?

No

If yes, what type?

Date(s) attended:

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 9 - Vocational Rehabilitation, Employment, or Other Support Services

EXHIBIT NO. B7E

PAGE: 5 OF 6

9. Since you last told us about your vocational rehabilitation, have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program?
- an individualized plan for employment with a vocational rehabilitation agency or any other organization?
- a Plan to Achieve Self-Support (PASS)?
- an individualized education program (IEP) through an educational institution (if a student age 18-21)?
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

No (Go to SECTION 10 - REMARKS)

If you need more space, use SECTION 10 - REMARKS on the last page.

(3441) Section 10 - Remarks

Use this space to provide any information you could not show in earlier sections of this form or any additional information you feel we should know about. Please be sure to include the number of the question you are answering (For example, 3A, 4D, etc.).

Unable to contact client at this time. Information current at last contact. No updates. Please process appeal.

I DECLARE UNDER PENALTY OF PERJURY THAT I HAVE EXAMINED ALL THE INFORMATION ON THE ACCOMPANYING STATEMENTS OR FORMS, AND IT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANYONE WHO KNOWINGLY GIVES A FALSE OR MISLEADING STATEMENT ABOUT A MATERIAL FACT IN THIS INFORMATION, OR CAUSES SOMEONE ELSE TO DO SO, COMMITS A CRIME AND MAY BE SENT TO PRISON, OR MAY FACE OTHER PENALTIES, OR BOTH.

EXHIBIT NO. B7E**PAGE: 6 OF 6**

Signature of claimant or person filing on claimant's behalf (parent, guardian)

Date (Month, day, year)

Address (Number and street, city, state and ZIP code)

e-mail Address (optional)

C/O KELLI ADAMS
PO BOX 46
BIG SANDY, WV 24816

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness

2. Signature of Witness

Address (Number and street, city, state and ZIP code)

Address (Number and street, city, state and ZIP code)

Form SSA-3441 EDCS

304-436-4149 McDowell Co BOE Special Ed
 1.12.18 08:36:13 Social Security Admin

12:17:55 p.m. 01-03-2019 1 / 22
 HelpDesk#: 8776974889 Page **EXHIBIT NO. B8E**
PAGE: 1 OF 15

West Virginia Social Security Disability Determination Section
 December 21, 2018



RQID:LWV0008I6I500 SITE:S55 DR:S
 SSN:794018055 DOCTYPE:0001 RF:D CS:b95f



MCDOWELL COUNTY SCHOOLS
 Attn: SPECIAL EDUCATION RECORDS
 30 CENTRAL AVENUE
 WELCH, WV 24801 2099

Vendor Code: 0001047A

Ref: NEVAEH HOPE ADAMS
SSN: 794-01-8055
DOB: 07/21/2015

***PLEASE FAX RECORDS WITH THIS AS COVER PAGE TO
 866 636 7503***

**** IF NO RECORDS EXIST FOR TIMEFRAME REQUESTED, CHECK BOX NO RECORDS****

TO RECEIVE PAYMENT: *DO NOT FAX INVOICE *
**SIGN ENCLOSED INVOICE IN BLUE INK AND MAIL IT TO DDS 500 QUARRIER STREET SUITE
 500 CHARLESTON WV 25301**

**IF FAXING OR MAILING RECORDS FOR MULTIPLE INDIVIDUALS, PLEASE USE EACH
 SEPARATE CORRESPONDING BARCODE PAGE AS THE COVER SHEET**

IF YOU ARE UNABLE TO FAX, PLACE THIS PAGE ON TOP OF RECORDS AND MAIL TO:

SSA S55 WV DDS CHARLESTON PO BOX 8726 LONDON, KY 40742-9975
--

DMAMERCV

Paper Case: N/QDD: N/DMA Case: Y

304-436-4149

McDowell Co BOE Special Ed

12:18:19 p.m. 01-03-2019

2 / 22

**INDIVIDUALIZED EDUCATION PROGRAM
MCDOWELL COUNTY BOARD OF
EDUCATION**

**EXHIBIT NO. B8E
PAGE: 2 OF 15**

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Student's Full Name ADAMS, NEVAEH

IEP Meeting Date June 22, 2018

PART I: STUDENT INFORMATION

Student's Full Name:	<u>ADAMS, NEVAEH</u>	DOB:	<u>July 21, 2015</u>
Parent(s)/Guardian(s)/Surrogate Parent:	<u>ADAMS, KELLI and ,</u>	Age:	<u>2</u>
Address:	<u>PO BOX 46</u>	Grade:	<u>P3</u>
(Address continued):	<u>BIG SANDY, 24816</u>	IEP Grade:	<u>P3</u>
School:	<u>MCDOWELL COUNTY-R/DISTRICT</u>	WVEIS#:	<u>600022696</u>
Telephone	Home: <u>(681) 7292017</u>	Work:	MOTHER - (0) 0 ext: - (0) 0 ext:

Reevaluation Due Date: May 30, 2020**Meeting Type:**

- Initial Annual Review Reevaluation Review
 Other: _____

Transferred From:

Transferred date:

PART II: Documentation of Attendance

Position	Name	Signature
Parent	<u>Kelli Adams</u>	<u>Kelli M. Adams</u>
Parent	_____	_____
Student	_____	_____
Certified N-6 General Education Teacher	<u>Tanya Cook</u>	<u>Tanya S. Cook</u>
Special Education Teacher	<u>Jewel Hawks</u>	<u>Jewel Hawks</u>
Chairperson	<u>INGRIDA BARKER</u>	<u>Ingrida B.</u>

Contracted School Psychologist Tanya Cook Tanya S. Cook**The following people participated in the IEP Team meeting via an alternate method:**

Name	Position	Alternate Method
_____	_____	_____
_____	_____	_____
_____	_____	_____

**INDIVIDUALIZED EDUCATION PROGRAM
MCDOWELL COUNTY BOARD OF
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**EXHIBIT NO. B8E
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Page 2 of 13

Student's Full Name ADAMS.NEVAAEH

IEP Meeting Date June 22, 2018

PART III A: EXTENDED SCHOOL YEAR (ESY) DETERMINATION

Will ESY be considered while developing this IEP?

Yes No (for gifted only)

The IEP Team in making its determination of a student's need for ESY shall review documentation that the student exhibits, or may exhibit:

- Significant regression during an interruption in educational programming;
- A limited ability to recoup, or relearn skills once programming has resumed;
- Regression/recoupmment problem(s) that interfere with the maintenance of identified critical skills as described in the current IEP; and
- Other factors that interfere with the maintenance of identified critical skills as described in the current IEP, such as predictive data; degree of progress; emerging skills and breakthrough opportunities; interfering behaviors; nature and/or severity of the disability; and special circumstances.

(The lack of clear evidence of such factors may not be used to deny a student ESY services, if the IEP Team determines the need for such services and includes ESY in the IEP.)

Does the student need extended school year services?

Yes No Defer until: _____

**INDIVIDUALIZED EDUCATION PROGRAM
MCDOWELL COUNTY BOARD OF
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**EXHIBIT NO. B8E
PAGE: 4 OF 15**

Page 3 of 13

Student's Full Name ADAMS,NEVAEH

IEP Meeting Date June 22, 2018

PART IV: CONSIDERATION OF FACTORS FOR IEP DEVELOPMENT/ANNUAL REVIEWS

The IEP team must consider the following factors for all students:

- The strengths of the student
- The concerns of the parent
- Results of the initial or most recent evaluation of the student. If additional evaluations are needed (specify):
- Academic, developmental and functional needs of the student

Do the following special considerations apply? If yes, document in appropriate section(s) of the IEP.

Yes No

1.	Is the student identified as gifted?	<input checked="" type="checkbox"/>
2.	Does the student need assistive technology devices or services?	<input checked="" type="checkbox"/>
3.	Does the student have communication needs?	<input checked="" type="checkbox"/>
4.	Does the student's behavior impede his or her learning or that of others?	<input checked="" type="checkbox"/>
5.	Does the student have blindness or low vision?	<input checked="" type="checkbox"/>
6.	Is the student deaf or hard of hearing?	<input checked="" type="checkbox"/>
7.	Does the student have limited English proficiency?	<input checked="" type="checkbox"/>
8.	Does the IEP team intend to invite a representative from a participating agency to the NEXT IEP meeting to discuss transition services?	<input checked="" type="checkbox"/>
9.	Will this IEP address Transition Services?	<input checked="" type="checkbox"/>

If the student understands instructional content at grade level, but is unable to read with sufficient accuracy and fluency to support comprehension at the same rate as his/her peers; or cannot physically manipulate the print medium; or due to blindness/low vision cannot see standard print materials, then click the links to learn more about Accessible Educational Materials. Please refer to the Accessible Educational Materials guidance documents on the WVDE website.)

**INDIVIDUALIZED EDUCATION PROGRAM
MCDOWELL COUNTY BOARD OF
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**EXHIBIT NO. B8E
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Page 4 of 13

Student's Full Name ADAMS,NEVAEH

IEP Meeting Date June 22, 2018

PART V: ASSESSMENT DATA

General Summative Assessment Data - WESTEST through 2014 / Smarter Balanced 2015 - Current

TEST YEAR	R/LA			Math			Science		Social Studies	
	SS	PL	LX	SS	PL	QT	SS	PL	SS	PL
2014										
2015							N/A		N/A	
2016							N/A		N/A	
2017									N/A	

(SS = scale score) (PL = performance level) (LX = lexile score) (QT = quantile score)

Alternate Assessment Data - APTA through 2014 / DLM 2015 - Current

TEST YEAR	R/LA	Math	Science	Social Studies
	PL	PL	PL	PL
2014				
2015				
2016				
2017				

(PL = performance level)

Interim, Formative, Transition and Additional Assessment Data

Using current, annual data, list the interim, formative, and transition assessments that have been used with the student and describe the results and implications for specially designed instruction. This could include data relevant to student behavior, setting demands, work habits/ learning skills, technology skills, workplace skills, independent living skills, performance based assessments. Describe the results and implications for specially designed instruction.

Assessment	Date	Description

**INDIVIDUALIZED EDUCATION PROGRAM
MCDOWELL COUNTY BOARD OF
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**EXHIBIT NO. B8E
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Page 5 of 13

Student's Full Name ADAMS, NEVAEH

IEP Meeting Date June 22, 2018

PART VII: PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

Narrative Descriptions of Present Levels of Academic Achievement and Functional Performance (refer to IEP instructions).

Function:

Nevaeh's Adaptive Domain skills in self-care (21 months) and personal responsibility skills (25 months) are similarly developed. Nevaeh does not take care of her own toileting needs. She will tell her mother she has peed. She will strip off all of her clothing when she wants to (did so during the evaluation/meeting). She does not distinguish between food and nonfood items. She is beginning to feed herself with a spoon and drinks from a Sippy cup. Nevaeh will put away toys when asked. She does not need continual supervision. She does appear to understand that hot is dangerous. She does not avoid common dangers and has had no opportunity to work in a group. She shows care around small children and animals.

Nevaeh's Personal-Social Domain scores in peer interaction (<24 months), adult interaction (25 months) skills and self-concept and social role (27 months) skills are similarly developed. Nevaeh responds positively to praise, greets familiar adults and shows appropriate affection. She does appear to enjoy listening to a story sometimes. She is beginning to help with simple household tasks and separate easier from her parents. She uses other adults as resources and allows other adults to participate in her activities. She does not ask for help when needed. She does not follow adult directions without resistance. Nevaeh does initiate social contact with peers in a play situation. She does not show sympathy or concern for other children. She will disturb the materials of others when playing. She does respond differently to familiar and unfamiliar children. Nevaeh displays independent behavior. She did not say her name or tell her age. She does exhibit a range of positive and negative emotions. She did not use objects in make-believe play. She is beginning to use words for social contact. She did use the word "me" and said, "give me my chair" during the evaluation.

Nevaeh's Communication scores in Expressive (26 months) skills and Receptive (23 months) skills are similarly developed. Nevaeh follows three or more familiar verbal commands but not two-step commands. She did respond to the prepositions "out" but not "on". She did respond to the possessive form "your" and "my". She did not respond to "who" and "what" questions or simple possessive form 's. she is beginning to look at or point to an object across the room when it is named. Nevaeh is beginning to use three and four word phrases. She usually uses gestures and words to get her needs met. She is beginning to use words to express what she sees or experiences. She does not use words to relate information about other people or engage in an extended conversation with others. She is beginning to use pronouns.

Nevaeh's gross motor skills (22 months), fine motor (28 months) skills and perceptual motor (30 months) skills are similarly developed. Her skills are within the range expected for her age group. Nevaeh can usually run 10 feet without falling but some days her balance is off and she falls. She is beginning to walk backward, jump with both feet together and attempt to kick the ball when it stopped. She is beginning to throw a ball with some direction, but did not catch the ball. She is beginning to walk up and down stairs without assistance. Nevaeh can remove pieces from the form board. She scribbled on the paper holding the pencil too high for control and held the paper. She did not point when asked to. She did not string beads. She cannot fasten clothing. She cannot trace designs with curves. Nevaeh was able to stack six blocks. She removed and replaced rings from/to a post. She scribbled but did not copy any lines.

Nevaeh's scores in reasoning and academic skills (24 months) are more developed than her perception and concepts skills (18 months) and attention and memory (15 months) skills. Nevaeh can occupy herself for ten minutes without demanding attention. She was unable to find a hidden object under one of two cups (lifted both cups). She does not attend to an activity for three minutes. She did not select the hand holding the toy. She will point to a picture in a book sometimes. Nevaeh would not match objects by color but did name yellow and blue items inconsistently. She did not respond to one and one more. She did not identify the source of common actions consistently. She will reach around a barrier for an item, recognizes herself as the cause of events and will pull a cloth to obtain an object. Nevaeh was able to place pieces in the form board. She did not sort by color. She did not identify familiar objects by their use. She did not match circles or squares after demonstration. She does investigate her surroundings and imitate simple facial gestures.

Impact Statement:

Nevaeh's delays require specialized instruction in the general education setting to meet her needs.

304-436-4149

McDowell Co BOE Special Ed

12:20:28 p.m. 01-03-2019

7 /22

**INDIVIDUALIZED EDUCATION PROGRAM
MCDOWELL COUNTY BOARD OF
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Student's Full Name ADAMS,NEVAEH

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IEP Meeting Date June 22, 2018

**INDIVIDUALIZED EDUCATION PROGRAM
MCDOWELL COUNTY BOARD OF
EDUCATION**

Page 7 of 13

Student's Full Name ADAMS,NEVAEH

IEP Meeting Date June 22, 2018

PART VIII: ANNUAL GOALS**Progress:**

How and when will the student's progress toward the IEP goals be reported to the parent(s)? Specify.

How? Progress reports

When? as per county directed

Goal 1: Functional Skills

By June 2019 with adult prompting and guidance when presented two options Nevaeh will distinguish between safe and unsafe 3 out of 4 times as recorded with anecdotal records

Goal 2: Functional Skills

By June 2019 with coaching and prompting Nevaeh will count and recognize numbers from 0 to 10 3 out of 4 times as recorded in anecdotal log

Goal 3: Functional Skills

By June 2019 with adult guidance and peer interaction Nevaeh will participate in large group activities 4 out of 4 times as recorded in anecdotal log

Goal 4: Functional SkillsCritical:

By June 2019 with guided practice and assistance Nevaeh will share and play cooperatively 4 out of 4 times as recorded in anecdotal records

Goal 5: Functional Skills

By June 2019 with guided practice and prompting Nevaeh will follow one and two step directions 4 out of 4 times as recorded in anecdotal records.

Goal 6: Functional Skills

By June 2019 with prompting and guidance Nevaeh will separate manipulatives by shape and color 3 out of 4 times as recorded in anecdotal records

Goal 7: Functional SkillsCritical:

By June 2019 with prompting and modeling Nevaeh will ask for help 4 out of 4 times as recorded by anecdotal records

Goal 8: Functional Skills

By June 2019 with modeling, and adult guidance Nevaeh will hold a pencil correctly 4 out of 4 times as recorded by anecdotal records

**INDIVIDUALIZED EDUCATION PROGRAM
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EDUCATION**

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Student's Full Name ADAMS,NEVAEH

IEP Meeting Date June 22, 2018

Goal 9: Functional Skills

By June 2019 with guidance and prompting Nevaeh will remain engaged in small group activities with other peers for 5 minutes 4 out of 4 times as recorded in anecdotal records.

Goal 10: Functional Skills

By June 2019 with guidance and prompting Nevaeh will follow classroom rules 4 out of 4 times as recorded in anecdotal records.

**INDIVIDUALIZED EDUCATION PROGRAM
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Student's Full Name ADAMS, NEVAEH

IEP Meeting Date June 22, 2018

PART IX: SERVICES

A. Supplementary Aids, Services/Program Modifications	Location of Services	Extent/Frequency	Initiation Date m/d/y	Duration m/y
modeling, praising and encouraging to correct behaviors	in preschool class	daily	08/20/2018	06/2019
B. Special Education Services	Location of Services	Extent/Frequency ____ per ____	Initiation Date m/d/y	Duration m/y
adaptive, communication, cognitive, adult and peer interaction skills	D GEE	1200.00 minutes per Month	08/20/2018	06/2019
C. Related Services	Location of Services	Extent/Freq Location Addtl Detail	Initiation	Duration

**INDIVIDUALIZED EDUCATION PROGRAM
MCDOWELL COUNTY BOARD OF
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Student's Full Name ADAMS NEVAEH

IEP Meeting Date June 22, 2018

PART X: Placement - Grade Preschool

Explain the extent, if any, to which the student WILL NOT participate in the general education classroom and/or extracurricular and other non-academic activities. Present levels of academic achievement and functional performance must explain why full participation is not possible.

Nevaeh's will receive specialized instruction in the general education setting to remediate her developmental delays.

Ages 3-5

A. For students in a Regular Early Childhood Program (RECP) (at least 50% nondisabled):

- 30 Hours per week student attends a Regular Early Childhood Program (bell to bell).
- 5 Hours per week of special education and related services delivered in the RECP.
- 0 Hours per week student receives special education and related services in some other location.

In a Regular Early Childhood Program at least 10 hours per week

- | | |
|---|---------------------|
| <input checked="" type="checkbox"/> Majority of hours of special education and related services in the RECP | WVEIS LRE Code
W |
| <input type="checkbox"/> Majority of hours of special education and related services in some other location | X |

In Regular Childhood Program less than 10 hours per week

- | | |
|---|---|
| <input type="checkbox"/> Majority of hours of special education and related services in the RECP | Y |
| <input type="checkbox"/> Majority of hours of special education and related services in some other location | Z |

Least Restrictive Environment (LRE) Considerations: The IEP team has considered:

- Annual placement determination based on IEP.
- Only schools and classroom settings appropriate to the student's chronological age.
- Education in a general classroom with the use of supplementary aids and services.
- Potentially harmful effects on the selected LRE placement on the student and the quality of the student's services.
- Education with age-appropriate non-exceptional peers.
- Placement as close to home as possible, in the school the student would normally attend if not exceptional, unless IEP requires other arrangements .

Ages 6-21

Percentage of time in: _____% General Education Environment _____% Special Education Environment

WVEIS LRE Code

- | | |
|---|---|
| <input type="checkbox"/> General Education: Full-Time (FT) 80% or more | 0 |
| <input type="checkbox"/> General Education: Part-Time (PT) 40% to 79% | 1 |
| <input type="checkbox"/> Special Education: Separate Class (SC) (general education less than 40%) | 2 |
| <input type="checkbox"/> Special Education: Special School (SS) Public or Private | 3 |
| <input type="checkbox"/> Special Education: Out-of-School Environment (OSE) | 5 |
| <input type="checkbox"/> Residential Facility (RF) Public or Private | 6 |
| <input type="checkbox"/> Parentally placed in private school (Service Plan only) | 8 |
| <input type="checkbox"/> Correctional facility | 9 |

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Student's Full Name ADAMS,NEVAEH

IEP Meeting Date June 22, 2018

PART XI: Statewide Testing(Please check all appropriate boxes)

- 1) Indicate the appropriate WV Measures of Academic Progress Assessment (WVMAP) by checking standard conditions or standard conditions w/ accommodations.
- 2) If the district requires a "District Wide Assessment", all selected WVMAP accommodations apply.

All WV-MAP Grades 3-11

Alternate Assessment Grades 3-11

Standard Conditions

Standard Conditions

Standard Conditions w/Accommodations

Standard Conditions w/Accommodations

NOTE: For Alternate Assessment eligibility, the student must exhibit significant intellectual disabilities, be instructed through Alternate Academic Achievement Standards and be pursuing an alternate (modified) diploma (ages 14+).

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Student's Full Name ADAMS,NEVAEH

IEP Meeting Date June 22, 2018

PART XII: PRIOR WRITTEN NOTICE OF DISTRICT'S PROPOSAL/REFUSAL

Dear Parent/Adult Student:

As a result of :

- an Individualized Education Program (IEP) Team Meeting conducted on **06-22-2018**.
- A disciplinary action occurring on: _____.
- other Eligibility Committee Meeting 06-22-2018

The district is proposing or refusing to initiate or change:

- the educational evaluation or reevaluation of the student.
- the educational placement of the student.
- the provision of a free appropriate public education (FAPE) to the student.

Specifically, the district is proposing to initiate:

specially designed instruction to remediate Nevaeh's developmental delays

The district is proposing this action because:

developmental delays were noted

The evaluation procedure(s), assessment(s), record(s), or report(s) the district used as a basis for the proposed action include:

Battelle Developmental Inventory 2, parent input

Other options the district considered, but rejected include:
no services

The reasons the above options were rejected include:

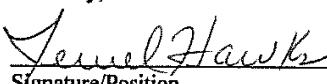
Nevaeh has documented developmental delays that need to be serviced.

Other factors relevant to the district's proposal include:

Least restrictive environment

Exceptional students and their parents have protections under the procedural safeguards. A copy of the Procedural Safeguards Brochure and assistance in understanding the provisions of the procedural safeguards may be obtained by contacting the Director of Special Education at 304-436-8441, if available, the local Parent Educator Resource Center at _____ and/or the West Virginia Department of Education, Office of Special Education at 304-558-2696 or 1-800-642-8541.

Sincerely,



Signature/Position

6-22-18

Date

304-436-4149

McDowell Co BOE Special Ed

12:25:25 p.m.

01-03-2019

14 /22

**INDIVIDUALIZED EDUCATION PROGRAM
MCDOWELL COUNTY BOARD OF
EDUCATION**

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Student's Full Name ADAMS,NEVAEH

IEP Meeting Date June 22, 2018

PART XIII: CONSENT

Completed only for initial placement.

I give my consent to my child's initial special education placement:

Parent Signature Kelli Adams Date 6-20-18

Parent Signature _____ Date _____

304-436-4149

McDowell Co BOE Special Ed

12:25:35 p.m. 01-03-2019

15 /22

EXHIBIT NO. B8E
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ELIGIBILITY COMMITTEE REPORT

McDowell County Schools

Re Eval due
6-22-21Student Full Name Nevaeh Hope AdamsDate June 22, 2018School Jaeger ElementaryDate of Birth July 21, 2015Parent(s)/Guardian(s) Rico and Kelli AdamsGrade E1Address P.O. Box 46WVEIS # 600022696City/State/Zip Big Sandy, WV 24816Telephone 681-729-2017 Initial Reevaluation**The Eligibility Committee (EC) considered the following multi-disciplinary reports and other relevant information.**

- | | | |
|---|--|---|
| <input type="checkbox"/> Academic Information | <input checked="" type="checkbox"/> Developmental Skills | <input type="checkbox"/> Social Skills |
| <input type="checkbox"/> Achievement | <input type="checkbox"/> Health | <input type="checkbox"/> Transition Assessments |
| <input type="checkbox"/> Classroom Performance | <input type="checkbox"/> Hearing | <input type="checkbox"/> Functional Vocational Evaluation |
| <input type="checkbox"/> Teacher Report | <input checked="" type="checkbox"/> Information from the Parents | <input type="checkbox"/> Vocational Aptitudes |
| <input type="checkbox"/> Adaptive Skills | <input type="checkbox"/> Intellectual Ability | <input type="checkbox"/> Interests/Preferences |
| <input type="checkbox"/> Assistive Technology | <input type="checkbox"/> Motor Skills | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Behavioral Performance | <input type="checkbox"/> Observation(s) | <input type="checkbox"/> Orientation and Mobility |
| <input type="checkbox"/> Functional Behavioral Assessment | <input type="checkbox"/> Perceptual-Motor | <input type="checkbox"/> Other |
| <input type="checkbox"/> Communication | | |

A student cannot be identified as a student in need of special education services if the primary reason for the decision is due to any of the following:

- A lack of appropriate instruction in the essential components of reading; or
- A lack of instruction in mathematics; or
- Limited English proficiency

For initial evaluation or reevaluation, the student meets the three-prong test of eligibility:

- Meets the eligibility requirements for one of the specific exceptionalities; and
- Experiences an adverse effect on educational performance; and
- Needs special education.

For reevaluation only:

If a student no longer meets the eligibility criteria in one of the designated exceptionalities, the EC must provide the justification for continued eligibility.

The Eligibility Committee has determined the student's primary area of exceptionality is (only one):

- | | | |
|--|---|--|
| <input type="checkbox"/> Autism (AU) | <input type="checkbox"/> Exceptional Gifted (EG) | <input checked="" type="checkbox"/> Developmental Delay (PS) |
| <input type="checkbox"/> Emotional/Behavioral Disorders (BD) | <input type="checkbox"/> Gifted (GF) | <input type="checkbox"/> Specific Learning Disability (LD) |
| <input type="checkbox"/> Blindness and Low Vision (VI)* | <input type="checkbox"/> Orthopedic Impairment (PH) | <input type="checkbox"/> Speech/Language Impairment (CD) |
| <input type="checkbox"/> Deafblindness (DB) * | <input type="checkbox"/> Other Health Impairment (OH) | <input type="checkbox"/> Traumatic Brain Injury (TB) |
| <input type="checkbox"/> Deafness (DF) * | <input type="checkbox"/> Intellectual Disability (Designate | <input type="checkbox"/> None |
| <input type="checkbox"/> Hard of Hearing (HI) * | <input type="checkbox"/> WVEIS Code <input type="checkbox"/> MM <input type="checkbox"/> MD <input type="checkbox"/> MS | |

* Provide information pertaining to the West Virginia Schools for the Deaf and Blind.

Additional evaluation data are needed in the following areas:

The Eligibility Committee has determined the student is not eligible for special education and submits the following recommendations for consideration by the school team (e.g., SAT or instruction and intervention team):

Eligibility Committee Members

Signature	Position
<i>Impala B.</i>	Administrator/Principal/Designee
<i>Tanya S. Coker, (Copied from School Psychologist)</i>	Evaluator/Specialist
<i>Debbie Hawk</i>	General and/or Special Educator
<i>Kelli U. Jackson</i>	Parent/Guardian/Adult Student
	Student
	Other



SOCIAL SECURITY ADMINISTRATION

**EXHIBIT NO. B9E
PAGE: 1 OF 11**

Refer To:
Nevaeh Hope Adams

Office of Hearings Operations
Charleston Fed Center
500 Quarrier Street
Suite 100
Charleston, WV 25301-2186
Tel: (888)527-9325

October 15, 2019

Jan Denise Dils
P. O. Box 901
Parkersburg, WV 26102

Dear Jan Denise Dils:

The above named claimant has filed a request for a Social Security hearing, and the record shows that you are representing this person.

Proposed exhibits in the above referenced file are now ready for your review. Please log into <http://ssa.gov/ar> to view the proposed exhibits which are shown in the exhibit list tab. Further processing of this case requires the following actions on your part:

1. It is the claimant's responsibility to provide medical evidence showing that he/she has an impairment(s) and how severe it is during the time he or she alleges disability. In order to expedite processing of this claim, you should submit the following information:
 - a. All medical records (*not duplicates*) from one year prior to the alleged onset date to the present and any other relevant medical, school or other records not already in file. Please refer to your client's electronic folder to avoid submitting duplicate records.
 - b. Completed Recent Medical Treatment, Medications and Work Background questionnaires, and signed Authorization to Release Information (enclosed).

EXHIBIT NO. B9E

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Nevaeh Hope Adams

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2. Advise us when all relevant evidence is up-to-date and the case is ready to be scheduled.

Please submit all evidence using one of the three electronic methods:

1. Fax using the enclosed barcode to the FECS server number (877)871-1882,
2. ARS (Appointed Representative Services) website or
3. Contract Scanner (**Note: Please do not send original documents directly to the contract scanner as they will not be returned.**)

Charleston, WV OHO
P. O. Box 8775
London, KY 40742-8775

As soon as you submit the foregoing, we will review your case to determine if we can make a fully favorable decision without holding a hearing. If we cannot make a decision on the record, we will schedule your case for hearing. Therefore, it is to your advantage to submit your evidence as soon as possible.

If you have any questions, please contact the number listed above.

Sincerely,

Kathy A. Lytton
Hearing Office Director

Enclosures:

HA-4631 (Claimant's Recent Medical Treatment)
HA-4632 (Claimant's Medications)
HA-4633 (Claimant's Work Background)
SSA-827 (Authorization to Disclose Information to the Social Security Administration (SSA))

cc: Kelli Adams on behalf of
Nevaeh Hope Adams
C/O Kelli Adams
P.O. Box 46
Big Sandy, WV 24816

**EXHIBIT NO. B9E
PAGE: 3 OF 11**

Social Security Administration

 Form Approved
 OMB No.0960-0292
CLAIMANT'S RECENT MEDICAL TREATMENT**A. To be completed by hearing office**

(Claimant and Social Security Number)
 Nevaeh Hope Adams
 794-01-8055

(Wage Earner and Social Security Number)
 (Leave blank if same as claimant)

The last time we brought your
 case up-to-date was:
 September 18, 2019

B. To be completed by claimant**PLEASE PRINT****Please Answer the Following Questions:**

- (1) Have you been treated or examined by a doctor (other than a doctor at a hospital) since the above date? Yes No

(If yes, please list the name, addresses and telephone numbers of doctors who have treated or examined you since the above date. Also list dates of treatment or examination. If possible, send updated reports from these doctors to the Administrative Law Judge prior to the date of your hearing.)

DOCTORS' NAME(S)	ADDRESS(ES) & TELEPHONE NO.(S)	DATE(S)

- (2) What have these doctors told you about your condition?
-
-
-
-

- (3) Have you been hospitalized since the above date? Yes No

(If yes, please list the name and address of the hospital. Also explain why you were hospitalized and what treatment you received.)

Name of Hospital	Address of Hospital (Include ZIP Code)
------------------	--

Reason for hospitalization:

Treatment received:

Form **HA-4631** (8-1996) ef (9-2012)
 Issue Old Stock



If more space is needed,
 use additional sheets.

RQID:0000000000000000265603418 SITE:Y09 DR:S
 SSN:794018055 DOCTYPE:3040 RF:D CS:323d

Privacy Act Statement**Collection and Use of Personal Information**

Sections 205(a), 702, 1631(e)(1)(A) and (B), and 1869(b)(1) and (C) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on any claim filed or could result in denial of the claim.

We will use the information to determine eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his or her affairs or his or her eligibility for or entitlement to benefits under the Social Security program when the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns his or her eligibility for benefits under the Social Security program; and
2. To specified business and other community members and Federal, State, and local agencies for verification of eligibility for benefits under section 1631(e) of the Act

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System, and 60-0320, entitled Electronic Disability (eDIB) Claim File. Additional information and a full listing of all our SORNs are available on our website at www.ssa.gov/privacy/sorn.html.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

Form **HA-4631** (8-1996) ef (9-2012)

**EXHIBIT NO. B9E
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SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No.0960-0289**CLAIMANT'S MEDICATIONS****A. To be completed by Hearing Office**

(Claimant and Social Security Number)	(Wage Earner and Social Security Number) (Leave blank if same as claimant)	The last time we brought your case up-to-date was: September 18, 2019
Nevaeh Hope Adams 794-01-8055		

B. To be completed by the claimant**PLEASE PRINT**

PLEASE LIST BELOW THE PRESCRIPTION MEDICATION WHICH YOU ARE PRESENTLY TAKING. IF THE NAME OF THE MEDICATION IS NOT SHOWN ON THE PRESCRIPTION CONTAINER, YOU MAY VERIFY THE NAME WITH YOUR PHARMACIST.

NAME OF MEDICATION & DOSAGE	DATE FIRST PRESCRIBED	DAILY AMOUNT TAKEN	REASONS FOR MEDICATION	NAME OF PHYSICIAN

PLEASE LIST BELOW THE NONPRESCRIPTION MEDICATION YOU ARE TAKING AND THE REASONS YOU TAKE THEM.

Form HA-4632 (2-1994) ef (10-2012)
Use Until Stock Is Exhausted



If more space is needed,
use additional sheets.

RQID:000000000000000265603422 SITE:Y09 DR:S
SSN:794018055 DOCTYPE:3045 RF:D CS:3303

**EXHIBIT NO. B9E
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Privacy Act Statement

Collection and Use of Personal Information

Sections 205, 223, 702, 1614, 1631, and 1869 of the Social Security Act, as amended allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from re-evaluating the decision on your claim.

We will use the information to determine your eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To representative payees, when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting the Social Security Administration in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees; and
2. To applicants, claimants, prospective applicants or claimants, other than the data subject, their authorized representatives or representative payees to the extent necessary to pursue Social Security claims and to representative payees when the information pertains to individuals for whom they serve as representative payees, for the purpose of assisting SSA in administering its representative payment responsibilities under the Act and assisting the representative payees in performing their duties as payees, including receiving and accounting for benefits for individuals for whom they serve as payees.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System and 60-0103, entitled Supplemental Security Income Record and Special Veterans Benefits. Additional information and a full listing of all our SORNs are available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*

Form **HA-4632** (2-1994) ef (10-2012)

EXHIBIT NO. B9E

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No.0960-0300**PAGE: 7 OF 11****CLAIMANT'S WORK BACKGROUND****A. To be completed by Hearing Office**

(Claimant and Social Security Number)

Nevaeh Hope Adams
794-01-8055(Wage Earner and Social Security Number)
(Leave blank if same as claimant)The last time we brought your case
up-to-date was:
September 18, 2019**B. To be completed by the claimant****PLEASE PRINT**

Start with your most recent job, and list that and any work performed within the past 15 years.

DATE OF EMPLOYMENT (APPROXIMATELY)	NAME OF EMPLOYER AND LOCATION OF EMPLOYMENT	DUTIES PERFORMED
FROM		
TO		
FROM		
TO		
FROM		
TO		

Form HA-4633 (2-1994) ef (10-2012)
Issue Old StockIf more space is needed,
use additional sheets.RQID:0000000000000000265603425 SITE:Y09 DR:
SSN:794018055 DOCTYPE:3050 RF:D CS:60e2

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 702, 1631 (e) and 1869(b)(1)(C) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failure to provide all or part of the information may prevent us from making an accurate and timely decision on your eligibility for disability benefits.

We will use this information to determine your eligibility for receiving disability benefits. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his/her affairs or his/her eligibility for or entitlement to benefits under the Social Security program when the individual is unable to provide information being sought. An individual is considered to be unable to provide certain types of information when: he/she is incapable or of questionable mental capability; he/she cannot read or write; he/she cannot afford the cost of obtaining the information; he/she has a hearing impairment, and is contacting SSA by telephone through a telecommunications relay system operator; a language barrier exists; or the custodian of the information will not, as a matter of policy, provide it to the individual; or the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual; and it concerns one or more of the following: his/her eligibility for benefits under the Social Security program; the amount of his/her benefit payment; or any case in which the evidence is being reviewed as a result of suspected abuse or fraud, concern for program integrity, or for quality appraisal or evaluation and measurement activities.
2. To specified business and other community members and Federal, State, and local agencies for verification of eligibility for benefits under section 1631(e) of the Act.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0089, entitled Claims Folders System; and 60-0320, entitled Electronic Disability Claim File. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.**

**EXHIBIT NO. B9E
PAGE: 9 OF 11**

WHOSE Records to be Disclosed		Form Approved OMB No. 0960-0623
NAME (First, Middle, Last, Suffix) Nevaeh Hope Adams		
SSN 794-01-8055	Birthday (mm/dd/yy) 07/21/2015	

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to :
 - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
 - Drug abuse, alcoholism, or other substance abuse
 - Sickle cell anemia
 - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
 - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM

The Social Security Administration and to the State agency authorized to process my case (usually called "disability determination services"), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE

Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redislosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

IF not signed by subject of disclosure, specify basis for authority to sign

Parent of minor Guardian Other personal representative (explain)

SIGN ►

(Parent/guardian/personal representative
sign here if two signatures required by State law) ►

Date Signed

Street Address
C/O Kelli Adams, P.O. Box 46

Phone Number (with area code)
(304)656-7434

City
Big Sandy

State
WV

ZIP
24816

WITNESS

I know the person signing this form or am satisfied of this person's identity:

SIGN ►

IF needed, second witness sign here (e.g., if signed with "X" above)
SIGN ►

Phone Number (or Address)

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Form SSA-827 (11-2012) ef (11-2012) Use 4-2009 and Later Editions Until Supply is Exhausted

Page 1 of 2

**EXHIBIT NO. B9E
PAGE: 10 OF 11**

**Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"**

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(l) and 1631(e)(l)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(d)(l) and 1383(e)(l)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090; Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 60-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory **or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)**. You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

EXHIBIT NO. B9E
PAGE: 11 OF 11



INSERT THIS END FIRST



**Please include this barcode cover sheet as the first page
of each set of documents returned.**

Fax the evidence to this fax number:

(877)871-1882



RQID:0000000000000000265603429 SITE:Y09 DR:S
SSN:794018055 DOCTYPE:5032 RF:D CS:9574

**Claimant: Nevaeh Hope Adams
SSN: 794-01-8055**

**EXHIBIT NO. B10E
PAGE: 1 OF 25**



As required under 20 CFR §404.1512(a) and/or 20 CFR §416.912(a), we are obligated to submit non-redacted and complete copies of all documents we receive that relate to our client's claim.

Accordingly, please make the enclosed medical record a part of the record in this claim.

Please note that if the medical provider returned to us the copies of form SSA-1696, our client's medical release and our cover letter requesting records, we are not enclosing copies of those documents as they do not relate to the issue of our client's disability. We do have those pages available and will submit them upon your request.

Finally, please also make this letter a part of the record in this matter.



Pre-K Family Report

Child Nevaeh Adams

Year 2019-2020

Teacher Phyllis Perkins

Location Fall River Elementary School

Child Accomplishments - Social and Emotional Development

Positive social and emotional development provides a critical foundation for lifelong development and learning. Social and emotional skills are necessary to foster secure attachment with adults and peers, maintain healthy relationships, regulate one's behavior and emotions, and develop a healthy concept of personal identity.

- Development of Self-Concept

- Development of Self-Expression and Self-Awareness

- Development and Demonstration of Pro-Social Behaviors

Child Accomplishments - English Language Arts

English Language Arts refers to language development and the ability to interpret meaning from written text. Language development refers to emerging abilities in receptive and expressive language. This domain includes understanding and using one or more languages. Literacy knowledge and skills refers to the knowledge and skills that lay the foundation for reading and writing, such as understanding print concepts and conventions, phonological awareness, alphabet knowledge, letter-sound relationships, and early writing.

- Expressive Language

- Book Appreciation and Knowledge

- Early Writing

Child Accomplishments - Mathematics

Mathematical thinking is a process and a core component of cognition. Young children need to analyze mathematical challenges in an environment where collaboration in creative mathematical thinking is encouraged. Formulating, representing, and solving simple mathematical problems through creative thinking is imperative to building mathematical competency. Mathematics is the ability to think logically, plan, solve problems, reason, make predictions, and notice patterns.

- Number Names

- Counting to Tell the Number of Objects

- Comparing and Ordering Numbers

- Shapes and Spatial Reasoning

Child Accomplishments - Science

Scientific thinking builds on children's prior experiences, backgrounds, and early theories. Children's fundamental math concepts support scientific experimentation, investigation, and inquiry, resulting in the development of new understandings of their world. Science and math concepts are best developed through active exploration of naturalistic, informal, and structured learning experiences.

- Foundational Knowledge of Scientific Inquiry

Pre-K Family Report



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West Virginia
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EXHIBIT NO. B10E
PAGE: 3 OF 25
EARLY LEARNING
REPORTING SYSTEM

Child Nevaeh Adams

Year 2019-2020

Teacher Phyllis Perkins

Location Fall River Elementary School

Child Accomplishments - Social and Emotional Development

Positive social and emotional development provides a critical foundation for lifelong development and learning. Social and emotional skills are necessary to foster secure attachment with adults and peers, maintain healthy relationships, regulate one's behavior and emotions, and develop a healthy concept of personal identity.

- Development of Self-Concept
- Development of Self-Expression and Self-Awareness
- Development and Demonstration of Pro-Social Behaviors

Child Accomplishments - English Language Arts

English Language Arts refers to language development and the ability to interpret meaning from written text. Language development refers to emerging abilities in receptive and expressive language. This domain includes understanding and using one or more languages. Literacy knowledge and skills refers to the knowledge and skills that lay the foundation for reading and writing, such as understanding print concepts and conventions, phonological awareness, alphabet knowledge, letter-sound relationships, and early writing.

- Expressive Language
- Receptive Language
- Early Writing

Child Accomplishments - Mathematics

Mathematical thinking is a process and a core component of cognition. Young children need to analyze mathematical challenges in an environment where collaboration in creative mathematical thinking is encouraged. Formulating, representing, and solving simple mathematical problems through creative thinking is imperative to building mathematical competency. Mathematics is the ability to think logically, plan, solve problems, reason, make predictions, and notice patterns.

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- Counting to Tell the Number of Objects
- Comparing and Ordering Numbers
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- Foundational Knowledge of Scientific Inquiry

**EXHIBIT NO. B10E
PAGE: 4 OF 25**
Child Accomplishments - The Arts

The Arts refers to opportunities for children to engage in creative expression and aesthetic appreciation in such forms as dramatic play, music, dance, visual arts, and other creative outlets for expression. Imagination and creativity are the foundation for new ideas and builds skills that are needed for problem solving, conflict resolution, and lifelong learning.

- Self-Expression (Music)
- Self-Expression (Creative Movement)
- Self-Expression (Dramatic Play)

Child Accomplishments - Health and Physical Development

Health and Physical Development refers to physical well-being, use of the body, muscle control, appropriate nutrition, exercise, hygiene, and safety practices. Early health habits lay the foundation for lifelong healthy living. Physical well-being, health, and motor development are equally important foundations to young children's learning.

- Safety Practices
- Healthy Development
- Gross Motor Development
- Fine Motor Development

Child Accomplishments - Approaches to Learning

Approaches to Learning refers to observable behaviors that indicate ways children become engaged in and respond to social interactions and learning experiences. Children's approaches to learning contribute to their success in school and influence their development and learning in all other domains. Children's ability to stay focused, interested, and engaged in activities supports a range of positive outcomes, including cognitive, language, and social and emotional development.

- Interest in varied topics and experiences, desire to learn, creativeness, and independence in learning
- Engagement in activities with persistence and attention
- Interest and engagement in group experiences

Social and Emotional Development

Continue to show progress in following rules and directions.
 Continue to show pride in her accomplishments.
 Continue praise for self help skills.

English Language Arts

Continue to listen to stories being read and ask questions about the story.
 Continue to use tools for writing daily.
 Continue uses her words to express her needs and wants.

Mathematics

Continue counting to ten and beyond, touching each item counted.
 Continue naming shapes the colors and the size of items.
 Continue learning to recognize one to ten numbers.

Science

Explore and ask questions about things she finds.

**EXHIBIT NO. B10E
PAGE: 5 OF 25**
The Arts - Music

Listen and move her body to different rhythms and beat of songs.

The Arts - Creative Movement

Use different types of art materials, chalk, markers, and paint to be creative.

The Arts - Visual Arts

Continue drawing, painting, adding dictation to her art work.

The Arts - Dramatic Play

Continue to use objects in play to express herself. puppets, dolls, etc.

Health and Physical Development

Play safely daily.

Continue practicing dressing, buttoning and zipping clothes.

Practice pedaling a small tricycle.

Continue healthy practices, toileting, washing hands independently.

Approaches to Learning - Initiative and Curiosity

Stay on task longer than ten minutes.

Approaches to Learning - Persistence and Attentiveness

Show interest in an activity and express her wants and needs to extend her play.

Approaches to Learning - Cooperation

Play with her peers and initiate the type of play.

Approaches to Learning - Executive Functioning and Cognitive Self-Regulation

Demonstrate actions, words, and behaviors independently.

Family Input

Nevaeh:

Attendance	1	2	3
Days Absent			
Tardy			

EXHIBIT NO. B10E
PAGE: 6 OF 25

Parent/Guardian Signature and Comments

Signature

Date

Comments



West Virginia
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RIS **EARLY LEARNING**
REPORTING SYSTEM

EXHIBIT NO. B10E

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Pre-K Family Report

Child Nevaeh Adams

Year 2019-2020

Teacher Phyllis Perkins

Location Fall River Elementary School

Descriptors

P (Progressing) - Student is advancing forward.

M (Meets Expectations) - Student demonstrates an understanding of the skill.

Mathematics/Science		REPORTING PERIOD		
		1	2	3
Functional Counting	Count in sequence to 10 and beyond.	P	P	M
Numerical Operations	Identify whether the number of objects in one group is more, less, greater than, fewer, and or equal to number of objects in another group for up to 5 objects (e.g., by using matching and counting strategies).	P	P	M
Written Numbers	Begin to identify and write some numerals.	P	P	P
Classification and Algebraic Thinking		1	2	3
Classification	Sort items into categories according to common characteristics	P	P	M
Algebraic Thinking	Duplicate, create, and extend simple patterns using concrete objects.	P	P	P
Geometry and Measurement		1	2	3
Identifying and Using Shapes	Correctly names basic shapes regardless of their orientation or overall size.	P	P	M
Measurement	Estimates the size of objects in comparison to a common unit of measurement.	P	P	P
Scientific Inquiry		1	2	3
Observation and Reporting	Explores and discusses similarities and differences among objects and materials.	P	P	P
Prediction	Makes predictions and brainstorms solutions.	P	P	P
Investigation	Asks questions that can be answered through active investigation.	P	P	P
Social Emotional/Social Studies				REPORTING PERIOD
				1 2 3
Self-Regulation		1	2	3
Independent Behavior	Increases independence in a variety of activities, routines, and tasks.	P	P	P
Regulation of Emotions and Behavior	Expresses a broad range of emotions and recognizes these emotions in self and others.	P	P	P
Pro-Social Behavior	Develops positive relationships with children and adults.	P	P	P
Social Problem Solving	Uses and accepts negotiation, compromise, and discussion to resolve conflicts.	P	P	P
Play				1 2 3
Quality and Attributes of Engagement and Exploration	Participates in a variety of classroom activities and tasks.	M	M	M
Quality and Attributes of Cooperative Play	Uses communication skills to initiate or join in classroom activities.	P	P	P
Quality and Attributes of Sociodramatic Play	Understands and describes the interactive roles and relationships among family members.	P	P	P

EXHIBIT NO. B10E**PAGE: 8 OF 25
PERIOD**

Language Arts/Literacy		REPORTING PERIOD
Oral Language		1 2 3
Speaking	With prompting and support, asks and answers questions in order to seek help and get information.	M M M
Story Retelling	Retells familiar stories from text with some accuracy and detail.	P P P
Phonological Awareness		1 2 3
Language Manipulation	Separates words into syllables.	P P P
Print Awareness		1 2 3
Alphabetic Awareness	Recognizes and names some upper and lower case letters of the alphabet.	P P M
Print Knowledge	Recognizes that letters are grouped to form words and words are a unit of print.	P P P
Writing		1 2 3
Composing	With prompting and support, uses a combination of drawing, dictating, and writing to compose opinion pieces in which the topic or the name of the text being discussed is included.	P M P
Production	Attempts to independently write some familiar words and writes own name.	P P P
Physical Health and Development		REPORTING PERIOD
Fine Motor		1 2 3
Small Muscle Coordination	Control and Manipulation; Eye-Hand Coordination; Manipulating Writing, Drawing and Art Tools; and Self-Help Skills	P P P
Gross Motor		1 2 3
Large Muscle Coordination	Control and Proficiency; Coordinating Movements; and Balance	P P P
Health Development		1 2 3
Health Development	Healthy Food Choices; Physical Fitness; Physical Growth, Daily Health Routines; and Understanding of Apparel	P P P
Safety Practices		1 2 3
Safety Practices	Safety Activities; Symbols and Rules	P P P
Social and Emotional Development		
Continue to show progress in following rules and directions. Continue to show pride in her accomplishments. Continue praise for self help skills.		
English Language Arts		
Continue to listen to stories being read and ask questions about the story. Continue to use tools for writing daily. Continue uses her words to express her needs and wants.		
Mathematics		
Continue counting to ten and beyond, touching each item counted. Continue naming shapes the colors and the size of items. Continue learning to recognize one to ten numbers.		

EXHIBIT NO. B10E
PAGE: 9 OF 25
Science

Explore and ask questions about things she finds.

The Arts - Music

Listen and move her body to different rhythms and beat of songs.

The Arts - Creative Movement

Use different types of art materials, chalk, markers, and paint to be creative.

The Arts - Visual Arts

Continue drawing, painting, adding dictation to her art work.

The Arts - Dramatic Play

Continue to use objects in play to express herself. puppets,dolls, etc.

Health and Physical Development

Play safely daily.

Continue practicing dressing, buttoning and zipping clothes.

Practice pedaling a small tricycle.

Continue healthy practices, toileting, washing hands independently.

Approaches to Learning - Initiative and Curiosity

Stay on task longer than ten minutes.

Approaches to Learning - Persistence and Attentiveness

Show interest in an activity and express her wants and needs to extend her play.

Approaches to Learning - Cooperation

Play with her peers and initiate the type of play.

Approaches to Learning - Executive Functioning and Cognitive Self-Regulation

Demonstrate actions,words, and behaviors independently.

Family Input

Nevaeh:

Attendance	1	2	3
Days Absent			
Tardy			

EXHIBIT NO. B10E
PAGE: 10 OF 25

Parent/Guardian Signature and Comments

Signature	Date
Comments	

Child Accomplishments - The Arts	EXHIBIT NO. B10E PAGE: 11 OF 25
The Arts refers to opportunities for children to engage in creative expression and aesthetic appreciation in such forms as dramatic play, music, dance, visual arts, and other creative outlets for expression. Imagination and creativity are the foundation for new ideas and builds skills that are needed for problem solving, conflict resolution, and lifelong learning.	
Self-Expression (Music)	
Self-Expression (Creative Movement)	
Self-Expression (Dramatic Play)	
Child Accomplishments - Health and Physical Development	
Health and Physical Development refers to physical well-being, use of the body, muscle control, appropriate nutrition, exercise, hygiene, and safety practices. Early health habits lay the foundation for lifelong healthy living. Physical well-being, health, and motor development are equally important foundations to young children's learning.	
Safety Practices	
Healthy Development	
Child Accomplishments - Approaches to Learning	
Approaches to Learning refers to observable behaviors that indicate ways children become engaged in and respond to social interactions and learning experiences. Children's approaches to learning contribute to their success in school and influence their development and learning in all other domains. Children's ability to stay focused, interested, and engaged in activities supports a range of positive outcomes, including cognitive, language, and social and emotional development.	
Interest in varied topics and experiences, desire to learn, creativeness, and independence in learning	
Engagement in activities with persistence and attention	
Interest and engagement in group experiences	
Social and Emotional Development	
Demonstrate growing confidence in a range of abilities and express pride in accomplishments. Demonstrate progress in expressing needs, wants, and feelings. Follow rules and routines. Potty train schedule.	
English Language Arts	
Use language to express ideas and needs. Show interest in shared reading and looking at books independently. Use scribbles, shapes, pictures, and letters to represent objects, stories, experiences, or ideas.	
Mathematics	
Count in sequence to 10 and beyond. Use one-to-one correspondence to count objects and match groups of objects. Correctly name shapes regardless of size. Name and recognize basic shapes.	
Science	
Express wonder and ask questions about the world around them.	

The Arts - Music

EXHIBIT NO. B10E
PAGE: 12 OF 25

Participate in music activities, including but not limited to listening, singing and finger plays.

The Arts - Creative Movement

Move to different patterns of beat and rhythm in music.

The Arts - Visual Arts

1 Explore color and textures using different mediums. (Examples: clay, natural materials, wood, paper, crayons, chalk, paint, glue, paste, etc.)

The Arts - Dramatic Play

Use dialogue, actions, and objects to tell a story or express thoughts and feelings.

Health and Physical Development

Participate in safety games and stories.
 Complete personal care tasks such as dressing, brushing teeth, toileting, and washing hands independently.
 Demonstrate increased accuracy of eye-hand coordination and use of opposing hand movements such as but not limited to building with blocks, stringing with beads, cutting with scissors, and putting puzzles together.

Approaches to Learning - Initiative and Curiosity

Demonstrate flexibility, imagination, and inventiveness in approaching tasks and activities.

Approaches to Learning - Persistence and Attentiveness

Engage in project or activity over an extended period of time.

Approaches to Learning - Cooperation

Initiate and engage in learning experiences and play with peers.

Approaches to Learning - Executive Functioning and Cognitive Self-Regulation

Demonstrate actions, words, and behaviors with increasing independence.

Family Input

Nevaeh:

Attendance	EXHIBIT NO. B10E	PAGE: 13 OF 25
Days Absent		
Tardy		

Parent/Guardian Signature and Comments	
Signature	Karen MacLean
Date	01-07-20
Comments	

Pre-K Family Report



Child Nevaeh Adams

Year 2019-2020

Teacher Phyllis Perkins

Location Fall River Elementary School

Descriptors

P (Progressing) - Student is advancing forward.

M (Meets Expectations) - Student demonstrates an understanding of the skill.

Mathematics/Science		REPORTING PERIOD		
		1	2	3
Functional Counting	Count in sequence to 10 and beyond.	P	P	
Numerical Operations	Identify whether the number of objects in one group is more, less, greater than, fewer, and or equal to number of objects in another group for up to 5 objects (e.g., by using matching and counting strategies).	P	P	
Written Numbers	Begin to identify and write some numerals.	P	P	
Classification and Algebraic Thinking		1	2	3
Classification	Sort items into categories according to common characteristics	P	P	
Algebraic Thinking	Duplicate, create, and extend simple patterns using concrete objects.	P	P	
Geometry and Measurement		1	2	3
Identifying and Using Shapes	Correctly names basic shapes regardless of their orientation or overall size.	P	P	
Measurement	Estimates the size of objects in comparison to a common unit of measurement.	P	P	
Scientific Inquiry		1	2	3
Observation and Reporting	Explores and discusses similarities and differences among objects and materials.	P	P	
Prediction	Makes predictions and brainstorms solutions.	P	P	
Investigation	Asks questions that can be answered through active investigation.	P	P	
Social Emotional/Social Studies		REPORTING PERIOD		
		1	2	3
Self-Regulation				
Independent Behavior	Increases independence in a variety of activities, routines, and tasks.	P	P	
Regulation of Emotions and Behavior	Expresses a broad range of emotions and recognizes these emotions in self and others.	P	P	
Pro-Social Behavior	Develops positive relationships with children and adults.	P	P	
Social Problem Solving	Uses and accepts negotiation, compromise, and discussion to resolve conflicts.	P	P	
Play		1	2	3
Quality and Attributes of Engagement and Exploration	Participates in a variety of classroom activities and tasks.	M	M	
Quality and Attributes of Cooperative Play	Uses communication skills to initiate or join in classroom activities.	P	P	
Quality and Attributes of Sociodramatic Play	Understands and describes the interactive roles and relationships among family members.	P	P	

		EXHIBIT NO. B10E PAGE: 15 OF 25D		
Language Arts/Literacy				
Oral Language				
Speaking	With prompting and support, asks and answers questions in order to seek help and get information.	M	M	
Story Retelling	Retells familiar stories from text with some accuracy and detail.	P	P	
Phonological Awareness		1	2	3
Language Manipulation	Separates words into syllables.	P	P	
Print Awareness		1	2	3
Alphabetic Awareness	Recognizes and names some upper and lower case letters of the alphabet.	P	P	
Print Knowledge	Recognizes that letters are grouped to form words and words are a unit of print.	P	P	
Writing		1	2	3
Composing	With prompting and support, uses a combination of drawing, dictating, and writing to compose opinion pieces in which the topic or the name of the text being discussed is included.	P	M	
Production	Attempts to independently write some familiar words and writes own name.	P	P	
Physical Health and Development				REPORTING PERIOD
Fine Motor		1	2	3
Small Muscle Coordination	Control and Manipulation; Eye-Hand Coordination; Manipulating Writing, Drawing and Art Tools; and Self-Help Skills	P	P	
Gross Motor		1	2	3
Large Muscle Coordination	Control and Proficiency; Coordinating Movements; and Balance	P	P	
Health Development		1	2	3
Health Development	Healthy Food Choices; Physical Fitness; Physical Growth, Daily Health Routines; and Understanding of Apparel	P	P	
Safety Practices		1	2	3
Safety Practices	Safety Activities; Symbols and Rules	P	P	
Social and Emotional Development				
Demonstrate growing confidence in a range of abilities and express pride in accomplishments. Demonstrate progress in expressing needs, wants, and feelings. Follow rules and routines. Potty train schedule.				
English Language Arts				
Use language to express ideas and needs. Show interest in shared reading and looking at books independently. Use scribbles, shapes, pictures, and letters to represent objects, stories, experiences, or ideas.				

Mathematics	EXHIBIT NO. B10E PAGE: 16 OF 25
Count in sequence to 10 and beyond. Use one-to-one correspondence to count objects and match groups of objects. Correctly name shapes regardless of size. Name and recognize basic shapes.	
Science	
Express wonder and ask questions about the world around them.	
The Arts - Music	
Participate in music activities, including but not limited to listening, singing and finger plays.	
The Arts - Creative Movement	
Move to different patterns of beat and rhythm in music.	
The Arts - Visual Arts	
1 Explore color and textures using different mediums. (Examples: clay, natural materials, wood, paper, crayons, chalk, paint, glue, paste, etc.)	
The Arts - Dramatic Play	
Use dialogue, actions, and objects to tell a story or express thoughts and feelings.	
Health and Physical Development	
Participate in safety games and stories. Complete personal care tasks such as dressing, brushing teeth, toileting, and washing hands independently. Demonstrate increased accuracy of eye-hand coordination and use of opposing hand movements such as but not limited to building with blocks, stringing with beads, cutting with scissors, and putting puzzles together.	
Approaches to Learning - Initiative and Curiosity	
Demonstrate flexibility, imagination, and inventiveness in approaching tasks and activities.	
Approaches to Learning - Persistence and Attentiveness	
Engage in project or activity over an extended period of time.	
Approaches to Learning - Cooperation	
Initiate and engage in learning experiences and play with peers.	

Approaches to Learning - Executive Functioning and Cognitive Self-Regulation**EXHIBIT NO. B10E
PAGE: 17 OF 25**

Demonstrate actions, words, and behaviors with increasing independence.

Family Input

Nevaeh:

Attendance

1 2 3

Days Absent

Tardy

Parent/Guardian Signature and Comments

Signature

-Kelli MacLean

Date

01-07-20

Comments

Pre-K Family Report



EL
RS

EXHIBIT NO. B10E
West Virginia
EARLY LEARNING REPORTING SYSTEM
OF 25

Child Nevaeh Adams

Year 2019-2020

Teacher Phyllis Perkins

Location Fall River Elementary School

Child Accomplishments - Social and Emotional Development

Positive social and emotional development provides a critical foundation for lifelong development and learning. Social and emotional skills are necessary to foster secure attachment with adults and peers, maintain healthy relationships, regulate one's behavior and emotions, and develop a healthy concept of personal identity.

- Development of Self-Expression and Self-Awareness
- Development and Demonstration of Pro-Social Behaviors
- Cooperation

Child Accomplishments - English Language Arts

English Language Arts refers to language development and the ability to interpret meaning from written text. Language development refers to emerging abilities in receptive and expressive language. This domain includes understanding and using one or more languages. Literacy knowledge and skills refers to the knowledge and skills that lay the foundation for reading and writing, such as understanding print concepts and conventions, phonological awareness, alphabet knowledge, letter-sound relationships, and early writing.

- Expressive Language
- Receptive Language
- Book Appreciation and Knowledge

Child Accomplishments - Mathematics

Mathematical thinking is a process and a core component of cognition. Young children need to analyze mathematical challenges in an environment where collaboration in creative mathematical thinking is encouraged. Formulating, representing, and solving simple mathematical problems through creative thinking is imperative to building mathematical competency. Mathematics is the ability to think logically, plan, solve problems, reason, make predictions, and notice patterns.

- Number Names
- Counting to Tell the Number of Objects
- Shapes and Spatial Reasoning

Child Accomplishments - Science

Scientific thinking builds on children's prior experiences, backgrounds, and early theories. Children's fundamental math concepts support scientific experimentation, investigation, and inquiry, resulting in the development of new understandings of their world. Science and math concepts are best developed through active exploration of naturalistic, informal, and structured learning experiences.

- Foundational Knowledge of Scientific Inquiry
- Utilization of Inquiry

Child Accomplishments - The Arts

EXHIBIT NO. B10E
PAGE: 19 OF 25

The Arts refers to opportunities for children to engage in creative expression and aesthetic appreciation in such forms as dramatic play, music, dance, visual arts, and other creative outlets for expression. Imagination and creativity are the foundation for new ideas and builds skills that are needed for problem solving, conflict resolution, and lifelong learning.

- Self-Expression (Music)
- Self-Expression (Creative Movement)
- Self-Expression (Visual Art)
- Self-Expression (Dramatic Play)

Child Accomplishments - Health and Physical Development

Health and Physical Development refers to physical well-being, use of the body, muscle control, appropriate nutrition, exercise, hygiene, and safety practices. Early health habits lay the foundation for lifelong healthy living. Physical well-being, health, and motor development are equally important foundations to young children's learning.

- Safety Practices
- Healthy Development
- Gross Motor Development
- Fine Motor Development

Child Accomplishments - Approaches to Learning

Approaches to Learning refers to observable behaviors that indicate ways children become engaged in and respond to social interactions and learning experiences. Children's approaches to learning contribute to their success in school and influence their development and learning in all other domains. Children's ability to stay focused, interested, and engaged in activities supports a range of positive outcomes, including cognitive, language, and social and emotional development.

- Interest in varied topics and experiences, desire to learn, creativeness, and independence in learning
- Engagement in activities with persistence and attention
- Interest and engagement in group experiences

Social and Emotional Development

Demonstrate progress in expressing needs, wants, and feelings.

Follow basic rules and routines.

Take turns with materials and during experiences.

English Language Arts

Use words to express her needs and wants.

Listen to stories being read.

Choose and look at books independently.

Mathematics

Count in sequence to 5 and beyond.

Use one-to-one correspondence to count objects and match groups to objects.

Use the names of basic shapes, circle, heart, star.

**EXHIBIT NO. B10E
PAGE: 20 OF 25**

Science

Explore and discuss similarities and differences among objects and materials.
Ask and answer questions about her surroundings.

The Arts - Music

Participate in music activities (e.g., listening, singing, and finger plays).

The Arts - Creative Movement

Move to different patterns of beat and rhythm in music.

The Arts - Visual Arts

Express thoughts and feelings through creative artwork (e.g., drawing, sculpting, and painting).

The Arts - Dramatic Play

Participate in a variety of pretend play to explore various roles (e.g., family and community members in the dramatic play area, blocks, and outdoors).

Health and Physical Development

Participate in safety stories, games, and drills (e.g., bus, fire, bike, and strangers). Complete personal care tasks (e.g., dressing, brushing teeth, toileting, and washing hands) independently. Demonstrate increased ability with self-help skills (e.g., buttoning, zipping, and lacing).

Approaches to Learning - Initiative and Curiosity

Demonstrate flexibility, imagination, and inventiveness in approaching tasks and activities.

Approaches to Learning - Persistence and Attentiveness

Persist in completing tasks, activities, projects, and experiences.

Approaches to Learning - Cooperation

Initiate and engage in learning experiences and play with peers.

Approaches to Learning - Executive Functioning and Cognitive Self-Regulation

Illustrate increasing abilities in impulse control, sustain attention.

Family Input

Nevaeh: *Slowly learning the potty schedule.*

Attendance		EXHIBIT NO. B10E PAGE: 21 OF 25		
Days Absent				
Tardy				
Parent/Guardian Signature and Comments				
Signature	<i>Kelli M. Adams</i>		Date	<i>10-3-19</i>
Comments	<i>She's slowly learning the potty</i>			

Pre-K Family Report



West Virgin
EARLY LEARNING OF 25
REPORTING SYSTEM

Child Nevaeh Adams

Year 2019-2020

Teacher Phyllis Perkins

Location Fall River Elementary School

Descriptors

P (Progressing) - Student is advancing forward.

M (Meets Expectations) - Student demonstrates an understanding of the skill.

Mathematics/Science		REPORTING PERIOD		
		1	2	3
Functional Counting	Count in sequence to 10 and beyond.	P		
Numerical Operations	Identify whether the number of objects in one group is more, less, greater than, fewer, and or equal to number of objects in another group for up to 5 objects (e.g., by using matching and counting strategies).	P		
Written Numbers	Begin to identify and write some numerals.	P		
Classification and Algebraic Thinking		1	2	3
Classification	Sort items into categories according to common characteristics	P		
Algebraic Thinking	Duplicate, create, and extend simple patterns using concrete objects.	P		
Geometry and Measurement		1	2	3
Identifying and Using Shapes	Correctly names basic shapes regardless of their orientation or overall size.	P		
Measurement	Estimates the size of objects in comparison to a common unit of measurement.	P		
Scientific Inquiry		1	2	3
Observation and Reporting	Explores and discusses similarities and differences among objects and materials.	P		
Prediction	Makes predictions and brainstorms solutions.	P		
Investigation	Asks questions that can be answered through active investigation.	P		
Social Emotional/Social Studies		REPORTING PERIOD		
		1	2	3
Self-Regulation				
Independent Behavior	Increases independence in a variety of activities, routines, and tasks.	P		
Regulation of Emotions and Behavior	Expresses a broad range of emotions and recognizes these emotions in self and others.	P		
Pro-Social Behavior	Develops positive relationships with children and adults.	P		
Social Problem Solving	Uses and accepts negotiation, compromise, and discussion to resolve conflicts.	P		
Play		1	2	3
Quality and Attributes of Engagement and Exploration	Participates in a variety of classroom activities and tasks.	M		
Quality and Attributes of Cooperative Play	Uses communication skills to initiate or join in classroom activities.	P		
Quality and Attributes of Sociodramatic Play	Understands and describes the interactive roles and relationships among family members.	P		

EXHIBIT NO. 10E
PAGE: 23 OF 25

Language Arts/Literacy		1	2	3			
Oral Language							
Speaking	With prompting and support, asks and answers questions in order to seek help and get information.	M					
Story Retelling	Retells familiar stories from text with some accuracy and detail.	P					
Phonological Awareness		1	2	3			
Language Manipulation	Separates words into syllables.	P					
Print Awareness		1	2	3			
Alphabetic Awareness	Recognizes and names some upper and lower case letters of the alphabet.	P					
Print Knowledge	Recognizes that letters are grouped to form words and words are a unit of print.	P					
Writing		1	2	3			
Composing	With prompting and support, uses a combination of drawing, dictating, and writing to compose opinion pieces in which the topic or the name of the text being discussed is included.	P					
Production	Attempts to independently write some familiar words and writes own name.	P					
Physical Health and Development		REPORTING PERIOD					
Fine Motor		1	2	3			
Small Muscle Coordination	Control and Manipulation; Eye-Hand Coordination; Manipulating Writing, Drawing and Art Tools; and Self-Help Skills	P					
Gross Motor		1	2	3			
Large Muscle Coordination	Control and Proficiency; Coordinating Movements; and Balance	P					
Health Development		1	2	3			
Health Development	Healthy Food Choices; Physical Fitness; Physical Growth, Daily Health Routines; and Understanding of Apparel	P					
Safety Practices		1	2	3			
Safety Practices	Safety Activities; Symbols and Rules	P					
Social and Emotional Development							
Demonstrate progress in expressing needs, wants, and feelings.							
Follow basic rules and routines.							
Take turns with materials and during experiences.							
English Language Arts							
Use words to express her needs and wants.							
Listen to stories being read.							
Choose and look at books independently.							

Mathematics

EXHIBIT NO. B10E
PAGE: 24 OF 25

Count in sequence to 5 and beyond.
 Use one-to-one correspondence to count objects and match groups to objects.
 Use the names of basic shapes, circle, heart, star.

Science

Explore and discuss similarities and differences among objects and materials.
 Ask and answer questions about her surroundings.

The Arts - Music

Participate in music activities (e.g., listening, singing, and finger plays).

The Arts - Creative Movement

Move to different patterns of beat and rhythm in music.

The Arts - Visual Arts

Express thoughts and feelings through creative artwork (e.g., drawing, sculpting, and painting).

The Arts - Dramatic Play

Participate in a variety of pretend play to explore various roles (e.g., family and community members in the dramatic play area, blocks, and outdoors).

Health and Physical Development

Participate in safety stories, games, and drills (e.g., bus, fire, bike, and strangers).
 Complete personal care tasks (e.g., dressing, brushing teeth, toileting, and washing hands) independently.
 Demonstrate increased ability with self-help skills (e.g., buttoning, zipping, and lacing).

Approaches to Learning - Initiative and Curiosity

Demonstrate flexibility, imagination, and inventiveness in approaching tasks and activities.

Approaches to Learning - Persistence and Attentiveness

Persist in completing tasks, activities, projects, and experiences.

Approaches to Learning - Cooperation

Initiate and engage in learning experiences and play with peers.

Approaches to Learning - Executive Functioning and Cognitive Self-Regulation

Illustrate increasing abilities in impulse control, sustain attention.

Family Input**EXHIBIT NO. B10E
PAGE: 25 OF 25**

Nevaeh: She's learning a lot.

Attendance

1 2 3

Days Absent

Tardy

Parent/Guardian Signature and CommentsSignature *Kelli M. Adams*Date *10-3-19*

Comments

Shes learning a lot

EXHIBIT NO. B11E
PAGE: 1 OF 1



November 19, 2020

The Honorable Judge Francine Serafin,
SSA, Office of Hearings Operations
500 Quarrier Street, Ste. 100
Charleston, WV 25301

Re: Nevaeh Hope Adams
SSN: 794-01-8055

Dear Judge Serafin:

The above-mentioned claimant has received medical treatment at the following locations and/or with the following providers. Medical treatment records are currently outstanding and may not be available for submission within five days of the scheduled hearing per **20 CFR 404.935**.

1. Mercer Medical Group ENT (09/26/2018 to Present)
Appointment 11/17/2020
11/18/2020-A medical records request was sent to the medical provider.
2. Office of Maternal, Child and Family Health (05/12/2017 to Present)
09/30/2020-A medical records request was sent to the medical provider.
10/23/2020-Julie called provider and spoke with receptionist. Receptionist said that the mother needs to sign their own release form. Mailed release form to client's mother.
11/13/2020-Julie spoke with client's mother and she will be mailing the release form today.

Thank you for additional time and consideration regarding this matter.

Respectfully submitted,

A handwritten signature in black ink that reads "Jan Dils".

Jan Dils, Attorney
JD/JAP

| MAIN OFFICE |
963 Market Street Parkersburg, WV 26101
P: 304.428.8900 F: 304.428.4500

PARKERSBURG | BECKLEY | CHARLESTON | HUNTINGTON | LOGAN | CHARLOTTE
I-877-JANDILS | JANDILS.COM

EXHIBIT NO. B12E
PAGE: 1 OF 2

Social Security Administration

OMB Control No. 0960-0671

COVID-19 Telephone Hearing Agreement Form

Claimant's Name: Nevaeh Hope Adams

Social Security Number: 794-01-8055

Wage Earner:

Representative's Name: Jan Denise Dils

RECEIVED

NOV 16 2020

ODAR/CHARLES CITY, WV

Due to the coronavirus 2019 (COVID-19) national public health emergency, we are conducting hearings only by telephone at this time. We will not conduct the hearing by telephone unless the claimant (hereinafter "you") voluntarily agrees to appear in that manner. If you, the claimant, agree to appear at your hearing by telephone, the administrative law judge (ALJ) assigned to your case will conduct the hearing from his or her personal residence.

Please check one of the boxes below to tell us whether you voluntarily agree to appear at your hearing by telephone. If you agree to appear by telephone, please be sure to provide the telephone number where we can reach you at the time of your hearing. If you do not agree to appear by telephone, we will wait to schedule your hearing until we resume standard operations and can schedule you to appear at a hearing by video teleconferencing or in person, as appropriate. If we have already scheduled your hearing and you do not agree to appear by telephone, we will postpone your hearing.

I agree to a telephone hearing. On the day of the hearing, I can be contacted at:

My contact number:

~~000-00-0000~~ 681-229-9295 ext 4
or ~~000-00-0000~~ 681-398-6159

My representative's contact number:

I do not agree to a telephone hearing. I understand that by selecting this option, my hearing will be delayed.

If your contact information changes or if you have questions, please call the Hearing Office at the telephone number on the COVID-19 Public Health Emergency Hearing Changes notice associated with this request.

Additional Comments:



Claimant

See Next Page

**EXHIBIT NO. B12E
PAGE: 2 OF 2**

[] I am the claimant whose name appears above, and the selection on this form accurately represents my voluntary determinations.

Claimant Signature:	Date:
---------------------	-------

— Or —

[] I represent the claimant whose name appears above and who presently is unable to sign this form due to COVID-19 precautions. As the authorized representative, I have consulted with the claimant, and the selection on this form accurately represents his or her voluntary determinations.

Representative Signature:	Date:
---------------------------	-------



See Next Page

Claimant

EXHIBIT NO. B13E
PAGE: 1 OF 1



December 18, 2020

The Honorable Francine Serafin
SSA, Office of Hearings Operations
500 Quarrier Street, Ste. 100
Charleston, WV 25301

Re: Nevaeh Hope Adams
SSN: 794-01-8055

Dear Judge Serafin:

This letter is submitted on behalf of the claimant, Ms. Nevaeh Hope Adams. Ms. Adams was scheduled before Your Honor on December 3, 2020. The record was left open in order to give us time to obtain Ms. Adams's treatment records from Office of Maternal, Child and Family Health and McDowell County Schools. Unfortunately, we have not yet received these records.

We respectfully ask Your Honor to keep the record open for 14 days to give us the additional time needed to obtain these treatment records.

Thank you for your time and consideration.

Respectfully submitted,

A handwritten signature in black ink that reads "Jan Dils".

Jan Dils, Attorney
JD/MDW

| MAIN OFFICE |

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EXHIBIT NO. B14E
PAGE: 1 OF 1



January 8, 2021

The Honorable Francine Serafin
SSA, Office of Hearings Operations
500 Quarrier Street, Ste. 100
Charleston, WV 25301

Re: Nevaeh Hope Adams
SSN: 794-01-8055

Dear Judge Serafin:

This letter is submitted on behalf of the claimant, Ms. Nevaeh Hope Adams. Ms. Adams was scheduled before Your Honor on December 3, 2020. The record was left open in order to give us time to obtain Ms. Adams's outstanding records. Unfortunately, we have not yet received the occupational therapy records from McDowell County Schools.

We respectfully ask Your Honor to keep the record open for 14 additional days to give us the time needed to obtain these treatment records.

Thank you for your time and consideration.

Respectfully submitted,

A handwritten signature in black ink that reads "Jan Dils".

Jan Dils, Attorney
JD/MDW

| MAIN OFFICE |

963 Market Street Parkersburg, WV 26101
P: 304.428.8900 F: 304.428.4500

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1-877-JANDILS | JANDILS.COM

**EXHIBIT NO. B1F
PAGE: 1 OF 4**

FROM:
Elizabeth Bodkin, M.A.
PO Box 11928
Charleston, WV 25339

DATE: 04/08/2019
RE: ADAMS, NEVAEH
SSN: 794-01-8055

AGE AT DOE: 3
COUNTY OF RESIDENCE: McDowell

DDS INVOICE#: **LWV0008M6YP00** D

DATE/PLACE: 07/07/2016/Mullens, West Virginia

PRESCHOOL MENTAL
PROFILE

ASSESSMENT COMPLETED:

1. Mental Status Examination (MSE).
2. Clinical Interview (CI).
3. Parenteral Interview (PI).
4. WPPSI.

REFERRAL AND BACKGROUND: This 3 year old female came to evaluation via motor vehicle driven by her mother taking approximately one hour and fifteen minutes. Ms. Adams' provided information. Nevaeh was cooperative and compliant.

CHIEF COMPLAINTS: Nevaeh resides in Roderfield, West Virginia with her mother, age 28, who is unemployed, her sister, age 11, and her sister, age 8. Nevaeh has no income. The mother reported the family receives \$762 a month in food stamps. When asked why the mother was applying for benefits for Nevaeh, the mother reported, "She still has the hip problems. She does speak pretty good, but she does have language issues. She don't understand stuff. She still doesn't eat with a spoon. She can't focus very long. She still has a eating problem. It has to be soft food, mashed potatoes, chicken nuggets, and cans of spaghetti and meatballs. She still has ear infections all the time. She's off balance a lot. She's no where near potty trained. She sees an endocrinologist. Foe her hip we go every three months to Shriners Hospital. She still has a leaky aortic valve. There is still clicking. She has Turner's syndrome. Her ovaries do not work."

Onset: Always.

Functional Interference: The mother reported problems at home and in the community.

EXHIBIT NO. B1F
PAGE: 2 OF 4

ELIZABETH BODKIN, M.A./ADAMS, NEVAEH /794-01-8055
 04/08/2019/PAGE 2

PRESENTING SYMPTOMS: Ms. Adams reported Nevaeh has sleeps through the night. She reported she has a good appetite but is a very picky eater. The mother reported Nevaeh exhibits a euthymic mood most days. Developmental delays were reported.

REVIEW OF RECORDS:

1. My evaluation dated 7-7-16 was reviewed.
2. A McDowell County Schools report was reviewed.

MENTAL HEALTH TREATMENT HISTORY: Nevaeh has never received any type of mental health treatment.

MEDICAL HISTORY: Nevaeh was hospitalized at the age of six months for three days because, "she was really sick, but they did not tell me what was wrong with her." She has had two hip surgeries at Shriners Hospital. She has been hospitalized for a thyroid storm. Allergies were reported to amoxicillin. She is taking Nortropin. Nevaeh has been diagnosed with Turner's Syndrome.

BIRTH AND MILESTONES: The mother reported she did not drink, smoke, or take medications during the pregnancy. She reported that she was told at eleven weeks gestation that Nevaeh had Turner's Syndrome.

SOCIAL HISTORY: The mother reported that Nevaeh was born in Roanoke, Virginia and reared in Panther, West Virginia before moving to Roderfield two years ago. She resided with both parents until they separated eight months ago. She is the third of four children.

EDUCATIONAL BACKGROUND: Ms. Adams reported Birth-to-Three began providing services when Nevaeh was fours month old. She is not receiving any educational training presently.

TYPICAL DAY: When asked to describe the day, the mother reported, "pretty much at the house. It's me. Her, and my two year old. She plays. She watches the phone. She eats breakfast, lunch, and dinner. We take a bath. Every now and then she goes to her grandma and grandpa's house."

MENTAL STATUS EXAMINATION: Nevaeh had brown hair and blue eyes. She weighs 36 pounds and is 37 inches long. She was dressed in casual clothing. Hygiene and groom were adequate. There were no scars or birthmarks. Attitude/Behavior: She had a good attitude and was cooperative. Social: She was personable; she smiled and was engaging during the interview. Speech: Delayed. Mood: Euthymic. Affect: Broad. Concentration: Within normal limits, based on clinical observations. Psychomotor Behavior: Within normal limits based on clinical observations.

INTELLECTUAL RESULTS: The results of the WPPSI-V are:

Composite Score Summary

Visual Spatial	73
Fluid Reasoning	70
Working Memory	73
Processing Speed	70
Nonverbal Index	70

**EXHIBIT NO. B1F
PAGE: 3 OF 4**

ELIZABETH BODKIN, M.A./ADAMS, NEVAEH /794-01-8055
04/08/2019/PAGE 3

<u>Object Assembly</u>	6
<u>Matrix Reasoning</u>	7
<u>Picture Concepts</u>	6
<u>Picture Memory</u>	7
<u>Zoo Location</u>	6
<u>Bug Search</u>	7
<u>Cancellation</u>	6

VALIDITY: Neveah put forth good effort and she attempted to answer to all questions. The results are valid.

DIAGNOSES:

V62.89 Borderline Intellectual Functioning

DIAGNOSTIC RATIONAL: The diagnosis of Borderline Intellectual Functioning is based upon MSE< CI< and obtained test results.

PROGNOSIS: Fair.

SOCIAL FUNCTIONING: Nevaeh was friendly. Rapport was established.

CAPABILITY: Not applicable.

ELIZABETH BODKIN, M.A.
Licensed Psychologist #791
DOE: 06/30/19

**EXHIBIT NO. B1F
PAGE: 4 OF 4**

Electronic Records Express Attestation: This document was electronically signed

Social Security Number: 794018055
Request ID: LWV0008M6YP00 D
SiteID: S55
Route: dma

Sender Name: Bodkin, Elizabeth
Date: Fri Apr 19 23:30:03 EDT 2019

The following affirmation was electronically signed:

I am certifying under penalty of perjury, that I have been authorized or contracted by the Disability Determination Services to examine the claimant named in the attached, and produced a consultative examination report for that claimant. The report is accurate. By clicking on the "Agree" button below, I am certifying that I personally conducted, or personally participated in conducting, the consultative examination and have electronically signed the report contained within.

EXHIBIT NO. B2F
PAGE: 1 OF 2

Looney Enterprises LLC
 794 Virginia Ave.
 Welch, WV 24801-0000
 304-436-8435 FAX: 304-436-8436

Formal Health Record

January 02, 2019

Patient: Adams, Mr. Nevaeh
Date of Birth: July 21, 2015

This report will provide you with a summary of pertinent clinical findings and observations from my examination. It is a pleasure to have the opportunity to share in the care of this patient.

Exam#: 249
Exam Date: 10/10/2017

EXAMINATION: Click on EXAMINATION to Document, Pediatric eye health and vision examination.

EXAM TECHNICIAN: Looney, Denetta

PRIMARY CARE PHYSICIAN: Dr. Musafar

COMANAGING DOCTOR: Template

CHIEF COMPLAINT: RT: Mother reports patient was diagnosed with Turner Syndrome and has lazy eye (RT)

Timeline: October 2015. , Doctor recommended follow up from previous examination, Mother reports needs to be close to television.

HPI NORMS: No complaints reported of physical ocular symptoms. Not experiencing routine headaches or double vision. No reports of visual floaters or light flashes.

VISION COMPLAINT: Mother reports needs to be close to tv

PATIENT HISTORY NORMS: No systemic medications reported. No ocular medications. No history of ocular surgery. No history of trauma or ocular injuries. Ocular family history is unremarkable. Patient is currently a non-smoker. No out-of-the-ordinary social history is reported. Past medical history, unremarkable.

SYSTEMIC MEDICATIONS: No systemic medications are currently used except: Unknown Hormonal medication (Growth hormone shot weekly), No known systemic medication allergies.

SPECTACLE Rx STATUS: No current Rx.

SYSTEM NORMS: No reported disorders or current medical treatment of: Allergy, Cardiovascular, Constitutional, Cranial / Facial, Endocrine, Gastrointestinal, Genitourinary, Hematologic / Lymphatic, Immunologic, Integumentary / Skin, Musculoskeletal, Neurologic, Psychiatric, Respiratory

COLOR DISCRIMINATION: Color vision was found to be normal.

EYE MOVEMENT SKILLS: Saccades 4+, smooth and accurate. Pursuits 4+, smooth and accurate.

PAM (Potential Acuity): Click here to document or right click on the heading to remove

GLARE ACUITY: Click here to document or right click on the heading to remove

CUP/DISC RATIO:

RT: Horz NR Vert NR

LT: Horz NR Vert NR

TONOMETRY: RT: Soft mmHg LT: Soft mmHg Test: Digital Time: 13:45 Category: Examination

EXTERNAL EXAM: Confrontation fields are full in all quadrants. Facial symmetry exists. Ocular adnexa and nodes normal. Eyelids and lashes clean, healthy and free of defects. Extraocular muscle motilities and versions full. Cover test testing ortho @ primary gaze, distance and near. Pupils are equal, round and fully reactive to light.

EXTRAOCULAR MUSCLES: Right Eye: Testing reveals convergent misalignment. Hirshburg testing shows misalignment temporally of light reflex OD.

SLIT-LAMP EXAM: Tears demonstrate normal surface qualities and chemistry. Corneal epithelium, stroma and endothelium clear and healthy. Bulbar and palpebral conjunctiva are healthy and white. Chambers are deep and free of cells and flare. Iris appears healthy, normal anatomy and convexity. Lens, both capsules, cortex, and nucleus are normal for age.

POSTERIOR SEGMENT: Vitreous body clear for age and fully attached. Nerve head well perfused, with good rim tissue. Healthy macula with no edema or degenerative pigmentation. Healthy peripheral retinal structures and vasculature. No drusen, exudate, hemorrhages or evidence of retinopathy. Unless otherwise noted below.

Bilateral: Unable to observe posterior segment or fundus. Red Reflex present OU.

DISPOSITION: This patient's mood is pleasant and sociable.

ORIENTATION: Patient is fully alert to time, place, and person. Recent and remote memory is fully intact.

COMPUTERIZED SCREENING FIELDS: Bilateral: Fields were found to be full in all quadrants.

**EXHIBIT NO. B2F
PAGE: 2 OF 2**

Patient: Adams, Mr. Nevaeh - Page: 2

IMPRESSION(S):

Right Eye: Esotropia, Unspecified esotropia

UNABLE TO EXAMINE PATIENT

PATIENT UNCOOPERATIVE WITH TESTING

Explained to patient's mother that child needs sedated exam to determine diagnosis and management

TREATMENT EXTRAOCULAR MUSCLES: Right Eye: Refer patient to ophthalmologist specializing in ocular motilities or binocularly. Pediatric Ophthal. Roanoke Vistar Eye Group

ORDERS:

Schedule on or about 10/10/2018: Examination: Eye Health and Vision Exam long Ordered by: Looney, Brian D. Entered by: Admin, Admin. [Active] on 10/10/2017 By Admin, Admin.

ELECTRONIC SIGNATURE: Electronically Signed By: Brian D Looney on 10/10/2017 02:26 PM.

FOLLOW-UP: Recall on or about : Eye Health and Vision Exam

DIAGNOSIS:

H50.021 Monocular esotropia with A pattern, right eye

PROCEDURE:

92002 Exam - Intermediate_New

Finalized Exam:

Brian D. Looney OD

Date: 10/10/2017

Respectfully submitted,

Brian D. Looney OD

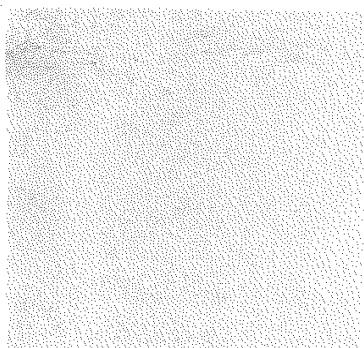
Note: The information contained in this report is confidential. Unauthorized disclosure may result in civil/criminal action as provided by HIPAA (1996) regulations.

From:MountainHeart WV BTT RAU 7

3044257367

01/08/2019 13:18

#284 P.002/037

EXHIBIT NO. B3F
PAGE: 1 OF 36


Click or tap here to enter text.

**WV Birth to Three
Evaluation/Assessment Summary Report**

Date: December 28,
2017

Child's Name: Nevaeh Adams Date of Birth: July 21, 2015
 Chronological Age: 29 months, 7 days Adjusted Age: N/A
 Parent(s)/Legal Guardian(s): Kelly and Rico Adams
 Mailing Address: P.O. Box 491, Panther, WV 24872

Individuals Present (Relationship to Child): Mom

Purpose:

- To gather information to determine:**
 Initial Annual eligibility for WV Birth to Three and plan for Individualized Family Service Plan (IFSP)
- To provide additional information to the IFSP team regarding the following area of concern:**

Click or tap here to enter text.

Family Information

She lives at home with her mom, dad, and siblings. Mom is an at home mom and dad works outside the house.

Medical History and Current Health Status

When mom was 13 weeks gestation when mom found out that Nevaeh had Turner Syndrome.

Vision

She has a lazy eye.

JAN 24 2018

From:MountainHeart WV BTT RAU 7

3044257367

01/08/2019 13:18

#284 P.003/037

EXHIBIT NO. B3F
PAGE: 2 OF 36
Hearing

She has not had her hearing tested in the past year. Mom says it seems alright her hearing. She has a lot of ear infections.

Developmental History

Nevaeh was born with Turner Syndrome that can affect the heart, height, weight, physical body malformations, and overall development in all domains of development. Nevaeh has a web new and left foot bigger than right. She has a lazy eye. She had hip dysphasia, but has had surgery. Her ears are low. She has other body abnormalities associated with Turner Syndrome. She also has Bio Ductus, which is one of the more common heart conditions associated with Turner Syndrome. She has a leaking valve which she sees a cardiologist.

Parent Reported Strengths and Concerns About the Child

Mom states that Nevaeh has good language skills and that her words are clear. Mom states that Nevaeh has a ver short attention span and doesn't focus on activities including not being able to sit through a meal, she wants to move around.

Observations and Assessment Results**Motor Development**

Assessment Tool(s) Used: E-LAP _____

 No observation or evaluation

Score: 85/52=24/17 Months

 Observation Only- Did Not Evaluate in this Area

Motor Development includes both gross and fine skills. Gross motor development refers to how a child uses his/her large muscles for rolling, crawling, walking, running, and jumping. Fine motor development refers to how a child uses his/her small muscles for eye-hand coordination, visual tracking, reaching for, and grasping and releasing objects.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

She walks and runs. She jumps in place and on a trampoline. She carries large and small objects while walking. Mom says it depends on what type of stairs she is going up and down on as to how well she does. At grandmother's house she does very well with the stairs. She throws a ball overhanded. She sits herself on the couch and child-size chair.

She stacked one block on top of another once. Mom says she doesn't stack. She inserted two squares into the shape sorter when it was pointed out to her, but the randomly tried to put in others then quickly gave up. She sometimes uses her index finger to point. She uses a palmer grasp. She held a pen with your forefinger and thumb and scribbled on paper. She did not imitate drawing a circle, vertical or horizontal line. She put beads a bowl. She tore the paper off her Christmas presents to unwrap them.

This description represents the equivalent of at least: X 40% delay 25% delay
 No concerns at this time

OR substantial atypical motor development such as: muscle tone, reflex or postural reaction responses, or movement patterns.

Communication Development

Assessment Tool(s) Used: E-LAP _____

 No observation or evaluation

Score: 41=24 months

 Observation Only- Did Not Evaluate in this Area

Communication development refers to how the child understands and expresses language.

JAN 24 2018

CHILD NAME: Nevaeh Adams

EVALUATED BY: Carolyn Fuller

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Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

She speaks approximately 75 words. Many of her words she repeats instead of using on her own. Her words are very clear and understandable. Mom will usually ask her a question such as if she's hungry or thirsty and she will respond by saying what mom said to let mom know what she wants. Mom says she sometimes things and sometime she says her whole hand. She doesn't really use the word more for something she wants, instead she'll repeat what mom says when mom asked her. She does not refer to her self by name, but she does recognize her name when it is mentioned. She imitates playful sounds. She will use some two word phrases, but mom says that she does not have a lot of two word phrases she uses. During evaluation she said some two word phrases and repeated some two word phrases. She does not usually use the pronouns, I you or me. She does not say her full name. She names three objects.

She turns her head and makes facial contact when her name is called. She smiles, laughs, and makes facial and Eye contact and social interactions. Mom says that she will sometimes follow a two-step directions such as, "go get your cup and bring it to me." Mom says that it depends on her mood. She does not follow three step directions yet. She turns her head to noises and voices.

This description represents the equivalent of at least: 40% delay 25% delay

No concerns at this time

OR substantial atypical communication such as: communication patterns, pragmatics or oral motor skills.

Cognitive Development

Assessment Tool(s) Used: E-LAP _____
 No observation or evaluation

Score: 56=14 months _____
 Observation Only- Did Not Evaluate in this Area

Cognitive development refers to how the child thinks, plays, and interacts with others and within his/her environment.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

She sings and moves to music. She sings approximately 10 songs. Some songs she sings the words. Some songs she sings to, but not necessarily the words to the song, but you can understand what she is singing. She turn pages randomly and books, sometime she pointed to pictures with her index finger and sometimes she used an open hand and patted the pictures. She named the ball, baby, and the dog. She repeated names of some of the other pictures. She lifted the lid of the container to take out the block she saw Hidden. She pointed to the picture cards I have a dog, car, cup of milk, jacket, and flower. She named the dog and repeated the names of the other picture cards. Her words were clear and understandable. She pointed to the body parts of nose, Eyes, ears. Mom says she knows all of her body parts. She did not hand in object similar to a familiar sample to practitioner (blocks/books/etc). She does not distinguish the difference between big and little. She did not imitate making a train out of blocks. When an adult counts to one, she will count up to five. She sings the ABC song. She just not at that shapes into a shape sorter

This description represents the equivalent of at least: X 40% delay 25% delay
 No concerns at this time

OR substantial atypical cognition such as: state regulation, attention span, perseveration, information processing or delayed response.

Social Emotional Development

Assessment Tool(s) Used: E-LAP _____
 No observation or evaluation

Score: 31=24 months _____
 Observation Only- Did Not Evaluate in this Area

Social emotional development refers to how the child perceives himself/herself, interacts with others, copes with frustration, and expresses his/her emotions.

CHILD NAME: Nevaeh Adams

EVALUATED BY: Carolyn Fuller

From:MountainHeart WV BTT RAU 7

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EXHIBIT NO. B3F
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Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

She does not separate well from mom, unless she is with her grandparents. She likes to play with dolls and dress up. It depends on the children she is playing with on how well she does playing with other children. Sometime she will do fine, other times she does not. She does have sibling rivalry and will want the toy that her sibling has. She will defend ownership of a toy, unless she sees something else that interests her then she'll drop the toy or give it away to go get the other toy. She imitates some grown-up activities. She seldom hands over a toy to an adult. She usually does not repeat an applauded performance. She has an almost nonexistent attention span. She is constantly on the move. Something has to be very interesting in order for her to engage in an activity. She doesn't focus on the task, instead she will get upset and frustrated if she can't do something right away. She does well with strangers when mom is around. She throws temper tantrums that usually consist of throwing are so backwards and crying. She smiles and laughs and makes facial and eye contact and social interactions.

This description represents the equivalent of at least: 40% delay 25% delay

No concerns at this time

OR substantial atypical emotional or social patterns such as: social responsiveness, affective development, attachment patterns, or self-targeted behaviors.

Adaptive Development

Assessment Tool(s) Used: E-LAP _____

No observation or evaluation

Score: 30=21 months _____

Observation Only- Did Not Evaluate in this Area

Adaptive development refers to how the child performs routine activities such as dressing and eating.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

She is picky about what she eats. Mom thinks it may have to do with the texture of some foods as to why she doesn't eat them. Peanut butter is something she does not like and mom thinks it might be the thick consistency. There were food since she was eating before that she will not eat now. She prefers more junk food items compared to more substantial foods. She drinks well from an open cup and from a water bottle. She drinks from a sippy cup. She likes soda. She wants to have a spoon at every meal, though she does not always use a spoon. She is doing OK with a spoon, but will still spill. Some food she eats better with a spoon than others. Sometime she will use a spoon, then use her hands instead because it's faster. She does not unwrapped candy, she asks mom to open it. She does not sit through a meal, she wants down from her chair and go walk around and eat. She seems to be better when she is walking around. She will reach over and put her plate in the sink.

She can take her pants and shoes off, but not her shirt on her own. She pulled her pants up and down. She will put on bras and underwear and other clothing around her neck and dress up. She puts shoes on her feet and like shoes. She cooperates with getting dressed such as Lifting her arms up to put her shirt on and lifting her leg to put her pants on. She loves her bath. Mom will ask her if her diaper is dirty and she will respond back. She is not toilet trained in yet. She is afraid of the big toilet, so mom wants to get her the child size potty chair.

She sleeps through the night well. She will wake up around eight in the morning and be up all day till she goes to bed at night, which is usually around 9 PM. She will help carry items. She will replace some items for they belong.

This description represents the equivalent of at least: 40% delay 25% delay

No concerns at this time

OR substantial atypical sensory motor development such as: sleeping patterns, feeding, or sensory integration.

Established Condition(s): x Not applicable.

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At Risk Factors

Based upon information from the Family Assessment and evaluation/assessment, the following risk factors have been identified.

CHILD NAME: Nevaeh Adams

EVALUATED BY: Carolyn Fuller

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<input type="checkbox"/> Low Birth Weight	<input type="checkbox"/> Severe Asphyxia	<input type="checkbox"/> Small for Gestational Age	<input type="checkbox"/> Gestational Age
<input type="checkbox"/> Technology Dependent	<input type="checkbox"/> Substantiated Child Abuse or Neglect	X <input type="checkbox"/> Family Barrier to Accessing Support	X <input type="checkbox"/> Parent has Serious Concern
<input type="checkbox"/> Primary Caregiver	X <input type="checkbox"/> Family Support Stressor	X <input type="checkbox"/> Chronic Otitis Media	
X <input type="checkbox"/> Chromosomal Abnormality/Genetic Disorder	<input type="checkbox"/> Congenital Disorder	<input type="checkbox"/> Severe Sensory Impairment	
Condition(s): TURNER SYNDROME	Condition(s):	Condition(s):	
<input type="checkbox"/> Nervous System Impairment	<input type="checkbox"/> Inborn Error of Metabolism	<input type="checkbox"/> Infectious Disease	
Condition(s):	Condition(s):	Condition(s):	
<input type="checkbox"/> Chronic Medical Illness	<input type="checkbox"/> Perinatal Factor	<input type="checkbox"/> Toxic Exposure	
Condition(s):	Condition(s):	Condition(s):	

Summary and Recommended Strategies to Promote Child's Participation

The following recommendations may be used for IFSP planning and development as appropriate. You may begin implementing any or all strategies immediately.

Click or tap here to enter text.

Name: Carolyn Fuller Date: 1-16-18

Signature/Credential: Carolyn Fuller

Contact Information: 304-922-8705

Name: _____ Date: _____

Signature/Credential: 1

Contact Information: _____

1

CHILD NAME: Nevaeh Adams

EVALUATED BY: Carolyn Fuller

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#284 P.007/037

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PAGE: 6 OF 36**

181 Gardenia Way
Princeton, WV 24739

WV Birth to Three Evaluation/Assessment Summary Report

Completed by: Kathy F. Quesenberry, MSM, OTR/L

Date: 12/1/17

Child's Name: Nevaeh Adams

Date of Birth: 7/21/15

Chronological Age: 2 years, 4 months, 10 days

Adjusted Age: N/A

Parent(s)/Legal Guardian(s): Kelly & Rico Adams

Mailing Address: P.O. Box 46

Bir Sandy, WV. 24816

Individuals Present (Relationship to Child): Kelly Adams (mother), Rico Adams (father), and Kyra (younger sister).

Purpose:

To gather information to determine:

Initial Annual eligibility for WV Birth to Three and plan for Individualized Family Service Plan (IFSP)

To provide additional information to the IFSP team regarding the following area of concern:

Family Information

There haven't been any changes in family situation or information since Nevaeh's last annual review. Mom was asked what her current concerns are in relation to Nevaeh and her development. Mom said she would still like to see progress with her cognitive development. Mom said her with textures and eating have gotten a little worse. Mom was asked what she would like to see in the next six

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months. Mom said she would like to see her being able to stack more blocks, being able to use a zipper, and continue to achieve her milestones.

Medical History and Current Health Status

Nevaeh had surgery on both hips. Both hips are in place but the cups around the hips are still forming. The doctor told the family that they would have to keep an eye on it until she is 4 years old. She goes back in May 2018 to have the hips re-checked. She has been diagnosed with thyroid issues; the endocrinologist is just monitoring for now. She has started growth hormones. She gets them three times a week. Nevaeh had dental surgery for caps and crowns. She went back for a cardiology check; she doesn't have to go back for 2 years.

Vision

Nevaeh has an appointment in December to see Dr. Facciani. She was seen by Dr. Looney who made the referral because of her lazy eye, and Nevaeh wouldn't let him really examine her. Mom said other than her lazy eye she really doesn't have any concerns.

Hearing

Nevaeh is scheduled to have her hearing checked after the first of the year. Mom said Nevaeh still has frequent ear infections, so she isn't sure if this has had any impact on her hearing. Mom said she hasn't noticed anything that has raised concerns.

Developmental History

Nevaeh has experienced developmental delays since beginning her Birth to Three services. The areas where her delays have been the greatest have been with her motor skills, cognitive skills, and some challenges with communication skills. Nevaeh has had two surgeries in the past years which resulted in Nevaeh having to wear Spica casts which limited her mobility during this time. Despite it all, Nevaeh has persevered.

Parent Reported Strengths and Concerns About the Child

Mom said her language skills are a real strength now. She has been picking up on her vocabulary and trying to talk. Nevaeh is very friendly and outgoing. She has taken everything in stride, medically, over the course of the past year. Mom said she has a strong, fighting spirit. When asked what her weaknesses are Mom said that there are still motor skills she has trouble picking up. She said she has trouble coordinating her movements to feed herself with utensils. Finally, Nevaeh gives up quickly when something isn't easy for her.

CHILD NAME: Nevaeh Adams

EVALUATED BY: Kathy Quesenberry, MSM, OTR/L

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**EXHIBIT NO. B3F
PAGE: 8 OF 36****Observations and Assessment Results*****Motor Development***

Assessment Tool(s) Used: Early Learning Accomplishment Profile (E-Lap) **Score:** 16 months Gross Motor (Raw Score 74), 21 months Fine Motor (Raw Score 55)

No observation or evaluation**Observation Only- Did Not Evaluate in this Area**

Motor Development includes both gross and fine skills. Gross motor development refers to how a child uses his/her large muscles for rolling, crawling, walking, running, and jumping. Fine motor development refers to how a child uses his/her small muscles for eye-hand coordination, visual tracking, reaching for, and grasping and releasing objects.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

(Gross Motor) Nevaeh is an active little girl. She walks around her home with ease. Nevaeh demonstrates good balance overall on even surfaces but uneven surfaces can still be challenging at times. She can get on and off the furniture on her own. Nevaeh crawls up and down the steps in front of her home by herself. Mom said she is afraid to try and walk up and down the steps, even with Mom or Dad holding her hand(s). Nevaeh moves in a hurried walk, but she hasn't started to run. Mom said she thinks Nevaeh isn't running because of tightness in her hips. Nevaeh will try to toss a ball, but she isn't throwing a ball with an overhanded approach. Nevaeh's active range of motion is within functional limits.

(Fine Motor) Nevaeh actively uses both hands during play. She can use her hands together and so independently of one another. She held a pen in her left hand with a fisted grasp as she made marks on a piece of paper. She holds a pen with a maturing grasp in her right hand. Mom said Nevaeh uses her right hand most of the time. She couldn't imitate making a vertical or horizontal stroke or circular scribble. Nevaeh was able to stack three one-inch blocks consistently before knocking them over. She was able to complete an individual, three-piece puzzle given time and trial and error. She will take toys out of a container and place them back in again. She was able to remove a lid to take small pegs out of a bottle. She used a pincer grasp to pick the pegs up and place them back in the bottle again. Nevaeh turned the pages of a book (thicker pages) one at a time. Occupational Therapist couldn't get Nevaeh to try to imitate folding a piece of paper.

This description represents the equivalent of at least: X 40% delay (Gross Motor) X 25% delay (Fine Motor)
No concerns at this time

OR substantial atypical motor development such as: muscle tone, reflex or postural reaction responses, or movement patterns.

Communication Development

Assessment Tool(s) Used: E-Lap

No observation or evaluation

Score: 24 months (Raw Score 48)

Observation Only- Did Not Evaluate in this Area

Communication development refers to how the child understands and expresses language.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

Nevaeh's communication has really taken off during the past year. Nevaeh understands when she is told "no". Sometimes she will stop what she is doing when told "no" and other times she won't. She will also tell others

CHILD NAME: Nevaeh Adams

EVALUATED BY: Kathy Quesenberry, MSM, OTR/L

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"no". Nevaeh can imitate some silly sounds with her mouth, but it depends on her mood as to whether she will do it or not. As noted, she will point to familiar named pictures when looking at a book. She will also name some familiar pictures and objects around her home. Nevaeh will use gestures as part of her communication. Nevaeh uses some single words to communicate, but more often she uses short phrases and sentences. Some other songs she likes to sing, in addition to what was already noted earlier in the report, include the I Love You song from Barney and Itsy-Bitsy Spider. Mom said Nevaeh easily uses in excess of 50 words. She hasn't started to use plurals. OT noted changes in pitch, intonation, and volume as Nevaeh talked and communicated during the evaluation.

This description represents the equivalent of at least: 40% delay 25% delay
 No concerns at this time
 OR substantial atypical communication such as: communication patterns, pragmatics or oral motor skills.

Cognitive Development

Assessment Tool(s) Used: E-Lap
 No observation or evaluation

Score: 24 months (Raw Score 77)
Observation Only- Did Not Evaluate in this Area

Cognitive development refers to how the child thinks, plays, and interacts with others and within his/her environment.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

Nevaeh has become much more interested in play over the course of the past year. She will sit to play with toys; the amount of time she sits depends on the toy. On average she will play with a toy for 5-10 minutes per Dad. She turns and looks when she hears her name called. Nevaeh loves to play on a tablet. She will point to familiar named pictures when looking at a book. She can name some familiar items when asked "what is this". She will sing when she hears music; there are some songs that she can sing from beginning to end. One of those songs is 'Johnny Johnny No Pie Pie'. She is tolerating hand over hand assistance better when she needs help with something. As noted, Nevaeh was able to stack three one-inch cubes before knocking them over. Nevaeh will ask for items by using words and gestures. Nevaeh will follow one and two step directives with consistency, but she isn't following three step directives with consistency. On occasion Nevaeh will try to say her name, but she doesn't refer to herself using her name with any regularity. She can point to more than 4 body parts when named. Nevaeh isn't showing a true understanding of size differences in objects as she plays. She has started to present play with her baby dolls. Dad said she loves to keep her baby with her all the time. Although Nevaeh likes to watch videos on Mom and Dad's phone she doesn't really have any interest in television. Mom said Nevaeh loves to color and she loves books.

This description represents the equivalent of at least: 40% delay 25% delay
 No concerns at this time
 OR X substantial atypical cognition such as: state regulation, attention span, perseveration, information processing or delayed response.

Social Emotional Development

CHILD NAME: Nevaeh Adams

EVALUATED BY: Kathy Quesenberry, MSM, OTR/L

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Assessment Tool(s) Used: E-Lap
No observation or evaluation

Score: 33 months (Raw Score 34)
Observation Only- Did Not Evaluate in this Area

Social emotional development refers to how the child perceives himself/herself, interacts with others, copes with frustration, and expresses his/her emotions.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

Nevaeh has become more social over the course of the past year, but she still acts shy when she is initially around someone who isn't familiar to her. She will turn, look, and smile when she hears her name called. Nevaeh is very attached to both Mom and Dad. She will give a person an item when asked most of the time, unless it is one of her siblings. She will fight for a toy she has or wants, especially with her siblings. Nevaeh will help put up some of her toys when verbally prompted. Nevaeh does get mad when she is told "no", when someone takes away her sippy cup, or if someone doesn't share something with her she wants. When she is upset she will scream and run to Mom or Dad. She typically gets over things in 4-5 minutes. Dad said she is very tender hearted and it "breaks her heart" when someone gets upset or frustrated with her. As noted, she will pretend play with her baby dolls. Nevaeh will join in with Twinkle Twinkle Little Star and Old MacDonald.

This description represents the equivalent of at least: 40% delay 25% delay
 X No concerns at this time

OR substantial atypical emotional or social patterns such as: social responsiveness, affective development, attachment patterns, or self-targeted behaviors.

Adaptive Development

Assessment Tool(s) Used: E-Lap
No observation or evaluation

Score: 18 months (Raw Score 24)
Observation Only- Did Not Evaluate in this Area

Adaptive development refers to how the child performs routine activities such as dressing and eating.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

Nevaeh goes to bed at 8:30 pm. She falls asleep on her own and sleeps in her own bed. Nevaeh sleeps through the night. She wakes up between 8:30 and 9:00 am. Nevaeh doesn't take naps anymore. Nevaeh loves bath time except for washing her hair which is a fight per Mom. She hasn't started to try and help wash. Nevaeh doesn't like to have her fingernails or toenails cut but she will let Mom paint her nails. Nevaeh hates to have her hair brushed. She likes to have hair bows put in her hair. Nevaeh doesn't like to have her teeth brushed. Nevaeh can take off all her clothes except for a coat and shirt. She can put on socks, shirt, and she will try to put on shoes. She will try to put on pants, but can only get one leg in. She is starting to answer when asked if she is wet or dirty. She is more consistent if she has had a bowel movement. She doesn't come to Mom on her own. Nevaeh is terrified of the "big" potty. Nevaeh finger feeds herself. She will try to use utensils, but she has a lot of difficulty and usually gives up. Mom and Dad both said she is a picky eater. She will mainly only eat with her Dad; it is rare she eats for other people. Some of the foods she likes to eat include the following: spaghetti and meatballs, chicken nuggets, chips, cookies, pork chops, macaroni and cheese, pinto beans with mayonnaise, bread, and fruit. Nevaeh doesn't eat any vegetables. She eats meats sporadically. She drinks from a sippy cup. She will drink from a regular cup or bottle (i.e.: water) held for her. Nevaeh likes to go "bye bye" and she does well in the car. Nevaeh doesn't like public places and often throws fits.

CHILD NAME: Nevaeh Adams

EVALUATED BY: Kathy Quesenberry, MSM, OTR/L
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This description represents the equivalent of at least: X 40% delay 25% delay
 No concerns at this time

OR substantial atypical sensory motor development such as: sleeping patterns, feeding, or sensory integration.

Established Condition(s): Not applicable.
Turner's Syndrome

At Risk Factors

Based upon information from the Family Assessment and evaluation/assessment, the following risk factors have been identified.

Low Birth Weight	Severe Asphyxia	Small for Gestational Age	Gestational Age
Technology Dependent	Substantiated Child Abuse or Neglect	X Family Barrier to Accessing Support	X Parent has Serious Concern
Primary Caregiver	Family Support Stressor	X Chronic Otitis Media	
Chromosomal Abnormality/Genetic Disorder	Congenital Disorder	Severe Sensory Impairment	
Condition(s):	Condition(s):	Condition(s):	
Nervous System Impairment	Inborn Error of Metabolism	Infectious Disease	
Condition(s):	Condition(s):	Condition(s):	
Chronic Medical Illness	Perinatal Factor	Toxic Exposure	
Condition(s):	Condition(s):	Condition(s):	

Summary and Recommended Strategies to Promote Child's Participation

Nevaeh has grown and matured over the course of the past year. She has been through a great deal physically, but despite these obstacles she has persevered. She has become more active and much more interactive and engaging in the environment around her. She shows interest in what others are doing and wants to be engaged and involved. Nevaeh has grown in her interest in playing and is able to attend to activities longer without losing interest. Nevaeh continues to demonstrate progress towards achieving her developmental milestones. It should be noted that over the course of the past year there has been an increase in the number of skills Nevaeh has been expected to obtain. The older a child becomes the more skills are added to their repertoire. Based on the occupational therapy evaluation Nevaeh is demonstrating developmental delays in those areas noted above. These areas also present the greatest opportunity for continued progress. The findings from the evaluation are not meant to be a definite representation of Nevaeh's abilities, however they represent her abilities at the time the re-evaluation was completed. Nevaeh's continued eligibility for birth to three services will be determined at her annual eligibility/IFSP review meeting. Thank you for the opportunity to re-evaluate Nevaeh. Should there be any questions or concerns regarding this report please don't hesitate to contact me.

CHILD NAME: Nevaeh Adams

EVALUATED BY: Kathy Quesenberry, MSM, OTR/L

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Name: Kathy F. Quesenberry, MSM, OTR/L

Date: 12/7/17

Signature/Credential:

Kathy F. Quesenberry, MSM, OTR/L

Contact Information: (304) 952-1099

Name:

Date:

Signature/Credential:

Contact Information:

CHILD NAME: Nevaeh Adams

EVALUATED BY: Kathy Quesenberry, MSM, OTR/L

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WV Birth to Three Evaluation/Assessment Summary Report

Completed by: Judy Anglin, MSW, LSWDate: 12/28/17Child's Name: Nevaeh Adams Date of Birth: 07/21/15Chronological Age: 2 yrs 5 months Adjusted Age: sameParent(s)/Legal Guardian(s): Ricco and Kelli AdamsMailing Address: P.O. Box 46 Big Sandy, WV 24816Phone Number: (681) 729 2017 This is the home number not a cell numberIndividuals Present (Relationship to Child): Judy Anglin, social worker, Ricco and Kelli Adams, Parents**Purpose:**

- To gather information to determine:
 Initial Annual eligibility for WV Birth to Three and plan for Individualized Family Service Plan (IFSP)
- To provide additional information to the IFSP team regarding the following area of concern:

Click or tap here to enter text.

Family Information: Nevaeh's family moved into their new home in Big Sandy WV in the summer of 2017. They are buying this home. The home has a large living room and kitchen, three bedrooms and bath, porch and a large yard for Nevaeh and her sisters to play. During the 2017-year Mr. Adams was laid off from his mining job, however, he has returned to work. Ms. Adams is a stay at home mom. Nevaeh has three sisters.

At the present time, the parents are concerned about medical coverage for Nevaeh and her sisters. Mr. Adams was told he had medical coverage for the children, however, the few times Ms. Adams has tried to use it the doctors have not accepted it. This is the same with prescriptions. Ms. Adams has called several times about the medical coverage, but no one seems to know what is wrong even though Mr. Adams is paying premiums as required. Having no dependable medical coverage for Nevaeh and her siblings is a constant worry for Mr. and Mrs. Adams. Ms. Adams said she will continue to call the insurance carrier and the

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company to find out what is happening with the coverage. She said she is paying for nothing.

Stress levels are high also due to work situation. Even though Mr. Adams is working now his income is not what it was previously and now the company has closed for a few weeks and he is receiving no pay and bills are coming due. Mr. Adams said that he is going to look for work if he does not go back to work after the first of the year.

Click or tap here to enter text.

Medical History and Current Health Status: Neveah has been diagnosed with Turner's Syndrome. This is caused by pockets of fluid gathering around the baby in utero. Neveah had to have genetic testing which confirmed the Turner's Syndrome diagnosis. She was also born with bio ducts open in her heart, but they closed within 72 hours after birth. She does have some leakage, but the doctor is not worried because the ducts should close as she ages.

Neveah also had hip dysplasia and was sent home in a harness to stabilize her hip. She had to wear this for 4 weeks. Her doctor's feel that this was due to the Turner's Syndrome. She has surgery on her left hip. She again had surgery on her left hip later in January of 2017. She was again in a case from her breast to her hip. She had to have her cast changed three times after surgery. She was in the cast for 13 weeks. Neveah did not develop skin breakdown; however, she did have a small rash. Mom stated it was hard to keep her clean with the case. Neveah's surgery was completed at Shriner's Hospital in Kentucky. She is doing well now after the surgery.

A few months before the surgeries Neveah was beginning to walk. She learned to take steps moving sideways. After the surgeries she had to learn to walk again. Neveah is now walking and doing great. She recently had an appointment at Shriners to look at the hips. The doctor said that he had to follow the hip to make sure the ball and the cup were beginning to form since Neveah did not have a ball or a cup in her hips. At her last visit the doctor stated that it was beginning to form, and he wanted to watch her progress. If it did not form as it should she would have to have other surgeries to try to correct this.

In May of 2017 Neveah was seen by an endocrinologist to determine if she needed hormone shots to help with growth. Mom was told that she if Neveah did not get hormone growth shots she would not grow in height. She has been receiving these shots.

Neveah also has problems with her thyroid. She has what is known as thyroid storms. She gets confused, does not know where she is and who is with her. She cries and is tired. Mom said that the doctors do not feel that she needs to be on medication since her thyroid levels are not that high, but they are higher than normal. Ms. Adams is trying to find another doctor for a second opinion. It appears these storms are getting closer together.

Neveah is walking, talking, saying two to three word sentences, uses a sippy cup, understands commands, climbs. She can also work puzzles, put stuff in and out of containers, look at picture books, counting to five, knows some of her body parts, and feeds herself. She is a very happy baby and is very active.

All shots are up to date. Her next appointment at Shriner's Hospital is May of 2018 and a well child checkup is in January of 2018.

CHILD NAME: Neveah Adams

EVALUATED BY: Judy Anglin

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Click or tap here to enter text.

Vision: no evaluation information

Click or tap here to enter text

Hearing: NO evaluation information

Click or tap here to enter text

Developmental History:

Neveah started to walk in November of 2016. She was about 18 months old. At that time, she walked sideways. She was unsteady. She had surgery in January of 2017 on both hips and was in a body cast for 13 weeks and had to learn to walk again. She is walking fine now. She can be unsteady, but she is doing well. She is saying two and three-word sentences now. She can count to five and beginning to say her ABC's. She can name her body parts, work puzzles, feeds herself, drinks from a sippy cup and regular cup. Neveah will tell you what she wants. She interacts well with her sisters. She does have a temper at times, but she is usually verbal and happy.

Click or tap here to enter text

Parental Reported Strengths and Concerns about the Child:

Neveah is a very friendly child. She is also active, independent and learns quickly. Family strengths include the fact that dad has a job and works at least five or more days a week. They have their own transportation and are currently buying their house. They do have some outside support from family members. Ms. Adams is very knowledgeable regarding Turner's Syndrome. She is constantly doing research on the Syndrome. Ms. Adams also works closely with Neveah's doctors to understand more about Neveah's diagnosis and how it may affect her future.

The parent's concerns include finding doctors that understand Turner's Syndrome. Ms. Adams stated that most doctor's in West Virginia do not fully understand this syndrome and how it can affect a child's development. This is very frustrating to her.

The parents are also concerned about the current medical insurance coverage. Neveah has to see specialist for her condition and Ms. Adams stated that she is not sure the medical insurance will cover the expenses. She has found out recently that most doctors are not accepting the coverage. Prescriptions have also been denied. This has caused a lot of stress and worry for this family.

Another area of concern that the parents have is regarding Social Security for Neveah. Ms. Adams and myself have applied for Social Security benefits for Neveah. The case has been denied several times. Ms. Adams had to retain the services of an attorney. As of this date she has not heard from the application. I gave Ms. Adams the number of the SSI advocate division and told her to call them to see if they could help with some type of information regarding the case. If she is approved for SSI then she will also receive Medicaid and this insurance will cover all Neveah's medical expenses.

Other concerns for the parents are that Neveah will have to continue her appointments with her doctors at Shriner's Hospital. The concern surrounds the expenses to and from her

CHILD NAME: Nevaeh Adams

EVALUATED BY: Judy Anglin

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appointments in Kentucky. Even though Shriner's does assist with cost of travel and lodging the trips are very tiring on Neveah. Mom also has three other children and she does not always have babysitters. Neveah's appointments last for days since she has to me be monitored regularly. Neveah also has appointments in Charleston, WV for growth hormone shots and these are out of pocket cost. Even with the income the cost of travel is causing some hardship for this family.

The everyday expense to run a household coupled with the expense of doctor bills and travel expenses to and from medical appointments has caused a financial burden on the family. This in turn causes high stress levels.

Barriers for the Family include the need for a more stable medical coverage. The family also needs assistance with finding resources to help with the cost of travel. This will require linkage/referral services.

Observations and Assessment Results

Motor Development

Assessment Tool(s) Used: _____
 No observation or evaluation

Score: _____
 Observation Only- Did Not Evaluate in this Area

Motor Development includes both gross and fine skills. Gross motor development refers to how a child uses his/her large muscles for rolling, crawling, walking, running, and jumping. Fine motor development refers to how a child uses his/her small muscles for eye-hand coordination, visual tracking, reaching for, and grasping and releasing objects.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

Neveah is walking, jumping, climbing, running, and very mobile. She can use an iPad and try to play games. She does puzzles, picks up things,

This description represents the equivalent of at least: 40% delay 25% delay
 No concerns currently

OR substantial atypical motor development such as: muscle tone, reflex or postural reaction responses, or movement patterns.

Communication Development

Assessment Tool(s) Used: _____
 No observation or evaluation

Score: _____
 Observation Only- Did Not Evaluate in this Area

Communication development refers to how the child understands and expresses language.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

Neveah makes her needs known. She is learning to talk in two and three-word sentences. She uses expressive language when she is excited and wants something. She does take tantrums at times

CHILD NAME: Neveah Adams

EVALUATED BY: Judy Anglin

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This description represents the equivalent of at least: 40% delay 25% delay

No concerns at this time

OR substantial atypical communication such as: communication patterns, pragmatics or oral motor skills.

Cognitive Development

Assessment Tool(s) Used: _____
 No observation or evaluation

Score: _____
 Observation Only- Did Not Evaluate in this Area

Cognitive development refers to how the child thinks, plays, and interacts with others and within his/her environment.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

Neveah interacts well with others. She plays with her sisters, and is comfortable in her own environment. Mom stated that she when she spends the night with her grandmother she does not want to come home. She uses her imagination when playing with herself or her sisters. She learns quickly. Likes books and puzzles.

This description represents the equivalent of at least: 40% delay 25% delay
 No concerns at this time

OR substantial atypical cognition such as: state regulation, attention span, perseveration, information processing or delayed response.

Social Emotional Development

Assessment Tool(s) Used: _____
 No observation or evaluation

Score: _____
 Observation Only- Did Not Evaluate in this Area

Social emotional development refers to how the child perceives himself/herself, interacts with others, copes with frustration, and expresses his/her emotions.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

Neveah appears to be very comfortable in her surroundings. She interacts well with others and her sisters. She does have tantrums if she does get her way at times. She has learned to express her emotions through laughter or crying.

This description represents the equivalent of at least: 40% delay 25% delay
 No concerns at this time

OR substantial atypical emotional or social patterns such as: social responsiveness, affective development, attachment patterns, or self-targeted behaviors.

Adaptive Development

Assessment Tool(s) Used: _____
 No observation or evaluation

Score: _____
 Observation Only- Did Not Evaluate in this Area

Adaptive development refers to how the child performs routine activities such as dressing and eating.

Interview, Observations, and/or Evaluation/Assessment Results Related to the Child's Participation in Daily Activities and Routines:

CHILD NAME: Nevaeh Adams

EVALUATED BY: Judy Anglin

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She plays with shoes putting them on and taking them off. Mom stated that she puts on clothes by layers when she plays. She feeds herself, drinks from regular cup and a sippy cup.

This description represents the equivalent of at least: 40% delay 25% delay
 No concerns at this time

OR substantial atypical sensory motor development such as: sleeping patterns, feeding, or sensory integration.

Established Condition(s): Not applicable. Thyroid problems and Turner's Syndrome

At Risk Factors

Based upon information from the Family Assessment and evaluation/assessment, the following risk factors have been identified.

<input type="checkbox"/> Low Birth Weight	<input type="checkbox"/> Severe Asphyxia	<input type="checkbox"/> Small for Gestational Age	<input type="checkbox"/> Gestational Age
<input type="checkbox"/> Technology Dependent	<input type="checkbox"/> Substantiated Child Abuse or Neglect	<input type="checkbox"/> Family Barrier to Accessing Support	<input checked="" type="checkbox"/> Parental Serious Concern
<input type="checkbox"/> Primary Caregiver	<input type="checkbox"/> Family Support Stressor	<input type="checkbox"/> Chronic Otitis Media	
<input type="checkbox"/> Chromosomal Abnormality/Genetic Disorder	<input checked="" type="checkbox"/> Congenital Disorder	<input type="checkbox"/> Severe Sensory Impairment	
Condition(s):	Condition(s):	Condition(s):	
<input type="checkbox"/> Nervous System Impairment	<input type="checkbox"/> Inborn Error of Metabolism	<input type="checkbox"/> Infectious Disease	
Condition(s):	Condition(s):	Condition(s):	
<input type="checkbox"/> Chronic Medical Illness	<input type="checkbox"/> Perinatal Factor	<input type="checkbox"/> Toxic Exposure	
Condition(s):	Condition(s):	Condition(s):	

Summary and Recommended Strategies to Promote Child's Participation

The following recommendations may be used for IFSP planning and development as appropriate. You may begin implementing any or all strategies immediately.

The family needs are still many. Emotional support with regards to stress, assisting with completing applications, and guiding the family through the SSI process, possible arranging transportation and lodging to family when they have to take Nevaeh to her doctor appointments are just a few of the family needs still remaining. This will be an ongoing need for this family with regards to Nevaeh's condition. The family will require linkage and referral services to access these resources. The Social Work Practitioner will use linkage/referral as needed. Social Work Practitioner will help the family obtain resources as needed and help them understand to access these resources. The Social Work Practitioner will use social/emotional support as needed by the family to assist with stressful situations as they arise. If the family would need counseling regarding stress and emotional issues the Social Work Practitioner will assist in arranging appointments.

CHILD NAME: Nevaeh Adams.

EVALUATED BY: Judy Anglin

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Click or tap here to enter text.

Name:

Judy AnglinDate: 12-28-17

Signature/Credential:

Judy Anglin MSW LSW

Contact Information:

Po Box 777 Bradshaw WV 24817

Name:

Date:

Signature/Credential:

Contact Information:

CHILD NAME: Nevaeh Adams.

EVALUATED BY: Judy Anglin

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WV BIRTH TO THREE
Office of Maternal, Child and Family Health
Bureau for Public Health
Department of Health and Human Resources

Child Last Name: Adams
Child First Name/Mi: Nevaeh
DOB: 7/21/2015
ID #: 201501327

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Individualized Family Service Plan For Nevaeh Adams and Family

Our Mission: WV Birth to Three partners with families and caregivers to build upon their strengths by offering coordination, supports, and resources to enhance children's learning and development.

TYPE OF MEETING: Initial IFSP Annual IFSP Other IFSP **DATE:** 12/29/2017 **Gender:** M F
Primary Language/Mode of Communication English **Interpreter Name:** _____

Family Information

Child Name: Adams Nevaeh DOB: Month/Day/Year 7/21/2015

Primary Contact Name: Kelli Adams Relationship to Child: Mother

Address: PO BOX 46 BIG SANDY, WV 24816

Phone Number: (681) 729-2017 Email: N/A

Secondary Contact/Alternate Contact Name: RICO ADAMS Relationship to Child: Father

Address: PO BOX 46 BIG SANDY, WV 24816

Phone Number: (681) 729-2017 Email: N/A

Service Coordinator Information

If you have questions about this IFSP or any of the individuals working with your child and family, contact your service coordinator

Service Coordinator Name: ESTELLA D. CRABTREE

Agency (If Applicable): TOTALLY SC INC.

Address: PO BOX 71 PAYNESVILLE, WV 24873

Phone Number: (304) 800-6036 Email: CRABTREE.ESTELLA@GMAIL.COM

Anticipated Meeting Dates

IFSP Six Month Review: 6/28/2018

IFSP Annual Review:

If Applicable, Transition Conference: 4/20/2018

Regional Administrative Unit (RAU) for WV Birth to Three

RAU/Name: RAU VII. MOUNTAIN HEART COMMUNITY SERVICES

Phone Number: (304) 425-3669

Address: 1411 NORTH WALKER ST. PRINCETON, WV 24740

Email: _____

RAU Parent Partner: TAMMY FLEISHMAN

JAN 04 2018

Birth to Three
WV BIRTH TO THREE
Office of Maternal, Child and Family Health
Bureau for Public Health
Department of Health and Human Resources

Child Last Name: Adams **EXHIBIT NO. B3F**
Child First Name/Mi: Nevaeh
DOB: 7/21/2015
ID #: 201501327

Multi-Disciplinary Evaluation for Eligibility

Evaluation and Assessment Methods and Procedures

The following evaluation and assessment activities were completed as part of the multi-disciplinary evaluation/assessment process for determining eligibility and planning for IFSP development when appropriate:

- Review Medical Records Consultation with Healthcare Provider Family Interview Observation of The Child

Developmental Screening

Formal Evaluation/Assessment Tools Used: ELAP

Meets Criteria for This Category	Established Condition						
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<p>List all physical or mental condition(s) that the child has, from the WV Birth to Three State Eligibility policy, that have a high probability in resulting in developmental delay. If a condition is not listed in the WV Birth to Three State Eligibility policy, list the diagnosis only if the team has written confirmation from the child's physician that the diagnosis will result in substantial delay for this child. Written documentation of the Established Condition is required.</p> <p>Does the child have a diagnosed vision impairment? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Does the child have a diagnosed hearing impairment? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>						

Meets Criteria for This Category	Developmental Delay						
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<p>Document all developmental areas where the child is experiencing a very substantial delay (40%), a substantial delay (25%) or atypical development. To be eligible a child must have the equivalent of: 40% delay in one or more areas, a 25 % delay in two or more areas or atypical development in two or more areas. A child can be found eligible with a 25 % delay in one area and atypical development in another area that is not expected to resolve on its own. Written documentation supporting the developmental delay is required.</p>						

Meets Criteria for This Category	At-Risk Factors						
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<p>Document all risk factors as identified in WV Birth to Three State Eligibility policy, the child is experiencing that are likely to result in substantial developmental delay if early intervention services were not provided. To be eligible a child must be experiencing at least 5 or more of the risk factors below. Written documentation of the biological/medical risk factors is required.</p>						

Check All That Apply	<input type="checkbox"/> Low Birth Weight	<input type="checkbox"/> Severe Asphyxia	<input checked="" type="checkbox"/> Small for Gestational Age	<input type="checkbox"/> Chronic Otitis Media	<input type="checkbox"/> Gestational Age
	<input type="checkbox"/> Technology Dependent	<input type="checkbox"/> Substantiated Child Abuse or Neglect	<input checked="" type="checkbox"/> Family Barrier to Accessing Support	<input checked="" type="checkbox"/> Parent has Serious Concern	<input type="checkbox"/> Primary Caregiver
	<input checked="" type="checkbox"/> Family Support Stressor	<input checked="" type="checkbox"/> Chromosomal Abnormality/Genetic Disorder	<input type="checkbox"/> Congenital Disorder	<input type="checkbox"/> Severe Sensory Impairment	<input type="checkbox"/> Nervous System Impairment
	<input type="checkbox"/> Inborn Error of Metabolism	<input type="checkbox"/> Infectious Disease	<input checked="" type="checkbox"/> Chronic Medical Illness	<input type="checkbox"/> Perinatal Factor	<input type="checkbox"/> Toxic Exposure

JAN 04 2018

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From:MountainHeart WV BTT RAU 7

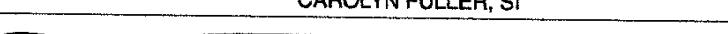
WV BIRTH TO THREE
 Office of Maternal, Child and Family Health
 Bureau for Public Health
 Department of Health and Human Resources

Child Last Name: Adams **EXHIBIT NO. B3F**
 Child First Name/Mi: Nevaeh **PAGE: 22 OF 36**
 DOB: 7/21/2015
 ID #: 201501327

Eligibility Determination

- | |
|--|
| <input checked="" type="checkbox"/> As determined by the multi-disciplinary team, the child has been found eligible for WV Birth to Three. Date: 12/29/2017 |
| <input type="checkbox"/> As determined by the multi-disciplinary team, the child is determined not eligible for WV Birth to Three because he/she did not meet any of the eligibility criteria. Date: |
| <input type="checkbox"/> The child has been found eligible for WV Birth to Three, but the parent(s) have declined any further service. Date: |

Multi-Disciplinary Evaluation Team Members

Print Name and Sign with Credential	Date	Role on Team	Method of Contribution
ESTELLA D. CRABTREE, SC 	12/29/2017	SERVICE COORDINATOR	<input checked="" type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input type="checkbox"/> By Report <input type="checkbox"/> Auth Representative
JUDY ANGLIN,SW 	12/29/2017	SOCIAL WORKER	<input checked="" type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input type="checkbox"/> By Report <input type="checkbox"/> Auth Representative
GLEND A ODELL,COTA 	12/29/2017	COTA	<input checked="" type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input type="checkbox"/> By Report <input type="checkbox"/> Auth Representative
CAROLYN FULLER, SI 	12/29/2017	DEVELOPMENTAL SPECIALIST	<input type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input checked="" type="checkbox"/> By Report <input type="checkbox"/> Auth Representative
			<input type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input type="checkbox"/> By Report <input type="checkbox"/> Auth Representative
			<input type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input type="checkbox"/> By Report <input type="checkbox"/> Auth Representative
			<input type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input type="checkbox"/> By Report <input type="checkbox"/> Auth Representative

- I/We agree with the determination of my/our child's eligibility/ineligibility.
 I/We disagree with the determination of my/our child's eligibility/ineligibility.
 I/We have received a written copy of the WV Birth to Three Procedural Safeguards.



12/29/2017

Parent/Legal Guardian Signature

Date

Prior Written Notice: Eligibility Determination

The 'Eligibility Determination for WV Birth to Three' section of this document summarizes the findings of the multidisciplinary evaluation team regarding this child's eligibility for WV Birth to Three. WV Birth to Three proposes this eligibility decision based on information gathered by the multidisciplinary team through the above referenced methods and activities. If you disagree with this decision, you have the rights as outlined in your Procedural Safeguards Booklet.

If the child has been found to be ineligible:

- Has a referral been made to Help Me Grow, WV? Yes No
- Has the family been given a completed Transition Resource Information form? Yes No
- List any other referrals that were made for the family:

JAN 04 2018

WV BIRTH TO THREE
 Office of Maternal, Child and Family Health
 Bureau for Public Health
 Department of Health and Human Resources

Child Last Name: Adams **EXHIBIT NO. B3F**
 Child First Name/MI: Nevaeh
 DOB: 7/21/2015
 ID #: 201501327 **PAGE: 23 OF 36**

Present Abilities, Strengths and Needs

Through the evaluation/assessment, we have learned a lot about your child and family. This information helps us understand your child's developmental strengths, as well as some of the things that are challenging for your child and may be affecting how he is able to participate in family and community activities. Let's work together to summarize what we learned.

Routine	Task Difficulty	Activity	Developmental Areas Where Concerns Exist	Related National Child Outcomes
 Waking Up	<input checked="" type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	What is going well? SHE WAKES UP AND WANTS JUICE AND STARTS PLAYING. SHE IS VERY HAPPY BABY IN THE MORNING. What could be better? NOTHING SHE DOES REALLY GOOD	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/Physical <input checked="" type="checkbox"/> Learning/Cognition <input type="checkbox"/> Social/Emotional Behaviors <input type="checkbox"/> Self-Help/Adaptive	<input type="checkbox"/> Positive Social/Emotional Skills, Including Social Relationships <input checked="" type="checkbox"/> Acquiring and Using Knowledge and Skills <input type="checkbox"/> Taking Appropriate Action to Meet Needs
 Dressing/Toileting	<input checked="" type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	What is going well? SHE IS EASY TO CHANGE HER DIAPER BUT NOT READ FOR POTTY TRAINING AND SHE DRESSES HERSELF NOT ALWAYS CORRECTLY What could be better? SHE IS NOT COMFORTABLE WITH TOILETING	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/Physical <input type="checkbox"/> Learning/Cognition <input type="checkbox"/> Social/Emotional Behaviors <input type="checkbox"/> Self-Help/Adaptive	<input type="checkbox"/> Positive Social/Emotional Skills, Including Social Relationships <input type="checkbox"/> Acquiring and Using Knowledge and Skills <input checked="" type="checkbox"/> Taking Appropriate Action to Meet Needs
 Meals/Feeding	<input type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input checked="" type="checkbox"/> Difficult	What is going well? NOTHING IT TAKES A LOT OF ENCOURAGEMENT TO GET HER TO EAT What could be better? SHE WILL NOT EAT A VARIETY OF TEXTURES AND FOODS,	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/Physical <input type="checkbox"/> Learning/Cognition <input type="checkbox"/> Social/Emotional Behaviors <input checked="" type="checkbox"/> Self-Help/Adaptive	<input type="checkbox"/> Positive Social/Emotional Skills, Including Social Relationships <input type="checkbox"/> Acquiring and Using Knowledge and Skills <input checked="" type="checkbox"/> Taking Appropriate Action to Meet Needs
 Outings	<input checked="" type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	What is going well? SHE IS GREAT WITH OUTINGS AND DOES WONDERFUL IN SOCIAL SETTINGS What could be better? NOTHING	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/Physical <input type="checkbox"/> Learning/Cognition <input checked="" type="checkbox"/> Social/Emotional Behaviors <input type="checkbox"/> Self-Help/Adaptive	<input checked="" type="checkbox"/> Positive Social/Emotional Skills, Including Social Relationships <input type="checkbox"/> Acquiring and Using Knowledge and Skills <input type="checkbox"/> Taking Appropriate Action to Meet Needs

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01/08/2019 13:25

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From:MountainHeart WV BTT RAU 7

WV BIRTH TO THREE
Office of Maternal, Child and Family Health
Bureau for Public Health
Department of Health and Human Resources

Child Last Name: Adams **EXHIBIT NO. B3F**
 Child First Name/MI: Nevaeh **PAGE: 24 OF 36**
 DOB: 7/21/2015
 ID #: 201501327

Routine	Task Difficulty	Activity	Developmental Areas Where Concerns Exist	Related National Child Outcomes
Playtime	<input checked="" type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	<p>What is going well? SHE IS GREAT WITH PLAYTIME SHE IS ATTENTIVE FOR A GOOD AMOUNT OF TIME</p> <p>What could be better? MAYBE SHE COULD WORK ON VARIETY OF PAY SKILLS</p>	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/Physical <input checked="" type="checkbox"/> Learning/Cognition <input type="checkbox"/> Social/Emotional Behaviors <input type="checkbox"/> Self-Help/Adaptive	<input type="checkbox"/> Positive Social/Emotional Skills, Including Social Relationships <input checked="" type="checkbox"/> Acquiring and Using Knowledge and Skills <input type="checkbox"/> Taking Appropriate Action to Meet Needs
Bath Time	<input checked="" type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	<p>What is going well? SHE LOVES A BATH AND DOESN'T WANT TO STOP</p> <p>What could be better? NOTHING</p>	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/Physical <input type="checkbox"/> Learning/Cognition <input type="checkbox"/> Social/Emotional Behaviors <input checked="" type="checkbox"/> Self-Help/Adaptive	<input type="checkbox"/> Positive Social/Emotional Skills, Including Social Relationships <input type="checkbox"/> Acquiring and Using Knowledge and Skills <input checked="" type="checkbox"/> Taking Appropriate Action to Meet Needs
Bedtime/ Naptime	<input checked="" type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	<p>What is going well? SHE DOES NOT TAKE ANY NAPS BUT DOES GREAT GOING TO BED</p> <p>What could be better? NOTHING</p>	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/Physical <input type="checkbox"/> Learning/Cognition <input type="checkbox"/> Social/Emotional Behaviors <input checked="" type="checkbox"/> Self-Help/Adaptive	<input type="checkbox"/> Positive Social/Emotional Skills, Including Social Relationships <input type="checkbox"/> Acquiring and Using Knowledge and Skills <input checked="" type="checkbox"/> Taking Appropriate Action to Meet Needs
Child Care	<input checked="" type="checkbox"/> Easy <input type="checkbox"/> Some Concerns <input type="checkbox"/> Difficult	<p>What is going well? SHE GOES TO GRANDPARENTS HOUSE AND SHE LOVES IT AND IT TAKES A LOT TO GET HER TO LEAVE.</p> <p>What could be better? NOTHING</p>	<input type="checkbox"/> Communication <input type="checkbox"/> Movement/Physical <input type="checkbox"/> Learning/Cognition <input checked="" type="checkbox"/> Social/Emotional Behaviors <input type="checkbox"/> Self-Help/Adaptive	<input checked="" type="checkbox"/> Positive Social/Emotional Skills, Including Social Relationships <input type="checkbox"/> Acquiring and Using Knowledge and Skills <input type="checkbox"/> Taking Appropriate Action to Meet Needs



WV BIRTH TO THREE
Office of Maternal, Child and Family Health
Bureau for Public Health
Department of Health and Human Resources

Child Last Name: Adams EXHIBIT NO. B3F
Child First Name/MI: Nevaeh
DOB: 7/21/2015
ID #: 201501327 PAGE: 25 OF 36

#284 P.026/037

01/08/2019 13:25

3044257367

From:MountainHeart WV BTT RAU 7

Child Outcome Summary – submit to RAU once completed

Facilitator: ESTELLA. D. CRABTREE

Discipline: SERVICE COORDINATOR

Date: 12/29/2017

Type of COSF completed today: Initial COSF Annual COSF Exit COSF

1. POSITIVE SOCIAL EMOTIONAL SKILLS (INCLUDING SOCIAL RELATIONSHIPS) - Check box that applies

1. A. To what extent does this child show behaviors and skills related to this outcome appropriate for his or her age across a variety of settings and situations?
For example: attachment/separation/autonomy, expressing emotions and feelings, social interactions and play, following rules if older than 18 months.

Completely		Somewhat		Emerging		Not Yet
<input type="checkbox"/> The child uses age expected behaviors and skills in all or almost all everyday situations – no concerns	<input checked="" type="checkbox"/> The child uses age expected behaviors and skills but there are still some significant concerns	<input type="checkbox"/> The child uses a mix of age expected and not age expected behaviors and skills across settings and situations	<input type="checkbox"/> The child occasionally uses age expected behaviors and skills across settings and situations – more not age expected	<input type="checkbox"/> The child uses immediate foundational skills most of the time across settings and situations – not yet age expected	<input type="checkbox"/> The child occasionally uses immediate foundational skills across settings and situations – more foundational skills	<input type="checkbox"/> The child uses no immediate foundational skills across settings and situations – has mostly foundational skills similar to a much younger child

1.B. Has the child shown any new skill/behaviors related to positive social emotional skills in the last 12 months? Yes No Not Applicable, Initial IFSP

2. ACQUIRING AND USING KNOWLEDGE AND SKILLS - Check box that applies

2. A. To what extent does this child show behaviors and skills related to this outcome appropriate for his or her age across a variety of settings and situations?
For example: attends, explores, imitates, object permanence, early concepts, expressive language and communication, problem solving.

Completely		Somewhat		Emerging		Not Yet
<input type="checkbox"/> The child uses age expected behaviors and skills in all or almost all everyday situations – no concerns	<input type="checkbox"/> The child uses age expected behaviors and skills but there are still some significant concerns	<input checked="" type="checkbox"/> The child uses a mix of age expected and not age expected behaviors and skills across settings and situations	<input type="checkbox"/> The child occasionally uses age expected behaviors and skills across settings and situations – more not age expected	<input type="checkbox"/> The child uses immediate foundational skills most of the time across settings and situations – not yet age expected	<input type="checkbox"/> The child occasionally uses immediate foundational skills across settings and situations – more foundational skills	<input type="checkbox"/> The child uses no immediate foundational skills across settings and situations – has mostly foundational skills similar to a much younger child

2.B. Has the child shown any new skill/behaviors related to acquiring and using knowledge in the last 12 months? Yes No Not Applicable, Initial IFSP

3. TAKING APPROPRIATE ACTION TO MEET NEEDS - Check box that applies

3. A. To what extent does this child show behaviors and skills related to this outcome appropriate for his or her age across a variety of settings and situations? For example: independent mobility, use of objects to make things happen, feeding, toileting, dressing, requests

Completely		Somewhat		Emerging		Not Yet
<input type="checkbox"/> The child uses age expected behaviors and skills in all or almost all everyday situations – no concerns	<input type="checkbox"/> The child uses age expected behaviors and skills but there are still some significant concerns	<input type="checkbox"/> The child uses a mix of age expected and not age expected behaviors and skills across settings and situations	<input checked="" type="checkbox"/> The child occasionally uses age expected behaviors and skills across settings and situations – more not age expected	<input type="checkbox"/> The child uses immediate foundational skills most of the time across settings and situations – not yet age expected	<input type="checkbox"/> The child occasionally uses immediate foundational skills across settings and situations – more foundational skills	<input type="checkbox"/> The child uses no immediate foundational skills across settings and situations – has mostly foundational skills similar to a much younger child

3.B. Has the child shown any new skill/behaviors related to taking action to meet needs in the last 12 months? Yes No Not Applicable, Initial IFSP

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Child Last Name: Adams **EXHIBIT NO. B3F**
 Child First Name/Mi: Nevaeh **PAGE: 26 OF 36**
 DOB: 7/21/2015
 ID #: 201501327

Child Outcomes in Daily Routines

Child outcomes are based on the changes the family wants to see in their child's ability to successfully participate in the daily activities and routines that are important to them. (Use additional pages as needed.)

Outcome # 4	What routine or activity will be the focus for this child outcome? NEVAEH WILL BE ABLE TO EAT A MEAL AT THE TABLE WITH FAMILY AT MEALTIME.		
Functional Outcome Statement (What we can accomplish in the next six months related to this routine or activity?)			
Who	NEVAEH	Will (do what)	EAT A MEAL WITH FAMILY AT THE TABLE AT MEALTIMES
Under what conditions	DURING FAMILY MEALTIMES	In order to or so that	THE FAMILY CAN ENJOY A FULL MEAL TOGETHER
We will know this outcome has been achieved when: NEVAEH IS ABLE TO SIT AT THE FAMILY TABLE FOR TWO MEALS A DAY AND EAT A COMPLETE MEAL WITH ENCOURAGEMENT.			
Describe the methods and strategies the family will use to achieve the outcome. CONSISTENCY VERBAL ENCOURAGEMENT PRAISE DESENSITIZATION OF TEXTURES			
What type of expertise/knowledge is needed to coach the family and how often does the family feel they need the support? WE WILL USE DEVELOPMENTAL SPECIALIST, OCCUPATIONAL THERAPY AND SERVICE COORDINATION AS WELL AS SOCIAL WORK TO SUPPORT THE FAMILY WEEKLY.			
How will the team measure progress (observable actions and behaviors)?			
<input checked="" type="checkbox"/> Intervention Activity notes	<input checked="" type="checkbox"/> Data Gathering	<input checked="" type="checkbox"/> Service Coordinator Activity Note	<input checked="" type="checkbox"/> Parent Report
<input checked="" type="checkbox"/> Ongoing Team Communication	<input type="checkbox"/> Other – Describe		

JAN 04 2018



WV BIRTH TO THREE
Office of Maternal, Child and Family Health
Bureau for Public Health
Department of Health and Human Resources

Child Last Name: ADAMS EXHIBIT NO. B3F
Child First Name/MI: NEVAEH PAGE: 27 OF 36
DOB: 7/21/2015
ID #: 201501327

Child Outcomes in Daily Routines

Child outcomes are based on the changes the family wants to see in their child's ability to successfully participate in the daily activities and routines that are important to them. (Use additional pages as needed.)

Outcome # 5	What routine or activity will be the focus for this child outcome? NEVAEH WILL BE ABLE TO ATTEND TO ADULT DIRECTED PLAY TO LEARN NEW SKILLS		
Functional Outcome Statement (What we can accomplish in the next six months related to this routine or activity?)			
Who	NEVAEH	Will (do what)	ATTEND TO ADULT DIRECTED PLAY
Under what conditions	WHILE SITTING AT A TABLE	In order to or so that	BUILD NEW PLAY SKILLS AND SIT FOR ADULT DIRECTED PLAY AT
We will know this outcome has been achieved when: NEVAEH WILL BE ABLE TO SIT FOR 15 MINS AT A TABLE DURING ADULT DIRECTED PLAY AND COMPLETE A PUZZLE			
Describe the methods and strategies the family will use to achieve the outcome. TIMERS ENCOURAGEMET MAGNADOODLE COLORING COLOR AND SHAPE IDENTIFICATION SENSORY EXPLORATION BLOCKS SHAPE SORTERS			
What type of expertise/knowledge is needed to coach the family and how often does the family feel they need the support? SI AND OT THERAPIST WILL WORK ON HAND ACTIONS WITH TOYS AND BE ABLE TO SIT AND SUPPLY ATTENTION TO TOYS, COLORS, SHAPES, AN ACTION WORDS.			
How will the team measure progress (observable actions and behaviors)?			
<input checked="" type="checkbox"/> Intervention Activity notes	<input type="checkbox"/> Data Gathering	<input checked="" type="checkbox"/> Service Coordinator Activity Note	<input checked="" type="checkbox"/> Parent Report
<input checked="" type="checkbox"/> Ongoing Team Communication	<input type="checkbox"/> Other – Describe		

#284 P.029/037

01/08/2019 13:26

3044257367

From:MountainHeart WV BTT RAU 7

WV BIRTH TO THREE
Office of Maternal, Child and Family Health
Bureau for Public Health
Department of Health and Human Resources

Child Last Name: Adams **EXHIBIT NO. B3F**
 Child First Name/MI: Nevaeh **PAGE: 28 OF 36**
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Family Outcome (Optional)

Family outcomes assist families in obtaining the knowledge, skills, information and resources needed to meet their desired goals as a family. For example: learning how to coordinate their child's health care services, applying for child care subsidy to return to work, meeting other families with special needs children, adjusting the family routine to allow time for siblings. (Use additional pages as needed.)

Outcome # 6	What will be the focus for this family outcome and why is it a priority for the family? NEVAEH HAS A LOT OF MEDICAL NEEDS INCLUDING TRANSPORTATION, LINKAGE AND REFERRAL TO DIFFERENT AGENCIES. FAMILY IS NOT CAPABLE OF FINDING PROPER RESOURCES TO AID IN HER MEDICAL NEEDS. FAMILY NEEDS TO BE LINKED TO OTHER AGENCIES FOR HELP WITH FINANCIAL AND MEDICAL NECESSITIES.		
Functional Outcome Statement (What we can accomplish in the next six months related to this outcome?)			
Who	MOM, DAD, NEVAEH, AND SIBLINGS	Will (do what)	BE ABLE TO FIND RESOURCES AND MANAGE REFERRALS
In order to do what	TO MEET ALL FAMILY'S BASIC NEEDS AND HEALTHCARE NEEDS ARE TAKEN CARE OF.		
We will know this outcome has been achieved when: THE FAMILY IS ABLE TO PROVIDE ALL OF NEVAEH'S MEDICAL NEEDS AND TRANSPORTATION TO AND FROM HEALTHCARE APPOINTMENTS AND FINANCIAL STABILITY.			
Strategies and Activities: What strategies and activities will we work on together toward this outcome? LINKAGE AND REFERRAL] COMPLETEING APPLICATIONS PHONE CALLS TO OUTSIDE AGENCIES			
What expertise is needed to assist the family to achieve this outcome? SOCIAL WORK AND SERVICE COORDINATION SERVICES THROUGH WBTT, POSSIBLE LINKAGE TO CHILDREN WITH SPECIAL HEALTHCARE NEEDS			
How will the team measure progress (observable actions and behaviors)?			
<input checked="" type="checkbox"/> Intervention Activity notes	<input checked="" type="checkbox"/> Data Gathering	<input checked="" type="checkbox"/> Service Coordinator Activity Note	<input checked="" type="checkbox"/> Parent report
<input checked="" type="checkbox"/> Ongoing Team Communication	<input type="checkbox"/> Other – Describe"		

#284 P.030/037

01/08/2019 13:26

3044257367 From:MountainHeart WV BTT RAU 7



WV BIRTH TO THREE
Office of Maternal, Child and Family Health
Bureau for Public Health
Department of Health and Human Resources

Child Last Name: Adams **EXHIBIT NO. B3F**
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Transition Plan

WV Birth to Three must ensure a smooth transition of infants and toddlers receiving early intervention services to other services when exiting WV Birth to Three at age three. There are specific timelines and activities that must be completed for these children. (See Transition Checklist). The WV Birth to Three team should begin development of the transition plan at least nine (9) months prior to child's third birthday. Every child must have a Transition Conference not fewer than 90 days, and no more than nine (9) months prior, to the child's third birthday.

Third Birthday: 7/21/2018

Anticipated Transition Conference Date: 4/20/2018

Not applicable at this time

List the possible options for services at age three that were discussed with the family:

MOM WANTS NEVAEH TO ATTEND HEADSTART BUT FATHER IS NOT ON BOARD.

What services would the family like more information about?

HEADSTART, CHILDREN WITH SPECIAL HEALTHCARE NEEDS, IEP INFORMATION FROM THE BOARD

What information does the family need to help prepare the child and themselves for transition?

THE FAMILY WANTS INFORMATION ON STARTING NEVAEH IN HEADSTART/PRE-K AND ALSO HOW TO START EITHER A 504 PLAN OR AN IEP. THE FAMILY ALSO WANTS LINKED TO CHILDREN WITH SPECIAL HEALTHCARE NEEDS FOR SERVICES AFTER WVBT EXIT.

What information does the family want to share with other agencies/programs? Which programs will the family be sharing this information with?

THE FAMILY AGREES THAT ANY AND ALL RECORDS FROM WVBT/ MEDICAL RECORDS/ AND ANY INFORMATION NEEDED CAN BE SHARED WITH ANY AGENCY THAT WILL BE HELPING THE FAMILY WITH FOLLOW UP AFTER WVBT EXIT.

What additional steps and services are needed to promote a successful transition?

FAMILY SUPPORT

LINKAGE AND REFERRAL TO OTHER AGENCIES

HELP WITH PAPERWORK

HELP WITH FINDING RESOURCES TO HELP THE FAMILY WITH GETTING STABILITY BEFORE TRANSITION



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Services in Natural Environments

To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments

#284 P.031/037

01/08/2019 13:27

3044257367

From:MountainHeart WV BTT RAU 7

Related to Outcomes #:	Part C Service	AT Services Y/N	Location (Settings for Services)	Intensity/Frequency (How often, how long)	Method	Start Date	Anticipated Duration	Funding Source	Parent Consent and Initials
4,5	SI	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Home <input type="checkbox"/> Child Care <input type="checkbox"/> Community Setting/NE <input type="checkbox"/> Residential Facility	90 mins 1 xs <input type="checkbox"/> Once <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Daily <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> A <input checked="" type="checkbox"/> B <input checked="" type="checkbox"/> C	12/29/2017	7/20/2018	<input checked="" type="checkbox"/> BTT/CFO <input type="checkbox"/> Other	KMM
4,5,6	SC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Home <input type="checkbox"/> Child Care <input type="checkbox"/> Community Setting/NE <input type="checkbox"/> Residential Facility	75 mins 1 xs <input type="checkbox"/> Once <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Daily <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> A <input checked="" type="checkbox"/> B <input checked="" type="checkbox"/> C	12/29/2017	7/20/2018	<input checked="" type="checkbox"/> BTT/CFO <input type="checkbox"/> Other	KMM
4,5,6	Sw	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Home <input type="checkbox"/> Child Care <input type="checkbox"/> Community Setting/NE <input type="checkbox"/> Residential Facility	75 mins 2 xs <input type="checkbox"/> Once <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Daily <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> A <input checked="" type="checkbox"/> B <input checked="" type="checkbox"/> C	12/29/2017	7/20/2018	<input checked="" type="checkbox"/> BTT/CFO <input type="checkbox"/> Other	KMM
4,5	Ot	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Home <input type="checkbox"/> Child Care <input type="checkbox"/> Community Setting/NE <input type="checkbox"/> Residential Facility	75 mins 2 xs <input type="checkbox"/> Once <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Daily <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> A <input checked="" type="checkbox"/> B <input checked="" type="checkbox"/> C	12/29/2017	7/20/2018	<input checked="" type="checkbox"/> BTT/CFO <input type="checkbox"/> Other	KMM
		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Home <input type="checkbox"/> Child Care <input type="checkbox"/> Community Setting/NE <input type="checkbox"/> Residential Facility	_____ mins _____ xs <input type="checkbox"/> Once <input type="checkbox"/> Monthly <input type="checkbox"/> Daily <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Quarterly	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other	
		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Home <input type="checkbox"/> Child Care <input type="checkbox"/> Community Setting/NE <input type="checkbox"/> Residential Facility	_____ mins _____ xs <input type="checkbox"/> Once <input type="checkbox"/> Monthly <input type="checkbox"/> Daily <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Quarterly	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other	

Method Codes:

- A = Coaching the family and/or caregiver in the use of strategies to enhance the development of the child.
- B = Consultation to family and IFSP team related to ongoing progress monitoring of the child.
- C = Service Coordination-Provides coordination, linkage and referral.



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From:MountainHeart WV BTT RAU 7

Part C Services Not Provided in Natural Environments

"The provision of early intervention services for any infant or toddler occurs in a setting other than the natural environment only when early intervention cannot be achieved satisfactorily in a natural environment." 636(a)(5)

Related to Outcomes #:	Part C Service	AT Services Y/N	Location (Settings for Services)	Transportation Reimbursement Needed? *	Intensity/Frequency (How often, how long)	Method	Start Date	Anticipated Duration	Fund Source	Parent Consent & initials
	SI	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Service Provider Location <input type="checkbox"/> Program – children with disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ mins ____ xs <input type="checkbox"/> Once <input type="checkbox"/> Monthly <input type="checkbox"/> Daily <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Quarterly	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other <hr/>	
	SC	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Service Provider Location <input type="checkbox"/> Program – children with disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ mins ____ xs <input type="checkbox"/> Once <input type="checkbox"/> Monthly <input type="checkbox"/> Daily <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Quarterly	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other <hr/>	
	Sw	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Service Provider Location <input type="checkbox"/> Program – children with disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ mins ____ xs <input type="checkbox"/> Once <input type="checkbox"/> Monthly <input type="checkbox"/> Daily <input type="checkbox"/> Yearly <input type="checkbox"/> Weekly <input type="checkbox"/> Quarterly	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C			<input type="checkbox"/> BTT/CFO <input type="checkbox"/> Other <hr/>	
* Transportation reimbursed only if service not available in natural environment		Method Codes: A = Coaching the family and/or caregiver in the use of strategies to enhance the development of the child. B = Consultation to family and IFSP team related to ongoing progress monitoring of the child. C = Service Coordination-Provides coordination, linkage and referral.								

Natural Learning Opportunities Justification: Why are services not being provided in natural environments? How will strategies and activities be included in the family daily settings? What is the plan to move services to natural environments (include timeline)?

JAN 04 2018


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"OTHER SERVICES/SUPPORTS" NEEDED BUT NOT REQUIRED UNDER PART C OF IDEA

To the extent appropriate, the IFSP should include other services needed or being received by the family or child, and not funded under Part C

Service or Resource	Receive	Need	List steps to be taken to secure services/resources, including potential funding source if relevant
Child Care	<input type="checkbox"/>	<input type="checkbox"/>	
Early Head Start	<input type="checkbox"/>	<input checked="" type="checkbox"/>	LINK FAMILY TO EARLY HEADSTART SERVICES AND McDOWELL CO BOE
Help Me Grow WV	<input type="checkbox"/>	<input checked="" type="checkbox"/>	LINK FAMILY TO HELP ME GROW FOR REFERRAL
Women, Infants, and Children (WIC)	<input type="checkbox"/>	<input type="checkbox"/>	
WV Home Visitation Programs (HFA, PAT, MIHOW, HAPI, RFTS)	<input type="checkbox"/>	<input type="checkbox"/>	
WV Children's Health Insurance Program (CHIP)	<input type="checkbox"/>	<input type="checkbox"/>	
Children with Disabilities Community Service Program (CDCSP)	<input type="checkbox"/>	<input type="checkbox"/>	
Children with Special Health Care Needs (CSHCN)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	SC AND SW HAS REFERRED AND FILLED OUT APPLICATIONS
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	
Supplemental Security Income (SSI)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	MOM HAS APPLIED AND APPEALED
Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/>	<input type="checkbox"/>	
Non-Emergency Medical Transportation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	SW GETS PARENTS HELP WITH TRANSPORTATION TO SHRINERS
Other (library, church, playgroups, Kindermusik, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	

Family has chosen not to be linked to other services.

NOTE:

The above community resources may help families to access "other" needed services and supports.

Direct links to most of these resources may be found on the WV Department of Health and Human Resources homepage (www.wvdhhr.org) or the WV Birth to Three website under 'Resources'. Parent Partners in each Regional Administrative Unit can provide additional information for resources in their community.

#284 P.034/037

01/08/2019 13:28

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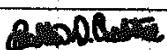
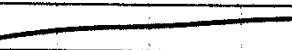
From:MountainHeart WV BTT RAU 7

WV BIRTH TO THREE
 Office of Maternal, Child and Family Health
 Bureau for Public Health
 Department of Health and Human Resources

Child Last Name: Adams **EXHIBIT NO. B3F**
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IFSP Team Membership

Each agency or person who has a direct role in the provision of services is responsible for making a good faith effort to assist the eligible child and his/her family in achieving the outcomes on the child's IFSP.

Print Name and Sign with Credential	Date	Role on Team	Telephone/Email	Method of Contribution
ESTELLA D. CRABTREE 	12/29/2017	SERVICE COORDINATOR	Phone: (304) 800-6036 Email:	<input checked="" type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input type="checkbox"/> By Report <input type="checkbox"/> Auth Representative
CAROLYN FULLER 	12/29/2017	DEVELOPMENTAL SPECIALIST	Phone: (304) 922-8705 Email:	<input type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input checked="" type="checkbox"/> By Report <input type="checkbox"/> Auth Representative
JUDY ANGLIN 	12/29/2017	SOCIAL WORKER	Phone: (304) 967-6001 Email:	<input checked="" type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input type="checkbox"/> By Report <input type="checkbox"/> Auth Representative
GLEND A ODELL 	12/29/2017	OCCUPATIONAL THERAPY	Phone: (606) 353-9931 Email:	<input checked="" type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input type="checkbox"/> By Report <input type="checkbox"/> Auth Representative
			Phone: Email:	<input type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input type="checkbox"/> By Report <input type="checkbox"/> Auth Representative
			Phone: Email:	<input type="checkbox"/> Face to Face <input type="checkbox"/> Telephone Conference <input type="checkbox"/> By Report <input type="checkbox"/> Auth Representative

Parent's Informed Consent for WV Birth to Three Services:

- I/We have helped develop this Individualized Family Service Plan (IFSP). I/We understand and agree with its content. I/We agree to each of the services I/We have initiated. I/We understand that my consent for services may be withdrawn by written request at any time.
- I/We do not accept this IFSP as written, however I/We do give permission for the following services to begin:
- I/We have received a copy of the Procedural Safeguards. Our Interim/Ongoing Service Coordinator has reviewed our rights and answered any questions I/We have.



Parent/Legal Guardian Signature

12/29/2017

Date

Notice of Action: IFSP Development

The IFSP is the documentation of the multi-disciplinary team's decision for the provision of early intervention services for each child found eligible for WV Birth to Three. The IFSP identifies the services and supports needed to achieve the IFSP outcomes as identified by the MDT team. WV Birth to Three is proposing to implement this plan of early intervention services that have been individualized to meet the needs of the child and family listed above.

JAN 04 2018



WV HHS'10 THREE
Office of Maternal, Child, and Family Health
Division for Public Health
Department of Health and Human Resources

EXHIBIT NO. B3F
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Child's Name: Child DO

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FRACTIIONER CONFIRMATION FORM

or affected by left or right gluteal vein. Coagulation times within normal limits, provided by preoperative.

SECTION I. Practices transferred or newly developed or assessment Activities

Evaluation/Accreditation services are to be provided within 15 days of evaluation or a new practice may be selected. EA services are authorized on a 15-day basis, not to exceed 120 minutes. E/A audit notifications are for one day max 30 days.

Part C Service Codes: A) Audiology, (FC) Family Training and Counseling, (H) Health, (I) Interventions, (M) Medical, (NRI) Nursing, (NT) Nutrition, (O) Occupational Therapy, (P) Physical Therapy, (PSY) Psychology, (SC) Speech Coordination, (SW) Social Work, (SI) Social Instruction, (SP) Speech Pathology, (V) Vision, Location Codes: (H) Home, (CC) Child Care, (S) Other Community Setting, (HI) Hospital Inpatient, (PCF) Program for Children with Developmental Delay, (SPL) Service Provider Location, (RF) Resident/Facility.

SECTION II. Must be completed for enrollment (ES) service providers

Payee	Practitioner	Part C Service Code	Date Practitioner Certified	Location Code	** Aged Practitioner/Payee for IFSP	** Remote Practitioner/Payer for IFSP?
TOTALLY SENSATIONAL CRAFTS INC	STELLA CRAIG	SC	1/26/2017	H	STELLA CRAIG/THE SENSATIONAL SC INC	
MILESTONES	JUDY ANGLIN	SN	1/26/2017	H	JUDY ANGLIN/MILE STONES	
LITTLE WONDER RLC	KATHY QLESHNER RLC	OT	1/26/2017	H	KATHY QLESHNER RLC/THE LITTLE WONDER RLC	
CAROLYN FULLER	CAROLYN FULLER	SI	1/26/2017	H	CAROLYN FULLER/CAROLYN FULLER	

acti lote s o n infr i med to p rovide IFF P ar r ule s a re au thorized to p rovide se rvices at the li tensity/fre quency and location as identified in the ch id/family's IFFP. Use these columns to compl i n th e family's se le ction, p rovi d i ng hen d iplay of it) for the IFFP.

¹⁴ It is important to indicate the practitioner being added or being replaced. The designation of ESP services and ESP services area must be fitting best to this information in § 8(1), when submitting to the DIA.

#284 P.036/037

01/08/2019 13:28

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WV BIRTH TO THREE
 Office of Maternal, Child and Family Health
 Bureau for Public Health
 Department of Health and Human Resources

EXHIBIT NO. B3F
PAGE: 35 OF 36

Child's Name: Nevash Adams
 Child's Date of Birth: 7/27/2015
 Date of Meeting: 12/29/2018

TEAMING ACTIVITY NOTE

Purpose of Meeting: Please check appropriate box below. All meetings have a four (4) unit cap, except the Initial Eligibility/IFSP Meeting is capped at six (6) units.

- Initial Eligibility Determination/Individualized Family Service Plan (IFSP) Meeting IFSP Plan Review (Six Month)
- Annual Individualized Family Service Planning (IFSP) Meeting Child Outcomes Summary Tool (COST) Meeting – Exit
- Individual Education Plan (IEP) Meeting (must be completed prior to the child's third birthday) Face-to-Face Transition Planning Meeting
- Requested IFSP Review or Problem-Solving Meeting

Document why the IFSP Review or Problem-Solving Meeting was requested: (Up to four (4) units every six months)

Annual Review

Meeting Summary: (For example: parent's priorities and concerns, child's current developmental/health status, progress or lack of progress towards achieving IFSP outcomes, information shared for transition planning, or IEP development, recommendations for next steps.)

Stacey mama came over to my medical office and reviewed it, we met as a team, added Carolyn developmental specialist to the team. Team completed COST and some new outcomes. We discussed areas of concern with the family and completed IFSP. Team scheduled six month end transition

Participant's Name	Title	Signature	Method of Participation	Start Time: Stop Time:
Kelli Adams	Parent	Kelli M. Adams	F2F	11:00 - 12:30
Estella Crabtree	SC	Estella D. Crabtree	F2F	11:00 - 12:30
Judy Anglin	SI	Judy Anglin	F2F	11:00 - 12:30
Glenda Odell	COTA	Glenda Odell	F2F	11:00 - 12:30
Carolyn Fuller	SI		report	11:00 - 12:30

Method of Participation Code: [Face-to-Face] [Phone with team] [Report] [Representative]

White Copy: EI RECORD

Canary Copy: EI TEAM

Pink Copy: FAMILY

WVDHHR/BPH/OMCFH/WVBTT/FORMS APPROVED/TeamingActivity_Revised012517

JAN 04 2018

**EXHIBIT NO. B3F
PAGE: 36 OF 36**
**WV BIRTH TO THREE**

Office of Maternal, Child and Family Health
Bureau for Public Health
Department of Health and Human Resources

Child Last Name: Adams
Child First Name/MI: Nevaeh
DOB: 07/21/2015

#284 P.037/037

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From:MountainHeart WV BTT RAU 7

AUTHORIZATION FOR TEAMING UNITS AND DOCUMENTATION OF TRANSITION CONFERENCE FORM

Form to be completed by Interim or Ongoing Service Coordinator and submitted within two working days to the RAU and to the practitioner.

SECTION I - TEAMING. Teaming Activities and BTT Service Limits: Initial Eligibility/IFSP Meeting (up to 6 units); Six-month Review (up to 4 units); Annual IFSP (up to 4 units); Transition Conference (up to 4 units); IEP Meeting, when invited by family if the meeting occurs prior to the child's third birthday (up to 4 units); Exit Meeting to complete COSF (up to 4 units); MDT Meeting when invited by DHHR (up to 4 units); Requested IFSP Review or Requested Problem – Solving Meetings (up to 4 units between each six month review)

Payee	Practitioner	Part C Service	Type of Meeting from List Above	Location Code	Meeting Date	Number of Units Practitioner Initials
Totally sc Inc.	Estella D. Crabtree	SC	Annual	H	12/29/2017	6 units <i>AC</i>
Little wonders llc	Kathy Qusenberry	OT	Annual	H	12/29/2017	6 units <i>af</i>
Milestones	Judy Anglin	SW	Annual	H	12/29/2017	6 units <i>af</i>
Carolyn Fuller	Carolyn Fuller	SI	Annual	Spl	12/29/2017	6 units _____

Part C Service Codes: (A) Audiology; (FC) Family Training and Counseling; (H) Health; (I) Interpreter; (M) Medical; (NR) Nursing; (NT) Nutrition; (O) Occupational Therapy; (P) Physical Therapy;

(PSY) Psychology; (SC) Service Coordination; (SW) Social Work; (SI) Special Instruction; (SP) Speech Pathology; (V) Vision

Location Codes: (H) includes Home, Child Care, Other Community Setting & Residential Facility; (SPL) Includes Service Provider Location, Hospital Inpatient & Program for Children with Devel. Delay

SECTION II -TRANSITION CONFERENCE. Complete this section for the Transition Conference required under Part C of IDEA. The Transition Conference must occur at least 90 days before the child's third birthday. Do not complete this section for any additional transition meetings held after the Transition Conference.

Date of Transition Conference: _____ Was the Transition Conference completed during the Initial IFSP meeting? Yes No
IF YES, has WVEIS child notification been entered by the RAU? Yes No

Was the Transition Conference held at least 90 days before the child's third birthday? Yes No

IF NO, select the appropriate reason or reasons for the delay from the list below and provide additional details. Child's record MUST include documentation of the reason(s) listed.

Exceptional Family Circumstance:

Extreme weather conditions:

Other:

Has a Transition Plan been started for this child/family? Yes No

JAN 04 2018

MCDOWELL COUNTY SCHOOLS
 Confidential Developmental Assessment Report

Name:	Nevaeh Hope Adams	Report Date:	June 3, 2018
Age:	2 years 10 months	Grade:	E1
Date of Birth:	July 21, 2015	School:	N/A
Parents:	Kelli & Rico Adams	Test Date:	May 31, 2018
Address:	P.O. Box 46 Big Sandy, WV 24816	WVEIS#:	600022696

Tests Administered:

Battelle Developmental Inventory – 2nd Edition
 Test Observations

Battelle Developmental Inventory – 2nd Edition

Domain	Percentile Rank	Scaled/ DQ Scores	Age Equivalent
Adaptive (ADP)		80	
Self-Care	2	4	21
Personal Responsibility	25	8	25
Personal-Social (PS)		80	
Adult Interaction	16	7	25
Peer Interaction	5	5	<24
Self-Concept/Social Role	9	6	27
Communication (COM)		75	
Receptive	2	4	23
Expressive	9	6	26
Motor (MOT)		88	
Gross Motor	5	5	22
Fine Motor	25	8	28
Perceptual Motor	50	10	30
Cognitive (COG)		70	
Attention & Memory	1	3	15
Reasoning & Academic	16	7	24
Perception & Concepts	1	3	18
BDI – 2 Total	5	76	

Developmental Report – Nevaeh Hope Adams

Adaptive

The Adaptive Domain measures the child's ability to use the information and skills acquired in the other domains. The Adaptive Domain is divided into two subdomains: Self-Care (SC) and Personal Responsibility (PR) and consists of 60 items. The primary developmental milestones in the Self-Care Subdomain begin at birth and generally are completed by age 6 years. Self-care milestones consist of a series of activities that move the child from complete dependence on the parent (as an infant) to a self-sufficient, functioning child. The Personal Responsibility milestones are assessed from age 2 years and older and look at the child's ability to assume responsibility for his or her actions and to move around his or her environment safely and productively.

Nevaeh's Adaptive Domain skills in self-care (21 months) and personal responsibility skills (25 months) are similarly developed.

Self-Care

The 35 items in this subdomain assess a child's ability to perform the tasks associated with daily routines with increasing autonomy. The items in this subdomain measure skills in the following broad areas:

- * Eating - The child's ability to eat and drink, use eating utensils, and perform efficiently those tasks that provide him or her with nourishment
- * Dressing - The child's ability to put on, fasten and unfasten, and remove articles of clothing; choose appropriate clothing; and take care of dressing needs generally
- * Toileting - The child's ability to establish bladder and bowel control and care for toileting needs
- * Grooming - The child's ability to care about and maintain appropriate personal standards of cleanliness by using a bath or shower, caring for teeth and hair, washing hands, and blowing and wiping his or her nose
- * Preparing for sleep - The child's ability to routinely perform bedtime tasks and go to sleep with little fussing

Nevaeh does not take care of her own toileting needs. She will tell her mother she has peed. She will strip off all of her clothing when she wants to (did so during the evaluation/meeting). She does not distinguish between food and nonfood items. She is beginning to feed herself with a spoon and drinks from a Sippy cup.

Personal Responsibility

The 25 items in this subdomain assess a child's ability to assume responsibility for performing simple chores, such as putting away toys, making a phone call, following rules in a game, or making his or her bed. These items also assess the child's ability to:

- * Initiate play and other meaningful activities
- * Stay appropriately focused on a task
- * Avoid common dangers

Nevaeh will put away toys when asked. She does not need continual supervision. She does appear to understand that hot is dangerous. She does not avoid common dangers and has had no opportunity to work in a group. She shows care around small children and animals.

Personal-Social

The Personal-Social Domain assesses abilities and characteristics that allow a child to engage in meaningful social interaction with adults and peers and to develop his or her own self-concept and social role. The Personal-Social Domain consists of 100 items. The behaviors measured in the Personal-Social Domain are divided into three subdomains: Adult Interaction (AI), Peer Interaction (PI), and Self-Concept and Social Role (SR). Self-Concept and Social Role are assessed over the entire range of the BDI-2. Assessment of Adult Interaction begins at birth, and Peer Interaction begins at age 2 years. Both of these subdomains are measured to age 6 years.

Developmental Report – Nevaeh Hope Adams

Nevaeh's Personal-Social Domain scores in peer interaction (<24 months), adult interaction (25 months) skills and self-concept and social role (27 months) skills are similarly developed.

Adult Interaction

The 30 items in this subdomain measure the quality and frequency of a child's interactions with adults. The milestones assessed include behaviors such as infant attachment and interaction with adults, response to and initiation of social contact with adults, and the use of adults as resources to solve problems. Sample milestones include:

- * Responds physically when held
- * Is aware of and identifies familiar people
- * Helps an adult with simple tasks

Nevaeh responds positively to praise, greets familiar adults and shows appropriate affection. She does appear to enjoy listening to a story sometimes. She is beginning to help with simple household tasks and separate easier from her parents. She uses other adults as resources and allows other adults to participate in her activities. She does not ask for help when needed. She does not follow adult directions without resistance.

Peer Interaction

The 25 items in this subdomain assess the quality and frequency of a child's interactions with children of a similar age, including the ability to form friendships and personal associations, respond to and initiate social contacts with peers, interact effectively in a small group, and cooperate. Sample milestones include:

- * Shares toys or other objects
- * Plays cooperatively with other children
- * Recognizes basic similarities and differences among all children

Nevaeh does initiate social contact with peers in a play situation. She does not show sympathy or concern for other children. She will disturb the materials of others when playing. She does respond differently to familiar and unfamiliar children.

Self-Concept and Social Role

The 45 items in this subdomain assess a child's development of self-awareness, personal knowledge, self-worth and pride, moral development, sensitivity to others' needs and feelings, and coping skills. Sample milestones include:

- * Ability to express emotions
- * Awareness of differences between males and females
- * Coping effectively with aggression, criticism or teasing

Nevaeh displays independent behavior. She did not say her name or tell her age. She does exhibit a range of positive and negative emotions. She did not use objects in make-believe play. She is beginning to use words for social contact. She did use the word "me" and said, "give me my chair" during the evaluation.

Communication

The Communication Domain measures how effectively a child receives and expresses information and ideas through verbal and nonverbal means. The Communication Domain consists of 85 items and is divided into two subdomains: Receptive and Expressive. Both subdomains measure development from birth to age 8 years.

Developmental Report – Nevaeh Hope Adams

Nevaeh's Communication scores in Expressive (26 months) skills and Receptive (23 months) skills are similarly developed.

Receptive Communication

The 40 items in this subdomain assess a child's ability to discriminate, recognize, and understand sounds and words as well as information received through gestures and other nonverbal means. These items also assess the child's understanding and use of conversational skills. Sample milestones include:

- * Responds to different tones of voice
- * Responds to who or what questions
- * Identifies initial sounds in words
- * Associates pictures with words

Nevaeh follows three or more familiar verbal commands but not two-step commands. She did respond to the prepositions "out" but not "on". She did respond to the possessive form "your" and "my". She did not respond to "who" and "what" questions or simple possessive form 's. she is beginning to look at or point to an object across the room when it is named.

Expressive Communication

The 45 items in this subdomain assess a child's production and use of sounds, words, or gestures to relate information to others. They also assess the child's knowledge of and ability to use simple rules of grammar to produce phrases and sentences. In addition, the items measure how the child uses language as a tool for social contact, aside from communicating his or her needs. Sample milestones include:

- * Produces vowel sounds
- * Clearly articulates familiar words
- * Uses five- or six-word sentences
- * Uses irregular plural forms correctly

Nevaeh is beginning to use three and four word phrases. She usually uses gestures and words to get her needs met. She is beginning to use words to express what she sees or experiences. She does not use words to relate information about other people or engage in an extended conversation with others. She is beginning to use pronouns.

Motor

The Motor Domain assesses a child's ability to control and use the large and small muscles of the body. The 100 items in the Motor Domain are divided into three subdomains: Gross Motor, Fine Motor and Perceptual Motor. The basic Gross and Fine Motor skills are assessed from birth to age 6 years. The Perceptual Motor milestones are assessed from age 2 years to age 8 years.

Nevaeh's gross motor skills (22 months), fine motor (28 months) skills and perceptual motor (30 months) skills are similarly developed. Her skills are within the range expected for her age group.

Gross Motor

The 45 items in this subdomain assess the development of the large muscle systems used in locomotion skills, such as walking, running, and jumping, and coordinated movements, such as throwing. Sample milestones include:

- * Walks without support
- * Walks up and down stairs without assistance
- * Throws a ball and hits a target using both dominant and nondominant hands
- * Hops forward on one foot

Developmental Report – Nevaeh Hope Adams

Nevaeh can usually run 10 feet without falling but some days her balance is off and she falls. She is beginning to walk backward, jump with both feet together and attempt to kick the ball when it stopped. She is beginning to throw a ball with some direction, but did not catch the ball. She is beginning to walk up and down stairs without assistance.

Fine Motor

The 30 items in this subdomain assess the development of a child's fine muscle control and coordination, particularly the small muscles in the arms and hands that allow performance of increasingly complicated tasks. Sample milestones include:

- * Picks up a small object using the thumb and index finger
- * Traces designs with corners or curved edges
- * Ties a simple overhand knot
- * Cuts paper with scissors on a straight line

Nevaeh can remove pieces from the form board. She scribbled on the paper holding the pencil too high for control and held the paper. She did not point when asked to. She did not string beads. She cannot fasten clothing. She cannot trace designs with curves.

Perceptual Motor

The 25 items in this subdomain measure the child's ability to integrate fine motor and perceptual skills for tasks such as stacking blocks; putting rings on pegs; copying circles and squares; and eventually drawing, printing, and writing. Sample milestones include:

- * Puts a small object into a bottle
- * Stacks a series of cubes vertically
- * Copies letters, numbers, and words
- * Writes in script

Nevaeh was able to stack six blocks. She removed and replaced rings from/to a post. She scribbled but did not copy any lines.

Cognitive

The Cognitive Domain measures those skills and abilities most commonly thought of as "mental" or "intellectual", except for language and communication skills. The Cognitive milestones involve activities such as attending to, perceiving, and processing information; remembering; thinking; and knowing. The 105 items in the Cognitive Domain are divided into three subdomains: Attention and Memory, Reasoning and Academic Skills, and Perception and Concepts. The skills measured by each of these subdomains are interrelated, with the acquisition of earlier skills providing the foundation for the development of increasingly complex and higher-level cognitive abilities.

Achievement of these milestones is related to early success in school-related activities, such as reading and arithmetic. Attention and Memory milestones are assessed from birth to 6-years. Reasoning and Academic skills are measured from age 2 years, and skills in Perception and Concepts are measured across the full BDI-2 age range.

Nevaeh's scores in reasoning and academic skills (24 months) are more developed than her perception and concepts skills (18 months) and attention and memory (15 months) skills.

Developmental Report – Nevaeh Hope Adams

Attention and Memory

The 30 items in this subdomain assess a child's ability to visually and auditorily attend to environmental stimuli for varying lengths of time and to retrieve information when given relevant clues to do so, in both the short term and long term. Sample milestones include:

- * Follows auditory and visual stimuli
- * Recites poems, stories, or songs from memory
- * Locates hidden items in a complex picture

Nevaeh can occupy herself for ten minutes without demanding attention. She was unable to find a hidden object under one of two cups (lifted both cups). She does not attend to an activity for three minutes. She did not select the hand holding the toy. She will point to a picture in a book sometimes.

Reasoning and Academic Skills

The 35 items in this subdomain assess the critical thinking skills a child needs to perceive, identify, and solve problems; analyze and appraise the elements of situations; identify missing components, contradictions, and inconsistencies; and judge and evaluate ideas, processes, and products. These items also measure the scholastic abilities necessary for reading, writing, spelling, enumeration, and mathematics. Sample milestones include:

- * Names and matches colors
- * Demonstrates skills in addition, subtraction, multiplication, and division
- * Uses simple logic to answer questions

Nevaeh would not match objects by color but did name yellow and blue items inconsistently. She did not respond to one and one more. She did not identify the source of common actions consistently. She will reach around a barrier for an item, recognizes herself as the cause of events and will pull a cloth to obtain an object.

Perception and Concepts

The early items in this 40-item subdomain assess an infant's active sensorimotor interactions with the immediate environment. Several of these interactions are considered social in nature and provide the child with the experiences that contribute to later development of self-concept and interaction skills. The later items in this subdomain assess a child's ability to conceptualize and discriminate object features, such as size and shape, draw relationships among them, and selectively respond to them. Sample activities for the various milestones include:

- * Compares objects based on their physical features, such as color, shape, and size, and properties, such as weight
- * Relates objects and events based on their position in time or space, and then sequences familiar events according to their occurrence in time or relative size
- * Brings together parts of a whole by putting together pieces of a puzzle
- * Groups and sorts similar objects and identifies similarities and differences among them based on common characteristics, functions, or attributes (for example, grouping together all the red objects or all the things that can be eaten)
- * Recognizes properties of objects that remain unchanged in the face of perceptual distortion, such as length and area

Nevaeh was able to place pieces in the form board. She did not sort by color. She did not identify familiar objects by their use. She did not match circles or squares after demonstration. She does investigate her surroundings and imitate simple facial gestures.

Developmental Report – Nevaeh Hope Adams

Summary/Recommendations:

It is recommended that the Multidisciplinary Evaluation Team carefully review the results of this evaluation, as well as all other pertinent information, as required by Policy 2419 of the State of West Virginia Regulations for the Education of Exceptional Children in reaching any educational decisions regarding Nevaeh. She has been diagnosed with Turner's Syndrome, which is a chromosomal condition that affects development in females. The most common feature of Turner syndrome is short stature, which becomes evident by about age 5. She has a leaky aortic valve. Most girls with Turner syndrome have normal intelligence. According to her mother, Nevaeh will have several surgeries before she turns 11.

Nevaeh's age equivalent scores on the BDI-2 range from 15 months through 30 months. Her skills in nine areas are developed at less than 75% (<25.5 months) of what is considered appropriate for her current chronological age. Delays were noted in the domains of adaptive and cognitive skills as well as the areas of adult and peer interaction, receptive communication and gross motor skills. This examiner feels that being around peers her age in a structured setting will assist in remediating several of these delays.



Tanya I. Cook, Ed.S.

Contracted School Psychologist for McDowell County Schools

WV Licensed School Psychologist

Level II License # 21035

EXHIBIT NO. B5F
PAGE: 1 OF 6
PATIENT INFORMATION

Name: Adams, Nevach Hope **MRN:** 3279454 **FIN:** 8712659
NickName:
DOB: 07/21/15 **Age:** 3 Years **Sex:** Female
Race: White
Language: English [Interpreter Required: No]
Emergency Contact: Home
Alternate MRN:
Email:
Parents Marital Status: Unknown

Home: (681) 729-2017 **Alt 1:**
Alt 2:
Alt 3:
Emergency: (681) 729-2017

City/State/Zip: BIG SANDY, WV 24816
Country: USA
Mailing Address: PO BOX 46

Living With:
City/State/Zip: BIG SANDY, WV 24816
Country: USA

MOTHER INFORMATION

Name: Adams, Kelli **Home:** (681) 729-2017 **Home Address:** 250 MELVIN ST
DOB: 04/20/91 **Alt 1:**
Alt 2:
City/State/Zip: BIG SANDY, WV 24816
Country: USA

FATHER INFORMATION

Name: Adams, Rico **Home:**
DOB: 05/19/90 **Alt 1:**
Alt 2:
City/State/Zip: BIG SANDY, WV 24816
Country: USA

LEGAL GUARDIAN INFORMATION

Name: Adams, Kelli **Home:** (681) 729-2017 **Home Address:** 250 MELVIN ST
Rel to Pat: Mother
Sex: Female **DOB:** 04/20/91 **Alt 1:**
Alt 2:
City/State/Zip: BIG SANDY, WV 24816
Country: USA

SECONDARY GUARDIAN INFORMATION

Name: Adams, Rico **Home:**
Rel to Pat: Father
Sex: Male **DOB:** 05/19/90 **Alt 1:**
Alt 2:
City/State/Zip: BIG SANDY, WV 24816
Country: USA

INSURANCE INFORMATION

- 1** **Company Name:** UniCare Health Plan of West Virginia **Subscriber #:** 00405164305 **Address:** PO BOX 91
Health Plan Name: UniCare Health Plan of West Virginia **Pt. Member #:** 00405164305 **City/State/Zip:** CHARLESTON, WV 25321-0091
Other Health Plan Name:
Health Plan Phone: (866) 655-7423 **Rel to Pt:** Self
Auth Nbr(s): [A-1] No [-2] [-3] **Date Verified:** 07/09/18 **Group Number:** 1863100001
Health Plan Type: Medicaid Managed Care
- 2** **Company Name:**
Health Plan Name:
Other Health Plan Name:
Health Plan Phone:
Auth Nbr(s): [-1] [-2] [-3]
- 3** **Company Name:**
Health Plan Name:
Other Health Plan Name:
Health Plan Phone:
Auth Nbr(s): [-1] [-2] [-3]

VISIT INFORMATION

Admit Date/Time: 07/25/18 12:40 EDT **Admit Clerk:** Dobson, Kasey L.
Medical Service: Ortho **Enc Type:** Outpatient Clinic **Admit Mode:** Personal Transp
Location: LXT Clinic **Accident Related Visit?:** No **Admit Type:** Elective
Care Coordinator: **Pt. Member #:** **Address:**
Address: Room/Bed: /
City/State/Zip: Fain RN, Alison B
Group Number: Hall MSW, George M.

PHYSICIAN INFORMATION

Referring Physician: Referring, None 4367655 **Attending Physician:** Muchow MD, Ryan David
Referring Physician: 000 Shriners Lane
Tampa, FL **Primary Care Physician:** Al-Attar MD, Inas H 5514209
Referring Physician: 143 Undercliff Terrace
Princeton, WV 24740
(304) 487-0415

PREVIOUS ENCOUNTER INFORMATION

11/27/17 15:28 EST **Outpatient Clinic** **Muchow MD, Ryan David**
07/24/17 14:18 EDT **Outpatient Clinic** **Muchow MD, Ryan David**
05/01/17 14:07 EDT **Outpatient Clinic** **Muchow MD, Ryan David**
03/21/17 13:18 EDT **Outpatient** **Muchow MD, Ryan David**

TEMPLE INFORMATION

Referring Temple: Referring Shriner:
Coord Temple: Beni Kedem **Referring Shriner:**
Coord Shriner:

Adams, Nevach Hope Female / 3 Years MRN: 3279454 FIN: 8712659



8712659

(PROD: SHCIS_FACESHEET_XR_PDF)

PATIENT ADMIT RECORD

12/31/18 09:19

**EXHIBIT NO. B5F
PAGE: 2 OF 6**



Shriners Hospitals for Children 801 870 0000 458
 Lexington Outpatient Specialty Care Center
 110 Conn Terrance
 Lexington, KY 40508-3206

Progress Notes

DOCUMENT NAME: Outpatient Progress Note 2
SERVICE DATE/TIME: 7/25/2018 16:43 EDT
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: Kuzma MD,Alexander L (7/25/2018 16:43 EDT)
SIGN INFORMATION: Muchow MD,Ryan David (8/6/2018 07:51 EDT); Kuzma MD,
 Alexander L (7/31/2018 12:10 EDT)

LXT Outpatient note 2

PATIENT: Adams, Nevaeh H MRN: 3279454

EXAM DATE: 07/25/2018

ATTENDING PHYSICIAN: Ryan David Muchow MD

DICTATING PROVIDER: Alexander Kuzma MD

SUBJECTIVE:

The patient is a 3-year-old female with a history of Turner syndrome, as well as bilateral hip dislocation. She was treated with a right open reduction and adductor tenotomy 01/05/2017 by Dr. Muchow. She underwent a left-sided open reduction and adductor tenotomy on 07/19/2017. She had a repeat arthrogram of the bilateral hips, as well as hip spica casting on 02/16/2018. She later had her hip spica cast removed. She has been doing well since that time. She is running and playing and keeping up with her peers. She is on growth hormone per her endocrinologist.

PHYSICAL EXAMINATION:

General: The patient is a 3-year-old female in no apparent distress who is alert and interactive.

Hips: Hip range of motion is symmetric and painless. Forward flexion is to 135 degrees, internal rotation is to 60 degrees, external rotation is to 75 degrees, and abduction is to 60 degrees. Distal neurological status and pulses are intact.

RADIOGRAPHS:

An x-ray of the pelvis was obtained today. This was reviewed by me. This shows the femoral heads are well seated under the acetabulum. The right side acetabular index measures 34 degrees and on the

Patient Name:	Adams, Nevaeh Hope
Admit Date:	7/25/2018 12:40 EDT
Attending:	Muchow MD,Ryan David
MRN:	3279454
FIN:	008712659
DOB:	7/21/2015 Gender: Female

This document contains Confidential Patient Information from the SHCIS Medical Record. This information is not for general use and should only be used and/or disposed of in accordance with SHC Policies and Procedures pertaining to the protection of Patient Privacy and Confidentiality.

User ID: Grosenbaugh,Brenda M

Report Request ID: 33647677

Page 2 of 3

Print Date/Time: 12/31/2018 09:19 EST

EXHIBIT NO. B5F
PAGE: 3 OF 6

Shriners Hospitals for Children 981 070000458
Lexington Outpatient Specialty Care Center

Progress Notes

left side measures 38 degrees.

ASSESSMENT/PLAN:

The patient is a 3-year-old female with Turner syndrome, as well as bilateral developmental dysplasia of the hips.

1. Discussed above radiographic findings with the patient and her family. At this point, she is doing well, and her deformity appears to be slowly correcting.
2. We will have the patient follow up in 6 months with repeat x-rays of the AP pelvis.

DD: 07/25/2018 16:43:10EDT

TD: 07/27/2018 08:12:47EDT/so

Attestation Statement: I saw the patient with the resident/fellow. I discussed the case with the resident/fellow and agree with the findings and plan as documented in the resident's/fellow's note.

Electronically Signed: Kuzma MD, Alexander L
Sign Date and Time: 07/31/2018 12:10 EDT

Electronically Signed: Muchow MD, Ryan David
Sign Date and Time: 08/06/2018 07:51 EDT

Patient Name: Adams, Nevaeh Hope

MRN: 3279454

DOB: 7/21/2015 Gender: Female

This document contains Confidential Patient Information from the SHCIS Medical Record. This information is not for general use and should only be used and/or disposed of in accordance with SHC Policies and Procedures pertaining to the protection of Patient Privacy and Confidentiality.

User ID: Grosenbaugh,Brenda M

Report Request ID: 33647677

Page 3 of 3

Print Date/Time: 12/31/2018 09:19 EST

**EXHIBIT NO. B5F
PAGE: 4 OF 6**

PATIENT INFORMATION			
Name: Adams, Nevaeh Hope NickName: DOB: 07/21/15 Age: 3 Years Sex: Female Race: White Language: English [Interpreter Required: No] Emergency Contact: Home Alternate MRN: Email: Parents Marital Status: Unknown	MRN: 3279454 Home: (681) 729-2017 Alt 1: Alt 2: Alt 3: Emergency: (681) 729-2017	FIN: 8564850 Home Address: 250 MELVIN ST City/State/Zip: BIG SANDY, WV 24816 Country: USA Mailing Address: PO BOX 46	
Living With:			
City/State/Zip: BIG SANDY, WV 24816 Country: USA			
MOTHER INFORMATION			
Name: Adams, Kelli DOB: 04/20/91	Home: (681) 729-2017 Alt 1: Alt 2:	Home Address: 250 MELVIN ST City/State/Zip: BIG SANDY, WV 24816 Country: USA	
FATHER INFORMATION			
Name: Adams, Rico DOB: 05/19/90	Home: Alt 1: Alt 2:	Home Address: 250 MELVIN ST City/State/Zip: BIG SANDY, WV 24816 Country: USA	
LEGAL GUARDIAN INFORMATION			
Name: Adams, Kelli Rel to Pat: Mother Sex: Female DOB: 04/20/91	Home: (681) 729-2017 Alt 1: Alt 2:	Home Address: 250 MELVIN ST City/State/Zip: BIG SANDY, WV 24816 Country: USA	
SECONDARY GUARDIAN INFORMATION			
Name: Adams, Rico Rel to Pat: Father Sex: Male DOB: 05/19/90	Home: Alt 1: Alt 2:	Home Address: 250 MELVIN ST City/State/Zip: BIG SANDY, WV 24816 Country: USA	
INSURANCE INFORMATION			
1 Company Name: Other Health Plan Name: Shrine Assistance Other Health Plan Name: Health Plan Phone: (813) 281-0300 Auth Nbr(s):	Subscriber #: _____ Pt. Member #: _____ Rel to Pt: Self Date Verified: _____	Address: 2900 ROCKY POINT DR City/State/Zip: TAMPA, FL 33607 Group Number: Health Plan Type: Uninsured	
2 Company Name: Health Plan Name: Other Health Plan Name: Health Plan Phone: Auth Nbr(s).	Subscriber #: _____ Pt. Member #: _____ Rel to Pt: _____ Date Verified: _____	Address: City/State/Zip: Group Number: Health Plan Type:	
3 Company Name: Health Plan Name: Other Health Plan Name: Health Plan Phone: Auth Nbr(s):	Subscriber #: _____ Pt. Member #: _____ Rel to Pt: _____ Date Verified: _____	Address: City/State/Zip: Group Number: Health Plan Type:	
VISIT INFORMATION			
Admit Date/Time: 11/27/17 15:28 EST Medical Service: Ortho Location: LXT Clinic Care Coordinator:	Admit Clerk: Hatton, Samantha M Enc Type: Outpatient Clinic	Admit Mode: _____ Accident Related Visit?: No Care Manager RN: _____ Social Worker: _____	Admit Type: Elective Room/Bed: / Fain RN, Alison B Hall MSW, George M.
PHYSICIAN INFORMATION			
Referring Physician: Referring, None 4367655 000 Shriners Lane Tampa, FL	Attending Physician: Muchow MD, Ryan David Primary Care Physician: Al-Attar MD, Inas H 5514209 143 Undercliff Terrace Princeton, WV 24740 (304) 487-0415		
PREVIOUS ENCOUNTER INFORMATION		TEMPLE INFORMATION	
07/25/18 12:40 EDT 07/24/17 14:18 EDT 05/01/17 14:07 EDT 03/21/17 13:18 EDT	Outpatient Clinic Outpatient Clinic Outpatient Clinic Outpatient	Muchow MD, Ryan David Muchow MD, Ryan David Muchow MD, Ryan David Muchow MD, Ryan David	Referring Temple: _____ Coord Temple: Beni Kedem Referring Shriner: _____ Coord Shriner: _____

Adams, Nevaeh Hope Female / 3 Years MRN: 3279454 FIN: 8564850



8564850

(PROD. SHCIS_FACESHEET_XR_PDF)

PATIENT ADMIT RECORD

12/31/18 09:19

**EXHIBIT NO. B5F
PAGE: 5 OF 6**



Shriners Hospitals for Children 9 8 1 0 7 0 0 0 0 4 5 8
 Lexington Outpatient Specialty Care Center
 110 Conn Terrance
 Lexington, KY 40508-3206

Progress Notes

DOCUMENT NAME: Outpatient Progress Note
 SERVICE DATE/TIME: 11/27/2017 16:39 EST
 RESULT STATUS: Auth (Verified)
 PERFORM INFORMATION: Wattles MD,Mitchell R (11/27/2017 16:39 EST)
 SIGN INFORMATION: Muchow MD,Ryan David (12/4/2017 12:41 EST); Wattles MD,
 Mitchell R (11/29/2017 08:34 EST)

LXT Outpatient Note

PATIENT: Adams, Nevaeh H MRN: 3279454

EXAM DATE: 11/27/2017

ATTENDING PROVIDER: Ryan David Muchow MD

DICTATING PROVIDER: Mitchell R Wattles MD

SUBJECTIVE:

Nevaeh is a 2-year-old female with a history of Turner syndrome and bilateral congenital hip dislocations. She presents to the clinic for followup today. She has been followed by us now with radiographs to evaluate her bilateral hips. She was last seen in our clinic to have well-seated hips with the presence of bilateral ossific nuclei in appropriate position, and it was deemed appropriate to continue therapy without any form of bracing, as the patient likely would not be able to tolerate this. Per mother today, she states that Nevaeh is doing well and is not having any problems with pain when ambulating, and is acting as normal. Mother does think that her hips might be a little stiff, but otherwise does not seem to have any problems. Patient has continued to do well otherwise

PHYSICAL EXAMINATION:

Patient is resting comfortably today in the exam room, alert, with appropriate affect, and in no acute distress. Patient has stable hips on internal and external rotation, with good flexion and extension at the bedside. Patient has grossly intact motor and sensation in the bilateral lower extremities. She has warm and well-perfused extremities.

RADIOGRAPHS:

Radiographs today were obtained, AP pelvis, which again demonstrates bilateral proximal femurs reduced within the acetabular cups, with increased size in the ossific nuclei of the femoral heads.

Patient Name: Adams, Nevaeh Hope
 Admit Date: 11/27/2017 15:28 EST
 Attending: Muchow MD,Ryan David
 MRN: 3279454
 FIN: 008564850
 DOB: 7/21/2015 Gender: Female

This document contains Confidential Patient Information from the SHCIS Medical Record. This information is not for general use and should only be used and/or disposed of in accordance with SHC Policies and Procedures pertaining to the protection of Patient Privacy and Confidentiality.

User ID: Grosenbaugh,Brenda M

Report Request ID: 33647678

Page 2 of 3

Print Date/Time: 12/31/2018 09:19 EST

EXHIBIT NO. B5F
PAGE: 6 OF 6

Shriners Hospitals for Children
Lexington Outpatient Specialty Care Center

Progress Notes

There appears to be slight increased acetabular coverage of the hips compared to last time.

IMPRESSION:

Nevaeh is a 2-year-old female with a history of Turner syndrome and bilateral hip dislocations, status post bilateral open reduction and adductor tenotomies in January 2017.

PLAN:

We discussed with the parent today that we are satisfied with the current progress of her hips. We will continue to manage them in the same way and observe for acetabular coverage, without the use of any braces at this time. We will plan to see the patient back in 6 months' time with repeat AP of the pelvis at that time.

DD: 11/27/2017 16:39:51EST

TD: 11/28/2017 13:53:42EST/sr

Attestation Statement: I saw the patient with the resident/fellow. I discussed the case with the resident/fellow and agree with the findings and plan as documented in the resident's/fellow's note.

Electronically Signed: Wattles MD, Mitchell R

Sign Date and Time: 11/29/2017 08:34 EST

Electronically Signed: Muchow MD, Ryan David

Sign Date and Time: 12/04/2017 12:41 EST

Patient Name: Adams, Nevaeh Hope

MRN: 3279454

DOB: 7/21/2015 Gender: Female

This document contains Confidential Patient Information from the SHCIS Medical Record. This information is not for general use and should only be used and/or disposed of in accordance with SHC Policies and Procedures pertaining to the protection of Patient Privacy and Confidentiality.

User ID: Grosenbaugh,Brenda M

Report Request ID: 33647678

Page 3 of 3

Print Date/Time: 12/31/2018 09:19 EST

EXHIBIT NO. B6F
PAGE: 1 OF 239

Patient Encounter(s) History Report Dec 28, 2018@14:29

(From: 05/08/18 --- Thru: 05/09/18)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
 HOSP : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B6F
PAGE: 2 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006408611
ADM: May 08,2018 20:31

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 3 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
ATTENDING:

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (MEDICAL RECORDS ASSISTANT)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J
Observed/Historical: Historical
==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 4 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
ATTENDING:

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 5 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
ATTENDING:

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----
DATE OF NOTE: MAY 8, 2018@20:40 ENTRY DATE: MAY 8, 2018@20:40:06
AUTHOR: HALE, ACHIA D EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ ACHIA D HALE
OFFICE ASSISTANT
Signed: 05/08/2018 20:40

**EXHIBIT NO. B6F
PAGE: 6 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006408611
 ADM: May 08,2018 20:31



ADAMS, NEVAEH	ACT# : 006408611
ADM : 5/08/18	MED# : 139580
DOB : 7/21/2015	FC : CO
SEX : F	AGE : 2 yr
SER : WIC	DR : CYCO, JOSE

WELCH COMMUNITY HOSPITAL
454 McDOWELL STREET
WELCH, WV 24801

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

EXHIBIT NO. B6F
PAGE: 7 OF 239

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

- 5. HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
 - 6. OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

ADAMS, NEVAEH
ADM : 5/08/18 ACT# : 006408611
DOB : 7/21/2015 MED# : 138580
SEX : F FC : CO
SER : WIC DR : 0YCO.JNSL AGE : 2 yr

EXHIBIT NO. B6F
PAGE: 8 OF 239

7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

If you would like to Opt out of HIV testing, please initial the box to the left.

There may be some instances where patients are not allowed to opt out for further information please refer to the information sheet given to you upon registration.

8. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: _____

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

9. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

ADAMS, NEVAEH
ADM: 510818 ACT# : 006408811
DOB: 7/21/2015 MED# : 138580
SEX: F FC: CO
SER: WIC DR: OYCO, JOSE
AGE: 2 YR

**EXHIBIT NO. B6F
PAGE: 9 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
ATTENDING:

----- IDENTIFICATION CARD/DRIVERS LICENCE -----
DATE OF NOTE: MAY 8, 2018@20:40 ENTRY DATE: MAY 8, 2018@20:40:20
AUTHOR: HALE, ACHIA D EXP COSIGNER:
URGENCY: STATUS: COMPLETED

ID unavailable

/es/ ACHIA D HALE
OFFICE ASSISTANT
Signed: 05/08/2018 20:40

----- INSURANCE CARD -----
DATE OF NOTE: MAY 8, 2018@20:39 ENTRY DATE: MAY 8, 2018@20:39:46
AUTHOR: HALE, ACHIA D EXP COSIGNER:
URGENCY: STATUS: COMPLETED

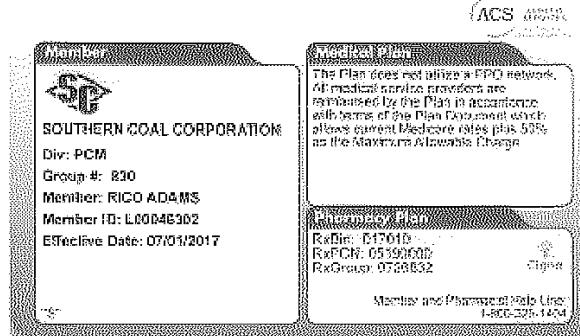
Insurance Card attached as scanned image.
INSURANCE CARD BACK (SCANNED) :

/es/ ACHIA D HALE
OFFICE ASSISTANT
Signed: 05/08/2018 20:40

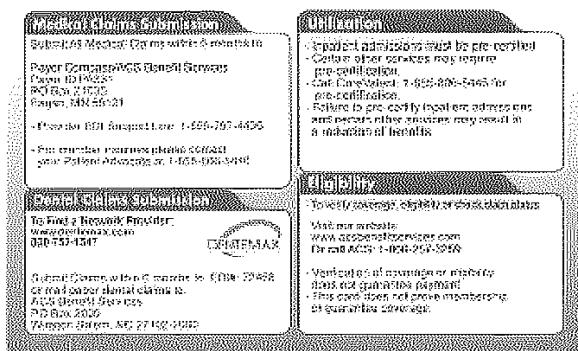
**EXHIBIT NO. B6F
PAGE: 10 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006408611
ADM: May 08, 2018 20:31



**EXHIBIT NO. B6F
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**EXHIBIT NO. B6F
PAGE: 12 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006408611
 ADM: May 08, 2018 20:31

Eligibility Information

Page 1 of 1

Eligibility Verification

From Inquiry Member Search Eligibility Verification

Eligibility Inquiry verifies whether a member was eligible for a covered program on the date(s) of service submitted in the request. This information does not guarantee eligibility or payment for the service rendered.

Member

Name	Date of Birth	Member ID	Gender
ADAMS, NEVAEH H	07/21/2015	03456164205	Female
Training Number		10222W000057243	

Eligibility Inquiry

Dates of Service (DOS)

* From Date Of Service 05/08/2018

* To Date Of Service 05/08/2018

* Inquiry Type Date Span Only



SEARCH

Enrollments

Program/Benefit Name	Coverage Status	Coverage Level	Plan Type	Effective Date	Termination Date	Member ID
- Medicaid Benefit Plan	Active	Primary	Medicare	05/01/2018	05/01/2018	03456164205
Rate Cads	Coverage	Effective Date	Termination Date			
FCMGRF	Categorically Needs	05/01/2018	05/31/2018			
FCAMGRF	tier 1 Copay	05/01/2018	05/31/2018			

Other Insurance

No Co-insurance of Benefits information found

Copay

It is the member's responsibility to pay the copay to the provider at the time of the service. Copays are at the benefit level (not individual service lines).

Reporting for claims with a Date of Service on or after May 08, 2018, copays for this member are:

Service	Copay Amount	Effective Date	Termination Date	Tier
N/A	\$0	05/08/2018	05/31/2018	Member is exempt

PCP / Medical Home

No PCP / Medical Home information found for this member

Lock-In

No Lock-In information found for DOS range requested

Spend Down

No Spend Down information found at this time

SEARCH

**EXHIBIT NO. B6F
PAGE: 13 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
ATTENDING:

----- PRESENTING SHEET (SCANNED) -----
DATE OF NOTE: MAY 8, 2018@20:39 ENTRY DATE: MAY 8, 2018@20:39:55
AUTHOR: HALE, ACHIA D EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ ACHIA D HALE
OFFICE ASSISTANT
Signed: 05/08/2018 20:40

**EXHIBIT NO. B6F
PAGE: 14 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006408611
 ADM: May 08, 2018 20:31

RURAL HEALTH CLINIC REGISTRATION FORM (OUTPATIENT)					
NAME:	Nevaeh Adams		TODAY'S DATE:		
TIME:	8:30	AGE:	2	BIRTHDAY:	7-21-15
CHIEF COMPLAINT (TELL US WHY YOU ARE HERE)					
<u>Pulling at Right ear, runny nose</u> <u>doesn't wanna eat</u>					
DISPOSITION:	WIC	PEDS	IM		
REGISTRATION COMPLAINT:	(Pneumonia)				
NURSE:	B. Jumel Jr.		TIME:	00:35	
			ADAMS, NEVAEH ADM: 5M001B ACT#: 006408611 MED#: 138580 DOB: 7/21/2015 FC: CO SEX: F AGE: 2 yr SER: WIC DR: BYCD, JOSE		

**EXHIBIT NO. B6F
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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
ATTENDING:

----- CODING ABSTRACT FORM (SCANNED) -----
DATE OF NOTE: MAY 8, 2018@12:13 ENTRY DATE: MAY 14, 2018@12:13:32
AUTHOR: PRUITT, STANLEY EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Coding Abstract Form(s).

/es/ STANLEY PRUITT
OFFICE ASSISTANT
Signed: 05/14/2018 12:14

**EXHIBIT NO. B6F
PAGE: 16 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006408611
 HOSP : WELCH COMMUNITY HOSPITAL ADM: May 08,2018 20:31
 ATTENDING:

DATE: 05/11/2018 WELCH HOSPITAL TIME: 03:51 PM
 PAGE: 1 OF 1 CODING SUMMARY - INPT

Patient Name: ADAMS, NEVAEH H MR #: 000138580 PAT #: 006408611

 Sex: F Admitted: 5/08/18
 Birthdate: 7/21/2015 Discharged: 5/08/18
 Age at Admit: 002 LOS: 1
 Attending Phys: 649228 OYCO, JOSE UB92 Disp: 01

 Current DRG: Outlier: 0

Diagnoses POA MOD HAC Description

 1. H66.93 Otitis media, unspecified, bilateral
 2. J30.9 Allergic rhinitis, unspecified

Date CPT Modifiers Description

 1. 05/08/18 99213 OFFICE/OUTPATIENT VISIT EST

To Attending Physician: Please review the above diagnoses and procedures and notify Health Information Management if there are any discrepancies or any inaccuracies. Thank you !!

**EXHIBIT NO. B6F
PAGE: 17 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
ATTENDING:

----- PRESCRIPTION COPY (SCANNED) -----
DATE OF NOTE: MAY 8, 2018@10:46 ENTRY DATE: MAY 9, 2018@10:46:28
AUTHOR: HALE, DIANNE M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned copy of Prescription(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 05/09/2018 10:46

**EXHIBIT NO. B6F
PAGE: 18 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006408611
 ADM: May 08, 2018 20:31

40535 WELCH COMMUNITY HOSPITAL
 Supervisor, Jose L. Cyco MD Julietta Sison, PA-C
 WV Lic# _____ NPI# (305) 630-3211 DEA# MS2130718
 Exp. _____ 454 McDowell St., Welch, WV 24801 (304) 436-8481

Name Nevaeh Adams Date 5-8-18
 Address _____
 Prescriber Jose L. Cyco MD Rx # 40535
 THIS PRESCRIPTION MAY BE FILLED WITH A CHEMICALLY EQUIVALENT DRUG PRODUCT UNDER THE SAME OR SIMILAR NAME AS THE PRESCRIBED PRODUCT. THE PRESCRIBER IS ADVISED THAT THE PRESCRIBED PRODUCT IS THE PREFERRED PRODUCT AND THAT THE PRESCRIBER IS RESPONSIBLE FOR THE MEDICAL DECISIONS MADE IN THE TREATMENT OF THE PATIENT.
 THIS IS A SECURITY RX

Cefdinri 250 mg susp
disp 3 g 2 ml q12h X 10 days
40 ml

Size 40 ml Refill No 1 2 3 4 5 jl

1-24
 25-49
 50-74
 75-100
 101-150
 151 and over

Prescription is void if more than one (1) prescriber is written per blank.

ADAMS, NEVAEH
 ADM: 5/08/18 ACT#: 006408611
 NUD#: 139590
 DOB: 7/21/2015 FC: CD
 SEX: F AGE: 2 yr
 SER: WIC DR: CYCO, JOSE

EXHIBIT NO. B6F
PAGE: 19 OF 239

40536 WELCH COMMUNITY HOSPITAL
 Supervisor, Jose L. Dyco MD Julietta Sison, PA-C
 WV Lic# 454 McDowell St., Welch, WV 24801 NPI# 1306683921
 Exp. (304) 436-6461 DEA# MS2130716

Name Nevaeh Adams Date 5-8-18

Address 100 1st Street, Welch, WV 24801
 THIS PRESCRIPTION MAY BE FILLED WITH A GENERICALLY EQUIVALENT DRUG PRODUCT UNLESS THE WORDS "STAND TO ORDER" OR THE
 WORDS "PRESCRIBED AS SPECIFIED" ARE WRITTEN IN THE PRESCRIPTION OR ON THE PRESCRIPTION FORM.
 THIS IS A SECURITY RX.

Cetirizine 5mg/15ml

Sac 2.5 ml daily
 due 20 ml

Refill NR 1 2 3 4 5

- 1-24
- 25-48
- 50-74
- 75-100
- 101-150
- 151 and over

Prescription is void if more than one (1) prescription is written per blank.

ADAMS, NEVAEH
 ADM: 500818 ACT#: 008408811
 MEOF: 139583
 DOB: 7/21/2015 FC: CO
 AOE: 2 yr
 SEX: F
 SER: WIC DR: DYCO, JOSE

**EXHIBIT NO. B6F
PAGE: 20 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006408611
ADM: May 08,2018 20:31

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----
DATE OF NOTE: MAY 8,2018@10:43 ENTRY DATE: MAY 9,2018@10:43:25
AUTHOR: HALE, DIANNE M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 05/09/2018 10:43

**EXHIBIT NO. B6F
PAGE: 21 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006408611
 ADM: May 08, 2018 20:31

RURAL HEALTH CLINIC

Name: Nevaeh Adams Age: 2 DOB: 7-21-15

Date/Time of Arrival: 2030

Reason for Visit: 9/c pulling @ R ear x 2 days
runny nose, lack of appetite

ALLERGIES Amoxicillin

Vitals: BP _____ HR 137 RR 24 Temp 98.7 Pulse Ox 98 % Ipm
 Pain (0-10) _____ Location _____ Wt. 28.9 Ht. _____ LMP _____

Medical History:

Asthma Gout: CHF: COPD: CVA Diabetes
 HTN Hyperlipidemia: Psych: Renal: Seizures

Other: Turner Syndrome, leaking aortic, hip dysplasia

Date of last mammogram _____ Date of last papsmear _____

Date of last colonoscopy _____

Surgical History:

Appendix Cardiac/Stent Gallbladder Hysterectomy BTL
 Other: hip

Social History: smoker ppd/never/quit drugs alcohol none/ recent/occasional

Primary Care Provider: Algar

Nurse Signature: B. Jester

******PATIENT REQUIRES HIGHER LEVEL OF CARE******

Focus assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider _____ Date _____ Time _____

Original 2-2017

ADAMS, NEVAEH
 ADM: 5/08/18
 ACT# : 006408611
 MED# : 139580
 DOB : 7/21/2015
 FG : CO
 SEX : F AGE : 2 yr
 SER : WIC DR : DYCD, JOSE

**EXHIBIT NO. B6F
PAGE: 22 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
ATTENDING:

----- CLINIC NOTE (SCANNED) -----
DATE OF NOTE: MAY 8, 2018@10:42 ENTRY DATE: MAY 9, 2018@10:42:55
AUTHOR: HALE, DIANNE M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Clinic Note(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 05/09/2018 10:43

**EXHIBIT NO. B6F
PAGE: 23 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006408611
 ADM: May 08, 2018 20:31

Circle or check affirmatives, backslash (/) negatives.

14 Welch Community Hospital RHC
URGENT CARE RECORD
Pediatric Illness+

DATE: 5/8/18 **TIME:** 20:30 **ROOM:** WLC

HISTORIAN: patient parent caregiver

MODE OF ARRIVAL: ambulatory other

chief complaint: fever cough / congested fussy pulling ears
 not eating loss active vomiting diarrhea rash ingestion
fussy now, pulling ears

HPI

onset / duration: min / hrs / days ago continues in clinic
X 2 days gone now / better
 intermittent / worse

context: sick contacts home school other

fugrant ear infection

severity: fever to °F / °C oral rectal axillary TM
 not measured subjective none noted

associated symptoms:

acting differently
not crying more not sleeping less active inconsolable
 drinking / eating less
not drinking last feeding / liquids
decreased urination last urinated
 sleeping more

Similar symptoms previously

Recently seen / treated by doctor / hospitalized

ADAMS, NEVAEH
 ADM: 5/08/18 ACT #: 006408611
 MED#: 138580
 DOB: 7/21/2015 EC: CO
 SEX: F AGE: 2 yr
 SER: WRC DR: OYCO, JOSE

ROS

ENT <i>pulling at ears RT/L</i>	CVS palpitations _____
skin <i>red eyes discharge</i>	NEURO seizure _____
RESPIRATORY <i>cough</i>	MS extremity pain / swelling _____
GI <i>vomiting / diarrhea</i>	SKIN rash _____
abdominal distention	facial trunk extremities diffuse <i>diaper rash</i>
blood in stools	Lymph swollen glands _____
GU <i>painful / swollen genital area</i>	PSYCH <i>anxiety / depression</i>
LNMP <i>preg premenstrual</i>	

except as marked positive, all systems above reviewed and found negative

PAST HX

Birth Hx <i>birth wt. _____</i>	ear infection(s) <i>febrile seizure</i>
complications at birth <i>premature birth wks</i>	pharyngitis
diabetes Type I insulin	pneumonia
asthma	seizure disorder
bronchitis / bronchiolitis	sickle cell disease
cardiac problems	urinary tract infection(s)
congenital heart disease	
development delay	

Tunner Sander, brak arthie valle, hip, dysplasia

Surgeries / Procedures *none*

VP shunt *hip*

Immunizations: UTD / referred to PCP

Medications <i>none</i>	Allergies <i>NKDA</i>
<i>aspirin ibuprofen acetaminophen</i>	<i>soo nurses note</i>
<i>last dose</i>	<i>Anexxa</i>

SOCIAL HX *smoker / 2nd hand exposure*

alcohol (recent / occasional) *drugs*

attends daycare / school *caretaker / foster care*

FAMILY HX *adopted*

**EXHIBIT NO. B6F
PAGE: 24 OF 239**

PHYSICAL EXAM	
General Appearance	
<input checked="" type="checkbox"/> acute distress	mild / moderate / severe distress
<input checked="" type="checkbox"/> active / playful / smiles	fussy / crying / cries on exam / irritable
<input checked="" type="checkbox"/> alertiveness nml	lethargic / weak cry
<input checked="" type="checkbox"/> good eye contact	
<input checked="" type="checkbox"/> sleeping/easily aroused	
INFANTS:	
<input checked="" type="checkbox"/> nml consolability	poor consolability / poor intake suck
<input checked="" type="checkbox"/> nml feeding / suck	poor muscle tone
<input checked="" type="checkbox"/> flat anter. fontanel	closed / bulging / sunken anter. fontanel
HEENT	
<input checked="" type="checkbox"/> conjunct. & lids nml	tenderness / swelling
<input checked="" type="checkbox"/> PERRL	conjunctal icterus / injected conjunctivae
<input checked="" type="checkbox"/> ears nml	EOM palsy / anisocoria / conjunctival exudate
<input checked="" type="checkbox"/> nose nml	sunken eyes / photophobia
<input checked="" type="checkbox"/> pharynx nml	TM symptoms / fullness (R/L)
<input checked="" type="checkbox"/> moist mucous membranes	loss of TM landmarks (R/L)
<input checked="" type="checkbox"/> nose nml	TM obscured by wax (R/L)
<input checked="" type="checkbox"/> pharynx nml	rhinorrhea / purulent nasal drainage
<input checked="" type="checkbox"/> moist mucous membranes	pharyngeal erythema / tonsillar exudate
<input checked="" type="checkbox"/> nose nml	ulcerations / vesicles
<input checked="" type="checkbox"/> pharynx nml	drooling / trismus / mass
<input checked="" type="checkbox"/> moist mucous membranes	dry mucous membranes
NECK	
<input checked="" type="checkbox"/> supple	meningismus / Brudzinski / Kernig's
<input checked="" type="checkbox"/> no masses	lymphadenopathy
RESPIRATORY	
<input checked="" type="checkbox"/> no resp. distress	respiratory distress
<input checked="" type="checkbox"/> breath sounds nml	retractions / accessory muscle use
CVS	
<input checked="" type="checkbox"/> reg. rate & rhythm	prolonged expiration
<input checked="" type="checkbox"/> heart sounds nml	grunting (infants)
<input checked="" type="checkbox"/> strong periph pulses	stridor
<input checked="" type="checkbox"/> nml capillary refill	wheezes / rales / rhonchi
ABDOMEN	
<input checked="" type="checkbox"/> non-tender	tenderness / guarding / rebound
<input checked="" type="checkbox"/> no distention	hepatomegaly / splenomegaly / mass
<input checked="" type="checkbox"/> no organomegaly	abnml bowel sounds
GENITALIA	
<input checked="" type="checkbox"/> nml inspection	discharge / erythema / swelling / tenderness
<input checked="" type="checkbox"/> circumcised (male)	testes undescended
<input checked="" type="checkbox"/> uncircumcised (male)	hernia
EXTREMITIES	
<input checked="" type="checkbox"/> non-tender	tenderness
<input checked="" type="checkbox"/> nml ROM	
SKIN	
<input checked="" type="checkbox"/> no rash / lesions	cyanosis / diaphoresis / pallor / icterus
<input checked="" type="checkbox"/> no petechiae	poor skin turgor
<input checked="" type="checkbox"/> normal color	diaper rash / skin rash
<input checked="" type="checkbox"/> warm, dry	urticarial exanthem / impetigo / vesicular form
<input checked="" type="checkbox"/> facial asymmetry	scarlatiniform morbilliform erythematous vesicular crusted skin lesions
<input checked="" type="checkbox"/> sensory nml	
<input checked="" type="checkbox"/> motor nml	sensory loss / weakness
<input checked="" type="checkbox"/> CN's nml (2-10)	depressed mood / affect
<input checked="" type="checkbox"/> mood / affect nml	
ADDITIONAL NOTES	

Pediatric Illness - 14 • Reportable Measure

ADAMS, NEVAEH

ADM : 5/08/18 ACT# : 008408611
 DOB : 7/21/2015 MED# : 138590
 FC : CO
 SEX : F AGE : 2 yr
 SER : WIC ... OR : OYCO, JOSE

LABS & XRAYS

CBC _____ UA _____
 BMP _____ Preg _____

XRAYS Interp. by me Viewed by me Discsd w/ radiologist
 CXR _____ nml / NAD _____ no infiltrates _____ nml heart size _____ nml mediastinum

Other _____

PROCEDURES

LP _____ discussed risks, benefits, alternatives; parent/guardian consents.
 Time: _____ fluid color: _____ RBC: _____ WBC: _____
 betadine prep glucose: _____ polys: _____ lymph: _____
 L3-4 L4-5 protein: _____ monos: _____ gm stn: _____

PROGRESS

Time: _____ unchanged improved re-examined

- ♦ Pharyngitis - 3y-18y / strep A test / antibiotic
- ♦ URI - 3m-18y / No antibiotic
- measure exclusions: refused / not indicated / indicated / contraindicated / not available / dispensed

CLINICAL IMPRESSION

Fever	Meningitis
Vomiting / Diarrhea	Otitis Media - R/L
Dehydration	♦ Pharyngitis - Strep / Mono
Asthma / Reactive Airway Disease	Pneumonia (location)
acute exacerb. status asthmaticus	Sepsis / SIRS - severe
Bronchitis / Bronchiolitis - RSV	Septic Shock
Croup	Sinusitis
Gastroenteritis / Enteritis	♦ Upper Respiratory Infection
Hypoxemia	UTI / Pyelonephritis
Ingestion	Viral Syndrome
Influenza seasonal HINI	Other

TREATMENT PLAN / DISCHARGE MEDICATION

Cefazolin 50 mg

Discussed with Dr. _____ will see patient in: office / clinic / hospital
 Counselled patient / family regarding: lab results diagnosis need for follow-up smoking/drug/alcohol cessation *for only cold*

Time spent counseling: _____ minutes Admit orders written: _____

DISPOSITION: home admit transfer *2100*

FOLLOW-UP: PCP return to clinic *yesterday*

CONDITION: unchanged Improved stable

total face-to-face time: _____ minutes

I have reviewed the chart and agree with the documentation as recorded by the MLP, including the assessment, treatment plan, and disposition.

I personally evaluated and examined the patient in conjunction with the MLP and agree with the management and disposition of the patient.

Template Complete

Rev. 09/16

SYSTEM © 1996 - 2016 T-System, Inc.

NP / PA C

MD / DO

**EXHIBIT NO. B6F
PAGE: 25 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
ATTENDING:

----- MEDICATION RECONCILIATION (SCANNED) -----
DATE OF NOTE: MAY 8, 2018@10:42 ENTRY DATE: MAY 9, 2018@10:43:10
AUTHOR: HALE, DIANNE M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 05/09/2018 10:43

**EXHIBIT NO. B6F
PAGE: 26 OF 239**

Name : ADAMS, NEVAEH H
DOB / SEX : JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN : WEL000138580
ACT: WEL006408611
ADM: May 08, 2018 20:31

**WELCH COMMUNITY HOSPITAL
MEDICATION RECONCILIATION FORM**

ADAMS, NEVAEH
ADM: 5/08/18 ACT#: 006408611
DOB: 7/21/2015 MED#: 138580
SEX: F FC: CO AGE: 2 yr
SER: WIC DR: OYCO, JOSE

Name: Allergies:	<input type="checkbox"/> Patient is on no medications at this time						
---------------------	--	--	--	--	--	--	--

LIST BELOW ALL OF THE PATIENT'S MEDICATION PRIOR TO ADMISSION INCLUDING OVER-THE-COUNTER AND HERBAL MEDS

Name of Medication/Dose	Amount	Route	Frequency	Last Dose	Reason for Medication	Continue on Admission	Continue after Surgery or Transfer	Continue on Discharge
1. Cough hormone	/	by mouth / topical Inject / inhale	3X Q Week Times a day as needed			Y N	Y N	Y N
2.		by mouth / topical Inject / inhale	times a day as needed			Y N	Y N	Y N
3.		by mouth / topical Inject / inhale	times a day as needed			Y N	Y N	Y N
4.		by mouth / topical Inject / inhale	times a day as needed			Y N	Y N	Y N
5.		by mouth / topical Inject / inhale	times a day as needed			Y N	Y N	Y N
6.		by mouth / topical Inject / inhale	times a day as needed			Y N	Y N	Y N
7.		by mouth / topical Inject / inhale	times a day as needed			Y N	Y N	Y N
8.		by mouth / topical Inject / inhale	times a day as needed			Y N	Y N	Y N
9.		by mouth / topical Inject / inhale	times a day as needed			Y N	Y N	Y N
10.		by mouth / topical Inject / inhale	times a day as needed			Y N	Y N	Y N

NEW MEDICATIONS ADDED

Date	Name of Medication/Dose	Amount	Route	Frequency	Duration	Reason	Provider Name
5/8/18	Notizine 5mg	2.5ml	by mouth/topical/inject/inhale	1 times a day as needed	Days	Notizine Offistnd. J. Sison	
5/8/18	Cetaphil oschy	2ml	by mouth/topical/inject/inhale	> times a day as needed	Days		
			by mouth/topical/inject/inhale	times a day as needed	Days		
			by mouth/topical/inject/inhale	times a day as needed	Days		
			by mouth/topical/inject/inhale	times a day as needed	Days		
			by mouth/topical/inject/inhale	times a day as needed	Days		
			by mouth/topical/inject/inhale	times a day as needed	Days		
			by mouth/topical/inject/inhale	times a day as needed	Days		

Source of Medication List

- Patient Medication List
- Patient/Family Recall
- Pharmacy:
- Primary Care Physician List
- Previous Discharge Paperwork
- Reconciled from patient's Medication bottles
- Reconciliation Prescriber (MD/DO)

Medication List Recorded/Reviewed by RN/MD/DD/PA/NP/LPN/RPh

By: B. Day Date: 5/8/18
 By: _____ Date: _____
 By: _____ Date: _____
 By: _____ Date: _____

Physician _____ Date _____

Physician _____ Date _____

Revised 2/13

**EXHIBIT NO. B6F
PAGE: 27 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

*** END ***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 28 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006408611
ADM: May 08,2018 20:31

***** CONFIDENTIAL ORDERS SUMMARY *****

Order Date: St: Requestor: Start Date: Stop Date:
Nature of Order: Signature:
Item Ordered:
=====

*** END ***** CONFIDENTIAL ORDERS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 29 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006408611
ADM: May 08,2018 20:31

***** CONFIDENTIAL LAB RESULTS SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL LAB RESULTS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 30 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006408611
ADM: May 08,2018 20:31

***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 31 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006408611
ADM: May 08,2018 20:31

***** CONFIDENTIAL DISCHARGE SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL DISCHARGE SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 32 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
HOSp : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
ATTENDING:

***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 33 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006408611
HOSp : WELCH COMMUNITY HOSPITAL ADM: May 08, 2018 20:31
ATTENDING:

ADRs: No ADRs on file.

Allergies: PENICILLIN
=====

****NO MEDICATIONS FOUND****

*** END ***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

{{{ END }}} Patient Encounter(s) History Report Dec 28, 2018@14:29

**EXHIBIT NO. B6F
PAGE: 34 OF 239**

Patient Encounter(s) History Report Dec 28, 2018@14:30

(From: 06/23/18 --- Thru: 06/24/18)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006412234
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 23, 2018 12:09
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B6F
PAGE: 35 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23,2018 12:09

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 36 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23, 2018 12:09

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (MEDICAL RECORDS ASSISTANT)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J

Observed/Historical: Historical

==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 37 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23,2018 12:09

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 38 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006412234
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 23, 2018 12:09
ATTENDING:

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- CODING ABSTRACT FORM (SCANNED) -----
DATE OF NOTE: JUN 28, 2018@12:50 ENTRY DATE: JUN 28, 2018@12:50:45
AUTHOR: WELLMAN, MELISSA J EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Coding Abstract Form(s).
DATE: 06/28/2018 WELCH HOSPITAL TIME: 12:45 PM

PAGE: 1 OF 1 CODING SUMMARY - INPT

Patient Name: ADAMS, NEVAEH H MR #: 000138580 PAT #: 006412234

Sex: F Admitted: 6/23/18

Birthdate: 7/21/2015 Discharged: 6/23/18

Age at Admit: 002 LOS: 1

Attending Phys: 629574 COWANS, RODNEY UB92 Disp: 01

Current DRG: Outlier: 0

Diagnoses POA MOD HAC Description

- 1. H66.92 Otitis media, unspecified, left ear
2. H10.30 Unspecified acute conjunctivitis, unspecified eye
3. L22 Diaper dermatitis

Date CPT Modifiers Description

- 1. 06/23/18 99213 OFFICE/OUTPATIENT VISIT EST

To Attending Physician: Please review the above diagnoses and procedures and
notify Health Information Management if there are any discrepancies or any
inaccuracies. Thank you !!

/es/ MELISSA J WELLMAN
MEDICAL RECORDS ASSISTANT, LPN
Signed: 06/28/2018 12:50

----- PRESCRIPTION COPY (SCANNED) -----
DATE OF NOTE: JUN 23, 2018@13:53 ENTRY DATE: JUN 24, 2018@13:53:56
AUTHOR: VAUGHN, MEGHAN T EXP COSIGNER:
URGENCY: STATUS: COMPLETED

**EXHIBIT NO. B6F
PAGE: 39 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23,2018 12:09

See attached scanned copy of Prescription(s).

/es/ MEGHAN T VAUGHN
OFFICE ASSISTANT
Signed: 06/24/2018 13:54

**EXHIBIT NO. B6F
PAGE: 40 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006412234
 ADM: Jun 23, 2018 12:09

ADAMS, NEVAEH
 ADM: 62318 ACT: 009412234
 MEG#: 138580
 DOB: 7/21/2015 FC: CO
 SEX: F AGE: 2 yr
 SER: WIC DR: COWANS, RODNEY

1130 WELCH COMMUNITY HOSPITAL
 SHIRLEY REPASS, FNP
 WV Lic# RXA 1487 DRA# MR0924577
 454 McDowell St. 6/26/2018 Welch, WV 24801
 (304) 436-8401

Name Nevaeh Adams
 Address wt: 32 Date 6/23/18

This PRESCRIPTION MAY BE FILLED WITH A GENERIALLY EQUIVALENT ERGUS PRODUCT UNLESS WORDS "BRAND NECESSARY" OR THE WORDS "BRAND INDIVIDUALLY NECESSARY" ARE WRITTEN IN THE PRACTITIONER'S OWN HANDWRITING ON THIS PRESCRIPTION FORM.

This is a security R

- 1-24
- 25-49
- 50-74
- 75-100
- 101-150
- 151 and over

Refill # 1 2 3 4 5

Sig Daud

Prescription is void if more than one (1) prescription is written per blank

EXHIBIT NO. B6F
PAGE: 41 OF 239

ADAMS, NEVAEH		ACT# : 008412234
ADM: 012318		MED# : 136580
DOB: 7/21/2015		FC: CO
SEX: F	AGE: 2 yr	
SER: WIC	DR: COWANS, RODNEY	
1128 WELCH COMMUNITY HOSPITAL SHIRLEY REPASS, FNP		
WV, Lic# DVA 1487 454 McDowell St.		Dean MT0024577 Welch, WV 24801
6/26/2018 (304) 436-8461		
Name: Nevaeh Adams		
Address: wt 32		Date 6-23-18
<small>THIS PRESCRIPTION MAY BE FILLED WITH A GENERIALLY EQUIVALENT DRUG PRODUCT UNLESS WORDS "BRAND NECESSARY" OR THE WORDS "BRAND MEDICALLY NECESSARY" ARE WRITTEN IN THE PHARMACIST'S OWN HANDWRITING ON THIS PRESCRIPTION FORM.</small>		
This is a security R cefdinir 250mg 500 515 ml BID x 10 days		
Refill NR	2 3 4 5	
<small>Prescription is void if more than one (1) prescription is written per blank</small>		

EXHIBIT NO. B6F
PAGE: 42 OF 239

1129 WELCH COMMUNITY HOSPITAL
 SHIRLEY REPASS, FNP
 WV, Lic# RXA 1487
 254 McDowell St. Sopb-30-19 (304) 436-8461 DEAF MTR924577
 Welch, WV 24861

Name: Nevaeh Adams Address: Wt 32 Date: 6-23-18

This PRESCRIPTION MAY BE FILLED WITH A DIFFERENTIALLY EQUIVALENT OVER THE COUNTER PRODUCT UNLESS WORDS "BRAND NECESSARY" OR THE WORDS "BRAND MEDICALLY NECESSARY" ARE WRITTEN ON THE PRESCRIPTION FORM.

This is a security R

ofloxacin ophthalmic solution
 5ml + oft Bilateral
 eyes T1D + 7day
 Rx# 1 2 3 4 5 

- 1-24
- 25-49
- 50-74
- 75-100
- 101-150
- 151 and over

Prescription is valid if more than one (1) prescription is written per blank

ADAMS, NEVAEH

ADM: 62318 ADT: 008412234
 MFTM: 138580
 DOB: 7/21/2015 FC: CD
 SEX: F AGE: 2 yr
 SER: WIC DR: COWANS, RONNEY

**EXHIBIT NO. B6F
PAGE: 43 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006412234
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 23, 2018 12:09
ATTENDING:

----- MEDICATION RECONCILIATION (SCANNED) -----
DATE OF NOTE: JUN 23, 2018@13:51 ENTRY DATE: JUN 24, 2018@13:51:24
AUTHOR: VAUGHN,MEGHAN T EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ MEGHAN T VAUGHN
OFFICE ASSISTANT
Signed: 06/24/2018 13:52

EXHIBIT NO. B6F
PAGE: 44 OF 239

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23, 2018 12:09

**WELCH COMMUNITY HOSPITAL
MEDICATION RECONCILIATION FORM**

Name: Allergies:	Patient is on no medications at this time							
LIST BELOW ALL OF THE PATIENT'S MEDICATION PRIOR TO ADMISSION (INCLUDING OVER-THE-COUNTER AND HERBAL MEDS)								
Name of Medication/Date	Amount	Route	Frequency	Last Dose	Reason for Medication	Continue on Admission	Continue after Surgery or Transfer	Continue on Discharge
<i>Arnulf Hormone</i>		by mouth / topical inject / inhale	_____ times a day □ as needed			Y N	Y N	Y N
2.		by mouth / topical inject / inhale	_____ times a day □ as needed			Y N	Y N	Y N
3.		by mouth / topical inject / inhale	_____ times a day □ as needed			Y N	Y N	Y N
4.		by mouth / topical inject / inhale	_____ times a day □ as needed			Y N	Y N	Y N
5.		by mouth / topical inject / inhale	_____ times a day □ as needed			Y N	Y N	Y N
6.		by mouth / topical inject / inhale	_____ times a day □ as needed			Y N	Y N	Y N
7.		by mouth / topical inject / inhale	_____ times a day □ as needed			Y N	Y N	Y N
8.		by mouth / topical inject / inhale	_____ times a day □ as needed			Y N	Y N	Y N
9.		by mouth / topical inject / inhale	_____ times a day □ as needed			Y N	Y N	Y N
10.		by mouth / topical inject / inhale	_____ times a day □ as needed			Y N	Y N	Y N

Source of Medication List

Patient Medication
Patti ADAMS, NEVAEH ACT# : 00041220
Phari ADM : 6/23/18 MEDR : 138580
Prindi FC : CO
Provdc DOB : 7/21/2015 AGE : 2 yr
Recom SEX : F
Serum SCR : WAC DR : COWANS, ROONEY

Medication List Recorded/Reviewed by RN/MD/DO/PA/NP/LPN/RP

By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____
By: _____ Date: _____

Physician _____ **Date** _____

Revised 3/13

**EXHIBIT NO. B6F
PAGE: 45 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23,2018 12:09

----- CLINIC NOTE (SCANNED) -----
DATE OF NOTE: JUN 23,2018@13:51 ENTRY DATE: JUN 24,2018@13:51:46
AUTHOR: VAUGHN,MEGHAN T EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Clinic Note(s).

/es/ MEGHAN T VAUGHN
OFFICE ASSISTANT
Signed: 06/24/2018 13:52

**EXHIBIT NO. B6F
PAGE: 46 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006412234
 ADM: Jun 23, 2018 12:09

Circle or check affirmatives, backslash (\) negatives.

14	Welch Community Hospital RHC
URGENT CARE RECORD	
♦Pediatric Illness♦	

DATE: 6-23-18 TIME 12:24P ROOM: 1
 HISTORIAN: patient parent caregiver
 MODE OF ARRIVAL: ambulatory other
 chief complaint: fever, cough / congested fussy pulling ears
 not eating less active vomiting diarrhea rash ingestion
~~drainage from ear~~
~~diaper rash~~

HPI

onset / duration: 2 min / hrs / days/ yrs. continues in clinic
~~exs.~~
 6 days gone now / better
 intermittent / worse
 contact: sick contacts home school other
~~drainage B. bilateral ears~~
~~Possible ear infection~~
 rash - Buttock 6 days

severity: fever to °F / °C oral rectal axillary TM
 not measured - subjective none noted

associated symptoms:

acting differently
 fussy crying more not sleeping less active inconsolable
 drinking / eating less
 not drinking fast feeding / liquids
 decreased urination fast urinated
 sleeping more

Similar symptoms previously.....

Recently seen / treated by doctor / hospitalized.....

ADAMS, NEVAEH
 ADM: 6/23/18 ACT#: 006412234
 MED#: 138580
 DOB: 7/21/2015 FC: CO
 SEX: F AGE: 2 yr
 SER: WIC DR: COWANS, RODNEY

ROS

ENT	CVS
pulling at ears R / L	palpitations
runny nose	NEURO
sores throat / mouth	seizure
EYES	MS
red eyes / discharge	extremity pain / swelling
RESPIRATORY	SKIN
cough	rash
trouble breathing	facial trunk extremities diffuse
GI	diaper rash
vomiting / diarrhea	LYMPH
abdominal distension	swollen glands
blood in stools	PSYCH
GU	anxiety / depression
painful / swollen genital area	LNMP
problems urinating	preg premenstrual
LNMP	

except as marked positive, all systems above reviewed and found negative

• CONST components also addressed in HPI

reviewed and updated: Past Hx Family Hx Social Hx
 Location: in chart Date:

PAST HX

Birth Hx birth wt	ear infection(s)
complications at birth	febrile seizure
premature birth	pharyngitis
	pneumonia
diabetes Type I / insulin	seizure disorder
asthma	sickle cell disease
bronchitis / bronchiolitis	urinary tract infection(s)
cardiac problems	
congenital heart disease	
development delay	

Surgeries / Procedures

none
 VP shunt *Bilat HIPS*

Immunizations: UTD / referred to PCP

Medications	none	see nurses note	Allergies	NKDA
aspirin	ibuprofen	acetaminophen	see nurses note	
last dose				
<i>Growth Hormone</i>			<i>Anoxit</i>	

SOCIAL HX

smoker / 2nd hand exposure	
alcohol (recent / occasional)	drugs
attends daycare / school	caretaker / foster care

FAMILY HX

adopted	
---------	--

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Rev. 09/16

**EXHIBIT NO. B6F
PAGE: 47 OF 239**

PHYSICAL EXAM	
General Appearance	
<input type="checkbox"/> no acute distress	mild / moderate / severe distress
<input checked="" type="checkbox"/> active / playful / smiles	fussy / crying / cries on exam / irritable
<input type="checkbox"/> attentive/nml	lethargic / weak cry
<input type="checkbox"/> good eye contact	
<input type="checkbox"/> sleeping/easily aroused	
INFANTS:	
<input type="checkbox"/> nml consolability	poor consolability / poor intake suck
<input type="checkbox"/> nml feeding / suck	poor muscle tone
<input type="checkbox"/> flat anter. fontanel	closed / bulging / sunken anter. fontanel
HEENT	
<input type="checkbox"/> conjunct & lids nml	tenderness / swelling
<input checked="" type="checkbox"/> PERL	stclor icterus / injected conjunctivae
<input type="checkbox"/> eyes nml	EOM palsy / anisocoria / conjunctival exudate
	sunken eyes / photophobia
<input type="checkbox"/> nose nml	TM erythema / dullness (R/L)
	loss of TM landmarks (R/L)
<input type="checkbox"/> pharynx nml	TM obscured by wax (R/L)
<input type="checkbox"/> moist mucous membranes	rhinorrhea / purulent nasal drainage
	pharyngeal erythema / tonsillar exudate
	ulcerations / vesicles
	drooling / trismus / mass
	dry mucous membranes
NECK	
<input type="checkbox"/> supple	meningismus / Brudzinski / Kernig's
<input type="checkbox"/> no masses	lymphadenopathy
RESPIRATORY	
<input checked="" type="checkbox"/> resp. distress	respiratory distress
	retractions / accessory muscle use
	prolonged expirations
	decreased air movement
	grunting (infants)
	stridor
	wheezes / rales / rhonchi
<input type="checkbox"/> CVS	murmur grade 1/6 sys / dias
	peripheral pulses weak / thready
	slow cap refill sec
ABDOMEN	
<input type="checkbox"/> non-tender	tenderness / guarding / rebound
<input type="checkbox"/> no distension	hepatomegaly / splenomegaly / mass
<input type="checkbox"/> no organomegaly	abnml bowel sounds
GENITALIA	
<input type="checkbox"/> nml inspection	discharge / erythema / swelling / tenderness
<input type="checkbox"/> circumcised (male)	testes undescended
<input type="checkbox"/> uncircumcised (male)	hernia
EXTREMITIES	
<input type="checkbox"/> non-tender	tenderness
<input type="checkbox"/> nml ROM	
SKIN	
<input type="checkbox"/> no rash / lesions	cyanosis / diaphoresis / pallor / icterus
<input type="checkbox"/> no petechiae	poor skin turgor
<input type="checkbox"/> normal color	diaper rash / skin rash
<input type="checkbox"/> warm, dry	urticaria / eczematous impetiginous variciform scarring / monilial erythematous vesicular crusted skin lesions
NEURO	
<input type="checkbox"/> sensation nml	facial asymmetry
<input type="checkbox"/> motor nml	sensory loss / weakness
<input type="checkbox"/> CN's nml (2-10)	depressed mood / affect
<input type="checkbox"/> mood / affect nml	
ADDITIONAL NOTES	

Pediatric Illness - 14 * Reportable Measure

ADAMS, NEVAEH
 ADM: 6/23/18 ACT# : 006412234
 MED# : 138580
 DOB: 7/21/2015 FC: CO
 SEX: F AGE: 2 yr
 SER: WIC DR: COWANS, RODNEY

LABS & XRAYS	
CBC	UA
BMP	Preg
XRAYS <input type="checkbox"/> Interp. by me <input type="checkbox"/> Viewed by me <input type="checkbox"/> Discrd w/ radiologist	
CXR	
nml / NAD	no infiltrates nml heart size nml mediastinum
Other	

PROCEDURES			
LP	discussed risks, benefits, alternatives; parent/guardian consents.		
Time:	fluid color	RBC	WBC
betadine prep	glucose	polys.	lymph
L3-4 L4-5	protein	monos.	gm/stn

PROGRESS
 Time: unchanged Improved re-examined

- * Pharyngitis - 3y - 1By / strep A test / antibiotic
 - * URI - 3m-1By / No antibiotic
- measure exclusions: refused / not indicated / indicated / contraindicated / not available / dispensed

CLINICAL IMPRESSION

Fever	Meningitis
Vomiting / Diarrhea	Otitis Media - R/L
Dehydration	♦ Pharyngitis - Strep / Mono
Asthma / Reactive Airway Disease	Pneumonia (location)
acute exacerb. status asthmaticus	Sepsis / SIRS - severe
Bronchitis / Bronchiolitis - RSV	Septic Shock
Croup	Sinusitis
Gastroenteritis / Enteritis	♦ Upper Respiratory Infection
Hypoxemia	UTI / Pyelonephritis
Ingestion	Viral Syndrome
Influenza seasonal H1N1	influenza A (H1N1) (2009)
	conjunctivitis, candidiasis, omo

TREATMENT PLAN / DISCHARGE MEDICATION

Rx Cefdinir 100mg po qid

Discussed with Dr. [Signature] 5/5/2017
 will see patient in: office / clinic / hospital [Signature]
 Counselled patient / family regarding:
 lab results need for follow-up smoking / drug / alcohol cessation

Time spent counseling: minutes Admit orders written

DISPOSITION home admit transfer

POLLOW-UP PCP return to clinic

CONDITION unchanged improved stable

total face-to-face time: 10 minutes

- Have reviewed the chart and agree with the documentation as recorded by the MLP, including assessments, treatment plan and disposition.
- I personally evaluated and examined the patient in conjunction with the MLP and agree with the management and disposition of the patient.

[Signature] NP/PA

MD / DO

Template Complete

**EXHIBIT NO. B6F
PAGE: 48 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006412234
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 23, 2018 12:09
ATTENDING:

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----
DATE OF NOTE: JUN 23, 2018@13:50 ENTRY DATE: JUN 24, 2018@13:51:06
AUTHOR: VAUGHN,MEGHAN T EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ MEGHAN T VAUGHN
OFFICE ASSISTANT
Signed: 06/24/2018 13:52

**EXHIBIT NO. B6F
PAGE: 49 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006412234
 ADM: Jun 23, 2018 12:09

RURAL HEALTH CLINIC

Name: Nevae Adams
 Date/Time of Arrival: 6/23/18 12:15

ADAMS, NEVAEH
 ADM: 6/23/18 ACT#: 008412234
 DOB: 7/21/2015 MED#: 138580
 SEX: F FC: CO
 SER: WIC AGE: 2 yr
 DR: COWANS, RODNEY

Reason for Visit:
Bil Eye Drawing x 2 days.
Rash on bottom x 6 days

ALLERGIES Amoxicilllin

Vitals: BP _____ HR 132 RR 28 Temp 98.5 Pulse Ox 98 % lpm
 Pain (0-10) _____ Location _____ Wt. 32 Ht. _____ LMP _____

Medical History:

Asthma Gout: CHF: COPD: CVA Diabetes
 HTN Hyperlipidemia: Psych: Renal: Seizures
 Other: Aortic valve, hip dysplasia

Date of last mammogram _____ Date of last papsmear _____
 Date of last colonoscopy _____

Surgical History:

Appendix Cardiac/Stent Gallbladder Hysterectomy BTI
 Other: hip (BBL)

Social History: smoker ppd/never/guit drugs alcohol/none/recent/occassional

Primary Care Provider: Allstar

Nurse Signature: K. Yarmor

******PATIENT REQUIRES HIGHER LEVEL OF CARE******

Focus assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider _____ Date _____ Time _____

Original 2-2017

**EXHIBIT NO. B6F
PAGE: 50 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006412234
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 23, 2018 12:09
ATTENDING:

----- PRIVACY NOTICE (SCANNED) -----
DATE OF NOTE: JUN 23, 2018@12:28 ENTRY DATE: JUN 23, 2018@12:28:07
AUTHOR: MATNEY, MCKENNA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Privacy notice attached as scanned document.

/es/ MCKENNA M MATNEY
OFFICE ASSISTANT
Signed: 06/23/2018 12:28

**EXHIBIT NO. B6F
PAGE: 51 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006412234
 ADM: Jun 23,2018 12:09

**Bureau for Behavioral Health and Health Facilities (BBHHF)/
WELCH COMMUNITY HOSPITAL**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND
CONSENT TO USE AND DISCLOSE FOR TREATMENT, PAYMENT AND HEALTH
OPERATIONS PURPOSES**

PATIENT/RESIDENT

Name: _____

Date of Birth: _____

ADAMS, NEVAEH

ADM : 6/23/18

ACT# : 006412234

MFD# : 1308380

DOB : 7/21/2015

FC : CR

SEX : F

AGE : 2 yr

SER : WIC

DR : GOWANS, ROBIN Y.

I hereby consent for the BBHHF/Welch Community Hospital to use and disclose my protected health information for treatment, payment and health care operations purposes. These purposes are described, and examples of each purpose are given, in the BBHHF/Welch Community Hospital's attached Notice of Privacy Rights. This also acknowledges that I have received a copy of the BBHHF/Welch Community Hospital Notice of Privacy Practices. This consent does not apply to protected health information for psychotherapy notes and marketing purposes, where an authorization is required under 45 CFR § 164.508. I retain the right to request restrictions on how and to whom the protected health information may be released, although the BBHHF/Welch Community Hospital does not have to accept my restrictions.

A person or organization that receives my information because of this consent may have the legal right to disclose this information to other people or organizations without my knowledge or consent.

The Welch Community Hospital values your privacy of information. However, in the unlikely incidence that a breach or inappropriate access or use of your information occurs, we wish to contact you most expeditiously based on your preferred method of contact.

- US Mail
- By Telephone
- By Email

If this authorization is signed by someone who is not the patient/resident listed at the top of this form, provide a description of the signer's authority to act for the patient.

Type of Authority: _____

Documentation Provided: _____ Yes _____ No

Signature: X Nevaeh Adams Date: 6-23-18

Witness: Elvyn Grey Witness: _____

Disposition: To be filed in the patient's medical record. May also be filed with the Privacy Official.

**EXHIBIT NO. B6F
PAGE: 52 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006412234
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 23, 2018 12:09
ATTENDING:

----- IDENTIFICATION CARD/DRIVERS LICENCE -----
DATE OF NOTE: JUN 23, 2018@12:28 ENTRY DATE: JUN 23, 2018@12:28:21
AUTHOR: MATNEY, MCKENNA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

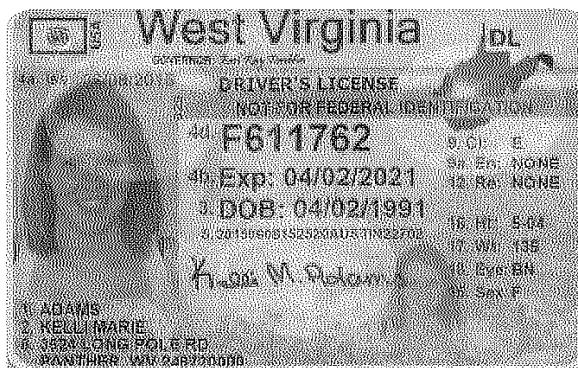
Scanned mother's ID

/es/ MCKENNA M MATNEY
OFFICE ASSISTANT
Signed: 06/23/2018 12:28

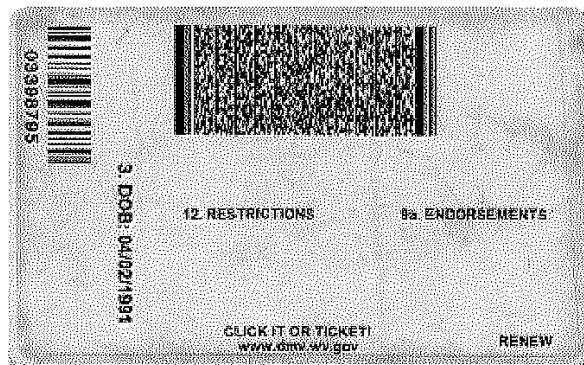
**EXHIBIT NO. B6F
PAGE: 53 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23,2018 12:09



**EXHIBIT NO. B6F
PAGE: 54 OF 239**



**EXHIBIT NO. B6F
PAGE: 55 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006412234
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 23, 2018 12:09
ATTENDING:

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----
DATE OF NOTE: JUN 23, 2018@12:27 ENTRY DATE: JUN 23, 2018@12:27:27
AUTHOR: MATNEY, MCKENNA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ MCKENNA M MATNEY
OFFICE ASSISTANT
Signed: 06/23/2018 12:28

**EXHIBIT NO. B6F
PAGE: 56 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006412234
 ADM: Jun 23, 2018 12:09



ADAMS, NEVAEH	
ADM : 6/23/18	ACT# : 006412234
DOB : 7/21/2015	MED# : 138580
SEX : F	FC : CO
SER : WIC	AGE : 2 yr
DR : COWANS, RODNEY	

WELCH COMMUNITY HOSPITAL
 454 McDOWELL STREET
 WELCH, WV 24801

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

EXHIBIT NO. B6F
PAGE: 57 OF 239

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

ADAMS, NEVAEH	ACT# : 066412234
ADM : 8/23/18	MED# : 138580
DOB : 7/21/2015	FC : CO
SEX : F	AGE : 2 yr
SER : WIC	DR : COWANS, RODNEY

EXHIBIT NO. B6F
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7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

If you would like to Opt out of HIV testing, please initial the box to the left.

There may be some instances where patients are not allowed to opt out for further information please refer to the information sheet given to you upon registration.

8. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: _____

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

9. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

ADAMS, NEVAEH	
ADM : 8/23/18	ACT# : 008412234
	MED# : 138580
DOB : 7/21/2015	FC : CO
SEX : F	AGE : 2 yr
SER : WIC	DR : COWANS, RODNEY

**EXHIBIT NO. B6F
PAGE: 59 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006412234
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 23, 2018 12:09
ATTENDING:

----- PRESENTING SHEET (SCANNED) -----
DATE OF NOTE: JUN 23, 2018@12:27 ENTRY DATE: JUN 23, 2018@12:27:42
AUTHOR: MATNEY, MCKENNA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

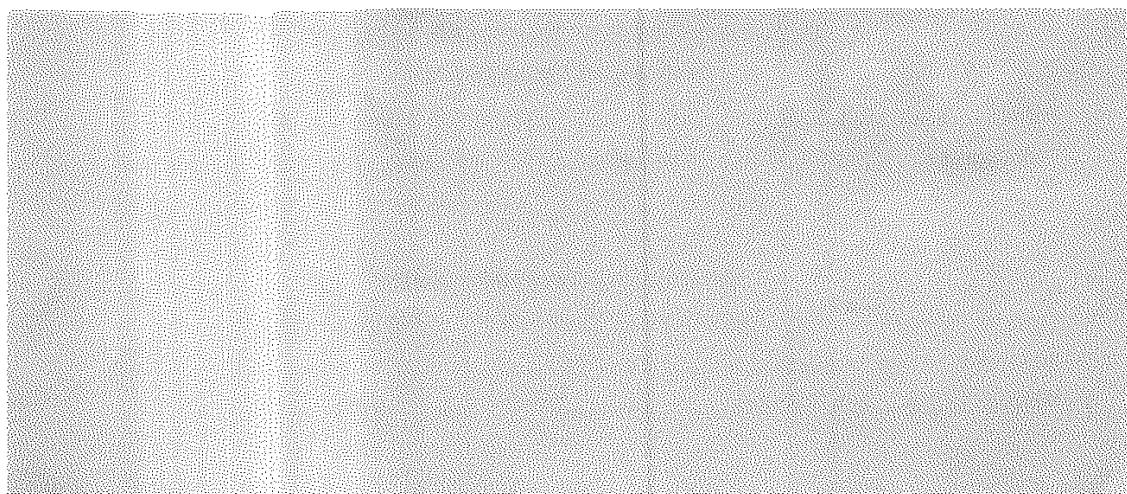
/es/ MCKENNA M MATNEY
OFFICE ASSISTANT
Signed: 06/23/2018 12:28

**EXHIBIT NO. B6F
PAGE: 60 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006412234
 HOSPT : WELCH COMMUNITY HOSPITAL ADM: Jun 23, 2018 12:09
 ATTENDING:

RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION FORM					
PLEASE FILL OUT TOP PORTION ONLY					
NAME: <u>Nevaeh Adams</u>	TIME: <u>12/15</u>	AGE: <u>2</u>	TODAY'S DATE: <u>6/23/18</u>	BIRTHDAY: <u>7/21/15</u>	
ADAMS, NEVAEH ADM: 062318 ACT#: 006412234 DOB: 7/21/2015 MED#: 138580 SEX: F FC: CN SER: WIC AGE: 2 yr DR: COWANS, RODNEY		***TO BE FILLED OUT BY HOSPITAL STAFF*** DISPOSITION: <input checked="" type="radio"/> WIC PEDS IM SURG OBGYN			
Registration Complaint: <u>Rock</u>			TIME: <u>12:17 pm</u>		
NURSE: <u>K. Hamm</u>					

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**EXHIBIT NO. B6F
PAGE: 62 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23,2018 12:09

----- INSURANCE CARD -----
DATE OF NOTE: JUN 23,2018@12:27 ENTRY DATE: JUN 23,2018@12:27:54
AUTHOR: MATNEY,MCKENNA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

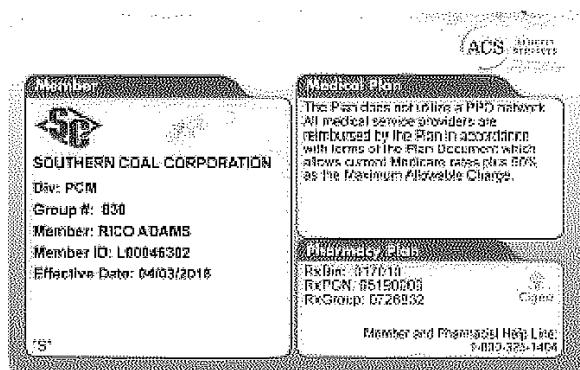
Insurance Card attached as scanned image.
INSURANCE CARD BACK (SCANNED):

/es/ MCKENNA M MATNEY
OFFICE ASSISTANT
Signed: 06/23/2018 12:28

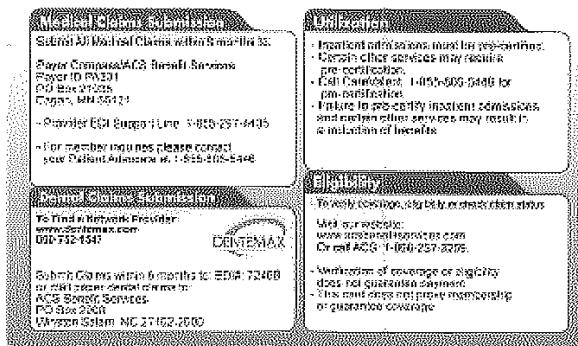
**EXHIBIT NO. B6F
PAGE: 63 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSPI : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23, 2018 12:09



**EXHIBIT NO. B6F
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**EXHIBIT NO. B6F
PAGE: 65 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

*** END ***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 66 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23,2018 12:09

***** CONFIDENTIAL ORDERS SUMMARY *****

Order Date: St: Requestor: Start Date: Stop Date:
Nature of Order: Signature:
Item Ordered:

*** END ***** CONFIDENTIAL ORDERS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 67 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23,2018 12:09

***** CONFIDENTIAL LAB RESULTS SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL LAB RESULTS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 68 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23,2018 12:09

***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 69 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006412234
ADM: Jun 23,2018 12:09

***** CONFIDENTIAL DISCHARGE SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL DISCHARGE SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 70 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006412234
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 23, 2018 12:09
ATTENDING:

***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 71 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006412234
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 23, 2018 12:09
ATTENDING:

ADRs: No ADRs on file.

Allergies: PENICILLIN
=====

****NO MEDICATIONS FOUND****

*** END ***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

{{{ END }}} Patient Encounter(s) History Report Dec 28, 2018@14:30

**EXHIBIT NO. B6F
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Patient Encounter(s) History Report Dec 28, 2018@14:22

(From: 01/06/18 --- Thru: 01/07/18)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B6F
PAGE: 73 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006398531
ADM: Jan 06,2018 13:27

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 74 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006398531
ADM: Jan 06, 2018 13:27

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (MEDICAL RECORDS ASSISTANT)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J

Observed/Historical: Historical

==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 75 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006398531
ADM: Jan 06,2018 13:27

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 76 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
ATTENDING:

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- CERTIFIED MAIL RECEIPT (SCANNED DOC) -----
DATE OF NOTE: MAY 2, 2018@14:08 ENTRY DATE: MAY 2, 2018@14:08:41
AUTHOR: STIMSON, MARLENA EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Certified mail receipt attached as scanned document. See attached image.

/es/ MARLENA STIMSON
OFFICE ASSISTANT
Signed: 05/02/2018 14:15

**EXHIBIT NO. B6F
PAGE: 77 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006398531
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06,2018 13:27
 ATTENDING:

Nevaeh Adams
 MR # 138580

Page 1 of 1


Shipment Receipt
Address Information

Ship to:	Ship from:
JAN DILLS LC	Hazel Addair
963 MARKET STREET	Welch Community Hospital
PARKERSBURG, WV	454 McDowell Street
26101	Welch, WV
US	24801
3044288900	US
	3044368647

Shipment Information:

Tracking no.: 772135891105
 Ship date: 05/02/2018
 Estimated shipping charges: 3.85 USD

Package Information

Pricing option: FedEx Standard Rate
 Service type: FedEx Ground
 Package type: Your Packaging
 Number of packages: 1
 Total weight: 1 LBS
 Declared Value: 0.00 USD
 Special Services:
 Pickup/Drop-off: pickup confirmation number:CPU1136981220

Billing Information:

Bill transportation to: welch community hospital-144
 Your reference:
 P.O. no.:
 Invoice no.:
 Department no.:

Thank you for shipping online with FedEx ShipManager at fedex.com.

Please Note

FedEx will not be responsible for any claim in excess of \$100 per package, whether the result of loss, damage, delay, non-delivery, misdelivery, or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim. Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, indirect, consequential or special is limited to the greater of \$100 or the declared declared value. Recovery cannot exceed actual documented loss. Maximum for items of extraordinary value is \$1000, e.g., jewelry, precious metals, negotiable instruments and other items listed in our Service Guide. Written claims must be filed within strict time limits. Consult the applicable FedEx Service Guide for details.

The estimated shipping charge may be different than the actual charges for your shipment. Differences may occur based on actual weight, dimensions, and other factors. Consult the applicable FedEx Service Guide or the FedEx Rate Sheets for details on how shipping charges are calculated.

**EXHIBIT NO. B6F
PAGE: 78 OF 239**

Nevach Adams
MR # 138580

Page 1 of 1

FROM:
Hazel Parker
Welch Community Hospital
4500 Market Street
Welch, WV 26087
US

TO: JAN DILLS LC

ACTIVATE COMPANY
CIO: 1807085584873980
BILL SENDER

SHIPPING DATE: 08/28/18

COD: 1807085584873980

PC:

DEPT:

(US)

552078060045

J1811190103019



TRK# 772135891105
PC: 26101

After printing this label:

1. Use the 'Print' button on this page to print your label to your laser or inkjet printer.
2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

Warning: IMPORTANT: TRANSMIT YOUR SHIPPING DATA AND PRINT A MANIFEST:

At the end of each shipping day, you should perform the FedEx Ground End of Day Close procedure to transmit your shipping data to FedEx. To do so, click on the Ground End of Day Close button. If required, print the pickup manifest that appears. A printed manifest is required to be tendered along with your packages if they are being picked up by FedEx Ground. If you are dropping your packages off at a FedEx drop off location, the manifest is not required.

Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide and applicable tariff, available upon request. FedEx will not be responsible for any claim in excess of \$100 per package, whether the result of loss, damage, delay, non-delivery, misdelivery, or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim. Limitations, including limitations on our liability, can be found in the current FedEx Service Guide and applicable tariff apply. In no event shall FedEx Ground be liable for any special, incidental, or consequential damages, including, without limitation, loss of profit, loss to the intrinsic value of the package, loss of sale, interest income or attorney's fees. Recovery cannot exceed actual documented loss. Items of extraordinary value are subject to separate limitations of liability set forth in the Service Guide and tariff. Written claims must be filed within strict time limits, see current FedEx Service Guide.

**EXHIBIT NO. B6F
PAGE: 79 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006398531
ADM: Jan 06, 2018 13:27

----- AUTHORIZATION FOR RELEASE OF MEDICAL RECORD (SCANNED -----
DATE OF NOTE: MAY 2, 2018@14:07 ENTRY DATE: MAY 2, 2018@14:07:48
AUTHOR: STIMSON, MARLENA EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned document(s).

/es/ MARLENA STIMSON
OFFICE ASSISTANT
Signed: 05/02/2018 14:08

**EXHIBIT NO. B6F
PAGE: 80 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006398531
 ADM: Jan 06, 2018 13:27

From: GFI FaxMaker To: 13044363389 Page: 1/3 Date: 4/20/2018 1:25:19 PM

2288



received
4/20/18
MRN# 138580

963 Market Street, Parkersburg, WV 26101
 Fax: 304-428-4500
 Email: records@jandils.com

To:	Welch Community Hospital *	From:	Bethany
	Attn: Medical Records		
	454 McDowell Street		
	Welch, WV 24801		
Fax:	(304) 436-3389	Pages:	3
Re:	Ms. Nevaeh Hope Adams	Date:	April 20, 2018

DOB: 7/21/2015

**Request for Medical Records for Social Security Disability/ Supplemental Security Income Claim
*DATES OF SERVICE ARE LISTED ON MEDICAL AUTHORIZATION.***

PLEASE CALL OUR OFFICE IF ANY FEES ARE ASSOCIATED WITH THIS REQUEST PRIOR TO FULFILLING.

If records are unavailable for the above-named patient, please check the appropriate box below and fax this cover sheet back to us at 304-428-4500. Thanks for your cooperation!

- No records for Dates of Service Requested (DATE LAST SEEN _____)
- Not a patient at this facility
- Records have been purged

Please fax your records to our email records@jandils.com or telephone 304-428-4500.

For information on a no-cost, HIPAA-CERTIFIED way to deliver your medical records, contact Beverly at 304-428-8900 or email Beverly@jandils.com to have your personal Citrix ShareFile folder created.

12-11-17 to 01-06-18
 rec'd 1 HR
 after

**The information contained in this facsimile message is attorney privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the address indicated above. Thank you.

This fax was sent with GFI FaxMaker fax server. For more information, visit: <http://www.gfi.com>

**EXHIBIT NO. B6F
PAGE: 81 OF 239**

From: GFI FaxMaker To: 13044363389 Page: 2/3 Date: 4/20/2018 1:28:19 PM

#138580

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: Ms. Nevaeh Hope Adams

Date of Birth: 7/21/2015

Address: Kelli Adams PO Box 491

City: Panther State: WV Zip: 24872

Telephone Number: (304)656-7434 SSN: (8055)

I hereby authorize: Welch Community Hospital to release my medical records to Jan Dils, Attorneys at Law. This is to include all medical records or other information regarding my treatment, hospitalizations, and/or outpatient care including psychiatric, drug/alcohol abuse, alcoholism, Acquired Immunodeficiency Syndrome (AIDS), tests for HIV, and blood alcohol serum tests and results.

Please forward records to: JAN DILS, ATTORNEY AT LAW, LC., 963 Market Street, Parkersburg, WV 26101. This information is needed by my attorney and I in connection with a claim for disability filed with the Social Security Administration.

Information to be disclosed: Complete Health Record(s) Laboratory Test

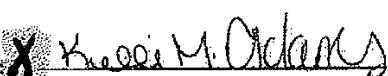
X-Ray Reports History & Physical Exam Consultation

Other (please specify) Office notes and summaries

For treatment date(s) if applicable: 8/30/2017 to present

A photocopy of this consent may be used as if it is the original. Refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enroll in a health plan. Unless otherwise revoked, this authorization will expire 180 days after the date of signature. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 963 Market Street, Parkersburg, WV, 26101.

Signed By:


Signature of Patient or Legal Guardian

Nevaeh Adams

Patient's Name

Kelli Adams

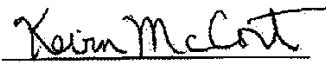
Print Name of Patient or Legal Guardian

Mother

Relationship to Patient

4/20/2018

Date



Witness

This fax was sent with GFI FaxMaker fax server. For more information, visit: <http://www.gfi.com>

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From: GFI FaxMaker To: 13044383389 Page: 3/3 Date: 4/20/2018 1:25:19 PM

#13850
Form Approved
OMB No. 1990-0527

#138
Form Approved
OMB No. 0930-0527

Part I **APPOINTMENT OF REPRESENTATIVE**

I appoint this person: Jan Dils, Attorney at Law

Name and Address

to act as my representative in connection with my claim(s) or asserted right(s) under:

- Title II
(RSDI) Title XVI
(SSI) Title XVIII
(Medicare Coverage) Title VIII
(SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

- I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

I appoint, or I now have, more than one representative. My main representative is _____.

JAN DUE _____ Name of Principal Researcher

Signature (Claimant) John M. O'Leary	Address Keili Adams, PO Box 491, Panther, WV 24872
Telephone Number (with Area Code) (304) 555-7434	Fax Number (with Area Code) Date October 27, 2018

I, Jan Dits, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: I am an attorney. I am a non-attorney eligible for direct payment under SSA law.
 I am a non-attorney not eligible for direct payment.

I am a non-attorney not eligible for direct payment.

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. Yes

No
I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms,

and it is true and correct to the best of my knowledge.		
Signature (Representative) <i>Jeanette</i>	Address Post Office Box 901, Parkersburg, WV 26102	
Telephone Number (with Area Code) (304) 425-1100	Fax Number (with Area Code) (304) 425-4501	Date October 27, 2016

FEES ARRANGEMENT

Part III

(Please answer five questions and omit this question.)

- Charging a fee and requesting direct payment of the fee from withheld past-due benefits. (SSA must authorize the fee unless a regulatory exception applies.)

Charging a fee but waiving direct payment of the fee from withheld past-due benefits – I do not qualify for or do not request direct payment. (SSA must authorize the fee unless a regulatory exception applies.)

Waiving fees and expenses from the claimant and any auxiliary beneficiaries – By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). (SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)

Waiving fees from any source - I am waiving my right to charge and collect any fee, under sections 208 and 1631(d)(2) of the Social Security Act, I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or appeal(s).

Signature (Representative) _____ **Date** _____
October 27, 2018

Jord Dila

1

Page 986 - 2006-113-122-204-13-43-103-201

This key was generated with CEF Embedder for Java. For more information, visit <http://cefembedder.com>

**EXHIBIT NO. B6F
PAGE: 83 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
ATTENDING:

----- IDENTIFICATION CARD/DRIVERS LICENCE -----
DATE OF NOTE: JAN 6, 2018@16:31 ENTRY DATE: JAN 6, 2018@16:31:12
AUTHOR: DAVIS, CINDI N EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Patient is a minor unable to obtain ID.

/es/ CINDI N DAVIS
OFFICE ASSISTANT
Signed: 01/06/2018 16:31

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----
DATE OF NOTE: JAN 6, 2018@16:28 ENTRY DATE: JAN 6, 2018@16:28:13
AUTHOR: DAVIS, CINDI N EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ CINDI N DAVIS
OFFICE ASSISTANT
Signed: 01/06/2018 16:30

**EXHIBIT NO. B6F
PAGE: 84 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006398531
 ADM: Jan 06,2018 13:27



ADAMS, NEVAEH	
ADM : 1/06/18	ACT# : 00R388531
DOB : 7/21/2015	MED# : 130500
SEX : F	FC : CR
SFR : WIC	AGE : 2 yr
RR : DYGD, JOSE	

WELCH COMMUNITY HOSPITAL
 454 McDOWELL STREET
 WELCH, WV 24801

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.

1. CONSENT TO HOSPITAL SERVICES: I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. MEDICAL EDUCATION: I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. PATIENT'S CERTIFICATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. FINANCIAL AGREEMENT: I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

**EXHIBIT NO. B6F
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deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. HOSPITAL TO ACT AS AGENT: I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.

6. OUTPATIENT MEDICARE PATIENTS: Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

ADAMS, NEVAEH
ADM : 1106118 ACT# : 008398531
DOD : 7/21/2015 MED# : 136580
FC : CB AGE : 2 yr
SEX : F MR : 0YCD, JOSE
SER : MIC

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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
ATTENDING:

----- PRESENTING SHEET (SCANNED) -----
DATE OF NOTE: JAN 6, 2018@16:28 ENTRY DATE: JAN 6, 2018@16:28:52
AUTHOR: DAVIS, CINDI N EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ CINDI N DAVIS
OFFICE ASSISTANT
Signed: 01/06/2018 16:30

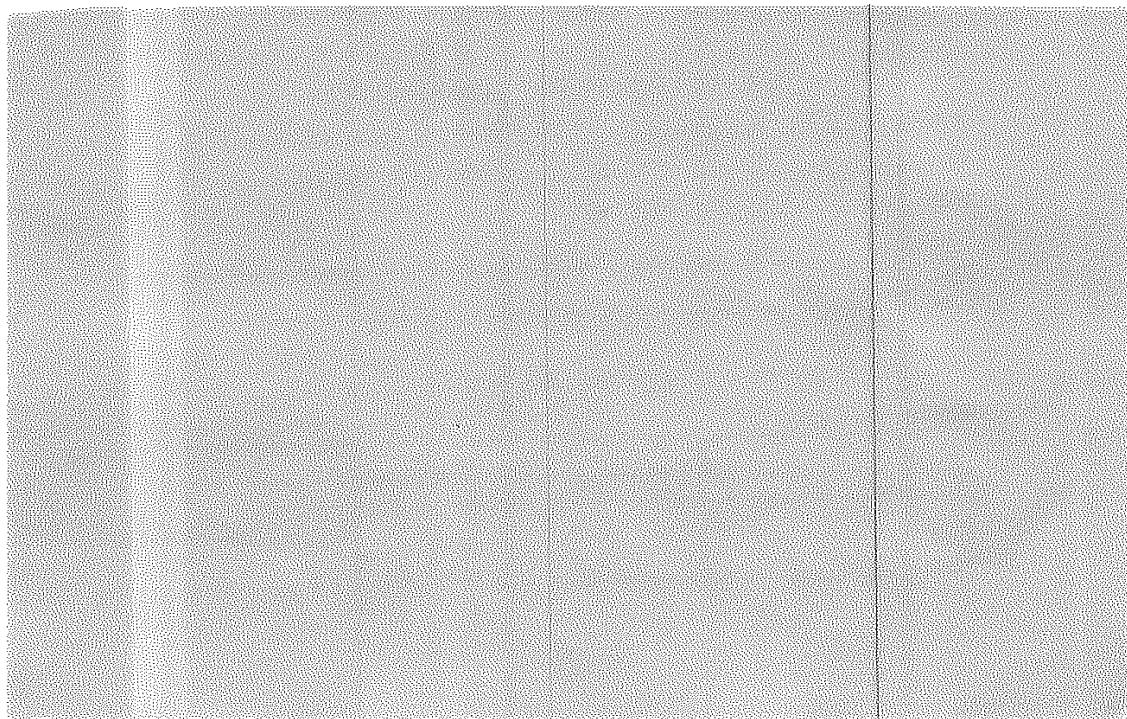
**EXHIBIT NO. B6F
PAGE: 88 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006398531
 ADM: Jan 06,2018 13:27

RURAL HEALTH CLINIC REGISTRATION FORM (OUTPATIENT)					
NAME: <u>Nevaeh Adams</u>	TODAY'S DATE: <u>1/6/18</u>				
TIME: <u>110</u>	AGE: <u>2</u>	BIRTHDAY: <u>7/21/15</u>			
CHIEF COMPLAINT (TELL US WHY YOU ARE HERE) <u>Cough, Muffy eyes, runny "green" nose, itchy eyes</u>					
DISPOSITION: <input checked="" type="radio"/> WIC <input type="radio"/> PEDS <input type="radio"/> IM			ADAMS, NEVAEH ADM: 1/06/18 ACT# 006398531 DOB: 7/21/2015 MED# 108580 SEX: F IC: CO SER: WIC AGE: 2 yr DR: RYCO, JOSE		
REGISTRATION COMPLAINT: <u>Itch and Congestion</u>					
NURSE: <u>Ryco, Daniel M</u>	TIME: <u>110</u>				

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Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006398531
ADM: Jan 06,2018 13:27

----- INSURANCE CARD -----
DATE OF NOTE: JAN 6,2018@16:27 ENTRY DATE: JAN 6,2018@16:27:49
AUTHOR: DAVIS,CINDI N EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

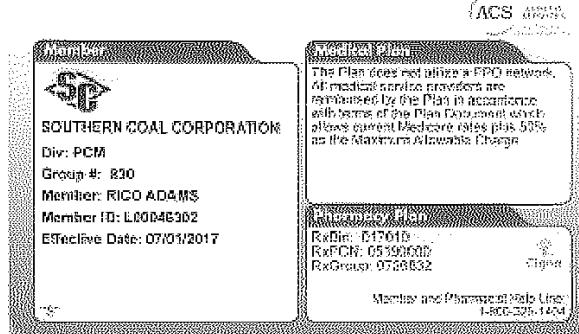
Insurance Card attached as scanned image.
INSURANCE CARD BACK (SCANNED):

/es/ CINDI N DAVIS
OFFICE ASSISTANT
Signed: 01/06/2018 16:30

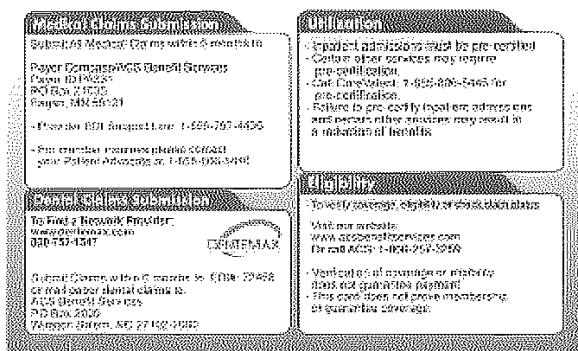
**EXHIBIT NO. B6F
PAGE: 91 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006398531
ADM: Jan 06, 2018 13:27



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Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006398531
 ADM: Jan 06, 2018 13:27

Eligibility Information

Page 1 of 1

Eligibility Verification

From Entry Member Search Eligibility Verification

Eligibility Inquiry verifies whether a member was eligible for a covered program on the date(s) of service submitted in the request. This information does not guarantee eligibility or payment for the service rendered.

Member

Name	Date of Birth	Member ID	Gender
ADAMS, NEVAEH H	2015-07-21	00405164365	Female
Tracking Number		18222W000307586	

Eligibility Inquiry

Dates of Service * From Date Of Service 1/6/2018 * To Date Of Service 1/6/2018
 * Inquiry Type Date Seen Only

Category: GESI

Enrollments

Program/Benefit Name	Coverage Status	Coverage Level	Plan Type	Effective Date	Termination Date	Member ID
- Medicaid Benefit Plan	Active	Primary	Medicaid	06/01/2018	09/31/2018	60405164365
Rate Code	Coverage	Effective Date	Termination Date			
FCMOKF	Categorically Needy	06/01/2018	06/30/2018			
FCNSKF	Tier 1 Coop	06/01/2018	06/30/2018			

No enrollments were found for the search criteria.

Other Insurance

No Co-insurance or Secondary information found.

Copay

It is the member's responsibility to pay the copay to the provider at the time of the service. Copays are at the benefit level (individual service codes).

Beginning for claims with a Date of Service on or after May 08, 2018, copays for this member are:

Service	Copay Amount	Effective Date	Termination Date	Tier
N/A	\$0	05/08/2018	05/08/2018	Member is exempt

No Copay information found for the member.

PCP / Medical Home

No PCP/Medical Home information found for the member.

Lock-In

No Lock-In information found for DDS range requested.

Spend Down

No Spend Down information found at this time.

00405164365

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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
ATTENDING:

----- CODING ABSTRACT FORM (SCANNED) -----
DATE OF NOTE: JAN 6, 2018@14:21 ENTRY DATE: JAN 26, 2018@14:21:22
AUTHOR: PRUITT, STANLEY EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Coding Abstract Form(s).

/es/ STANLEY PRUITT
OFFICE ASSISTANT
Signed: 01/26/2018 14:21

**EXHIBIT NO. B6F
PAGE: 95 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006398531
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06,2018 13:27
 ATTENDING:

DATE: 01/24/2018 TIME: 01:15 PM
 PAGE: 1 OF 1 WELCH HOSPITAL
 CODING SUMMARY - INPT

Patient Name: ADAMS, NEVAEH H MR #: 000138580 PAT #: 006398531

Sex: F Admitted: 1/06/18
 Birthdate: 7/21/2015 Discharged: 1/06/18
 Age at Admit: 002 LOS: 1
 Attending Phys: 649228 OYCO, JOSE UB92 Disp: 01

Current DRG: Outlier: 0

Diagnoses	POA	MOD	HAC	Description
1. J00				Acute nasopharyngitis [common cold]
2. H10.33				Unspecified acute conjunctivitis, bilateral

Date	CPT	Modifiers	Description
1. 01/06/18	99213		OFFICE/OUTPATIENT VISIT EST

To Attending Physician: Please review the above diagnoses and procedures and notify Health Information Management if there are any discrepancies or any inaccuracies. Thank you !!

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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
ATTENDING:

----- CLINIC NOTE (SCANNED) -----
DATE OF NOTE: JAN 6, 2018@14:03 ENTRY DATE: JAN 7, 2018@14:03:16
AUTHOR: HALE, DIANNE M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Clinic Note(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 01/07/2018 14:04

**EXHIBIT NO. B6F
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Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006398531
 ADM: Jan 06, 2018 13:27

Circle or check off relatives, backslash (/) negative. 14 Welch Community Hospital RHC URGENT CARE RECORD •Pediatric Illness•	
DATE: <u>1/11/18</u> TIME: <u>13:30</u> ROOM: <u>WALKIN'</u>	
HISTORIAN: <u>parent</u> patient parent caregiver	
MODE OF ARRIVAL: <u>ambulatory</u> other	
chief complaint: fever <u>20.5</u> congested runny nose pulling ears not eating less active vomiting diarrhea rash ingestion <u>Watery eyes this am (Runny Nose)</u>	
HPI onset / duration: <u>2 days</u> continues in clinic gone now / better Intermittent / worse contact: sick contacts <u>None</u> home school other <u>from PTI</u>	
Afebrile severity: fever to <u>*F / *C</u> and rectal axillary TM not measured - subjective nose noted	
Associated symptoms: acting differently fussy crying more not sleeping less active inconsolable drinking / eating less not drinking lost feeding / liquids decreased urination lost urinated sleeping more	
Similar symptoms previously <u>N/A</u>	
Recently seen / treated by doctor / hospitalized	

ADAMS, NEVAEH ACT# : 006398531 MRN# : 138580 DOB : 7/21/2015 FC : CO SEX : F AGE : 2 yr SER : WIC DR : OYCO, JOSE	
ROS ENT pulling at ears R/L _____ runny nose _____ sores throat / mouth _____ EYES red eyes / discharge _____ RESPIRATORY cough _____ trouble breathing _____ G vomiting / diarrhea _____ abdominal distension _____ blood in stools _____ GU painful / swollen genital area _____ problems urinating _____ Lymph preg premenstrual _____ <input checked="" type="checkbox"/> except as marked positive, all systems above reviewed and found negative	
CVS palpitations _____ NEURO seizures _____ MS extremity pain / swelling _____ SKIN rash _____ fever / trunk extremities diffuse _____ diaper rash _____ LYMPH swollen glands _____ PSYCH anxiety / depression _____	
PAST HX Birth HX birth wt. _____ complications at birth _____ premature birth _____ diabetes Type I insulin _____ asthma _____ bronchitis / bronchiolitis _____ cardiac problems _____ congenital heart disease _____ development delay _____ <u>Feverish Syndrome</u>	
Surgeries / Procedures _____ VP shunt _____ <u>B</u>	
Immunizations: UTD / referred to PCP Medications _____ none see nurses note aspirin Ibuprofen acetaminophen last dose _____	
Allergies _____ NKDA see nurses note	
SOCIAL HX _____ smoker / 2nd hand exposure _____ alcohol (frequent / occasional) _____ drugs _____ attends daycare / school _____ caretaker / foster care _____	
FAMILY HX _____ adopted _____	

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Rev. 09/16

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PHYSICAL EXAM	
General Appearance	
<input checked="" type="checkbox"/> no acute distress	mild / moderate / severe distress
<input checked="" type="checkbox"/> active / playful / alert	fussy / crying / cries on exam / irritable
<input checked="" type="checkbox"/> attentiveness nml	lethargic / weak cry
<input checked="" type="checkbox"/> good eye contact	
<input checked="" type="checkbox"/> sleeping/easily aroused	
INFANTS	
<input checked="" type="checkbox"/> nml consciousness	poor consciousness / poor intake suck
<input checked="" type="checkbox"/> nml feeding / suck	poor muscle tone
<input checked="" type="checkbox"/> flat anterior fontanel	closed / bulging / sunken anterior fontanel
HEENT	
<input checked="" type="checkbox"/> conjunctiva & lids nml	tenderness / swelling
<input checked="" type="checkbox"/> EYERL	conjunctival hemorrhage
<input checked="" type="checkbox"/> ears nml	EOM palsy / anisocoria / conjunctival exudate
<input checked="" type="checkbox"/> nose nml	sunken eyes / photophobia
<input checked="" type="checkbox"/> pharynx nml	TM erythema / edema (R/L)
<input checked="" type="checkbox"/> moist mucous membranes	loss of TM landmarks (R/L)
<input checked="" type="checkbox"/> nose nml	TM obscured by wax (R/L)
<input checked="" type="checkbox"/> pharynx nml	rhinorrhea / purulent nasal drainage
<input checked="" type="checkbox"/> moist mucous membranes	pharyngeal erythema / tonsillar exudate
<input checked="" type="checkbox"/> NECK	ulcerations / vesicles
<input checked="" type="checkbox"/> supple	drooling / trismus / mass
<input checked="" type="checkbox"/> no rashes	dry mucous membranes
RESPIRATORY	
<input checked="" type="checkbox"/> no resp. distress	meningismus / Brudzinski / Kernig's
<input checked="" type="checkbox"/> breath sounds nml	lymphadenopathy
<input checked="" type="checkbox"/> respiratory distress	respiratory distress
<input checked="" type="checkbox"/> retractions / accessory muscle use	retractions / accessory muscle use
<input checked="" type="checkbox"/> prolonged expirations	prolonged expiration
<input checked="" type="checkbox"/> decreased air movement	decreased air movement
<input checked="" type="checkbox"/> grunting (infant)	grunting (infant)
<input checked="" type="checkbox"/> stridor	stridor
<input checked="" type="checkbox"/> wheezes / rales / rhonchi	wheezes / rales / rhonchi
<input checked="" type="checkbox"/> murmur grade ___ /6 sys/dex	murmur grade ___ /6 sys/dex
<input checked="" type="checkbox"/> peripheral pulses weak / thready	peripheral pulses weak / thready
<input checked="" type="checkbox"/> slow cap refill	slow cap refill sec
CVS	
<input checked="" type="checkbox"/> reg. rate & rhythm	
<input checked="" type="checkbox"/> heart sounds nml	
<input checked="" type="checkbox"/> strong periph pulses	
<input checked="" type="checkbox"/> nml capillary refill	
ABDOMEN	
<input checked="" type="checkbox"/> non-tender	tenderness / guarding / rebound
<input checked="" type="checkbox"/> no distention	hepatomegaly / splenomegaly / mass
<input checked="" type="checkbox"/> no organomegaly	abdominal bowel sounds
GENITALIA	
<input checked="" type="checkbox"/> nml inspection	discharge / erythema / swelling / tenderness
<input checked="" type="checkbox"/> circumcised (male)	testes undescended
<input checked="" type="checkbox"/> uncircumcised (male)	hernia
EXTREMITIES	
<input checked="" type="checkbox"/> non-tender	tenderness
<input checked="" type="checkbox"/> nml ROM	
SKIN	
<input checked="" type="checkbox"/> no rash / lesions	cyanosis / diaphoresis / pallor / icterus
<input checked="" type="checkbox"/> no petechiae	poor skin turgor
<input checked="" type="checkbox"/> normal color	diaper rash / skin rash
<input checked="" type="checkbox"/> warm / dry	urticaria / scutellatum / impetigo / vesicular vesicular crusted skin lesions
NEURO	
<input checked="" type="checkbox"/> sensation nml	facial asymmetry
<input checked="" type="checkbox"/> motor nml	sensory loss / weakness
<input checked="" type="checkbox"/> CN's nml (2-10)	depressed mood / affect
<input checked="" type="checkbox"/> mood / affect nml	
ADDITIONAL NOTES	

Pediatric Illness - 14 Reportable Measure

ADAMS, NEVAEH

ADM : 108/18 ACT# : 006398531
 MED# : 138590
 DOB : 7/21/2015 FC : CO
 SEX : F AGE : 2 yr
 SER : WIC IH : CYCO, JOSE

LABS & XRAYSCBC _____ UA _____
BMP _____ Preg _____XRAYS Interpret by me Viewed by me Discussed w/ radiologist

CXR nml / NAD no infiltrates nml heart size nml mediastinum

Other _____

PROCEDURES

LP discussed risks, benefits, alternatives; parent/guardian consent.
 Time: field color RBC WBC
 betadine prep glucose polyn lymph
 L3-4 I.M-S protein menses g/m m

PROGRESS

Time: unchanged improved re-examined

- ♦ Pharyngitis - 3y-18y / strep A test / antibiotic
- ♦ URI - 3m-18y / No antibiotic
- measure exclusions: refused / not indicated / indicated / contraindicated / not available / dispensed

CLINICAL IMPRESSION

Fever	Meningitis
Vomiting / Diarrhea	Otitis Media - R / L
Dehydration	♦ Pharyngitis - Strep / Mono
Asthma / Reactive Airway Disease	Pneumonia (location)
acute exacerb. status asthmaticus	Sepsis / SIRS - severe
Bronchitis / Bronchiolitis - RSV	Septic Shock
Croup	Shock
Gastroenteritis / Enteritis	♦ Upper Respiratory Infection
Hypoxemia	UTI / Pyelonephritis
Ingestion	Viral Syndrome
Influenza second H1N1	♦ Influenza C
Urinary tract infection	♦ Bacteremia (Conjunctivitis)

TREATMENT PLAN / DISCHARGE MEDICATION

Empyema right pleural cavity

Discussed with Dr. [Signature]

will see patient in office / clinic / hospital

Counseled patient / family regarding:

lab results (diagnose) need for follow-up smoking / drug / alcohol cessation

Time spent counseling minutes Admin orders written

DISPOSITION: Home admit transfer

DISPO TIME: _____

FOLLOW-UP: PCP return to clinic

CONDITION: unchanged improved stable

total face-to-face time: 5 minutes

- I have reviewed the chart and agree with the documentation as recorded by the PSP, including the assessment, treatment plan, and disposition.
- I previously evaluated and examined the patient in conjunction with the PSP and agree with the management and disposition of the patient.

Henry Blue ROC NP / PA

MD / DO

 Template Complete

Rev. 09/16

**EXHIBIT NO. B6F
PAGE: 99 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
ATTENDING:

----- MEDICATION RECONCILIATION (SCANNED) -----
DATE OF NOTE: JAN 6, 2018@14:03 ENTRY DATE: JAN 7, 2018@14:03:29
AUTHOR: HALE, DIANNE M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 01/07/2018 14:04

**EXHIBIT NO. B6F
PAGE: 100 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX : JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN : WEL000138580
ACT: WEL006398531
ADM: Jan 06, 2018 13:27

**WELCH COMMUNITY HOSPITAL
MEDICATION RECONCILIATION FORM**

ADAMS, NEVAEH
ADM : 110818 ACT# : 006398531
MED# : 139580
DOB : 7/21/2015 FC : CO
SEX : F AGE : 2 yr
SER : WIC DR : OYCO, JOSE

Name:	<input type="checkbox"/> Patient is on no medications at this time
Allergies:	

LIST BELOW ALL OF THE PATIENT'S MEDICATION PRIOR TO ADMISSION / INCLUDING OVER-THE-COUNTER AND HERBAL MEDS

Name of Medication/Dose	Amount	Route	Frequency	Last Dose	Reason for Medication	Continue on Admission	Continue after Surgery or Transfer	Continue on Discharge
1. Growth Hormone		by mouth / topical Inject / Inhaler	_____ times a day as needed	3 times week		Y N	Y N	Y N
2.		by mouth / topical Inject / Inhaler	_____ times a day as needed			Y N	Y N	Y N
3.		by mouth / topical Inject / Inhaler	_____ times a day as needed			Y N	Y N	Y N
4.		by mouth / topical Inject / Inhaler	_____ times a day as needed			Y N	Y N	Y N
5.		by mouth / topical Inject / Inhaler	_____ times a day as needed			Y N	Y N	Y N
6.		by mouth / topical Inject / Inhaler	_____ times a day as needed			Y N	Y N	Y N
7.		by mouth / topical Inject / Inhaler	_____ times a day as needed			Y N	Y N	Y N
8.		by mouth / topical Inject / Inhaler	_____ times a day as needed			Y N	Y N	Y N
9.		by mouth / topical Inject / Inhaler	_____ times a day as needed			Y N	Y N	Y N
10.		by mouth / topical Inject / Inhaler	_____ times a day as needed			Y N	Y N	Y N

NEW MEDICATIONS ADDED

Date	Name of Medication/Dose	Amount	Route	Frequency	Duration	Reason	Provider Name
			by mouth/topical/inject/inhaler	times a day as needed	Days		
			by mouth/topical/inject/inhaler	times a day as needed	Days		
			by mouth/topical/inject/inhaler	times a day as needed	Days		
			by mouth/topical/inject/inhaler	times a day as needed	Days		
			by mouth/topical/inject/inhaler	times a day as needed	Days		
			by mouth/topical/inject/inhaler	times a day as needed	Days		
			by mouth/topical/inject/inhaler	times a day as needed	Days		
			by mouth/topical/inject/inhaler	times a day as needed	Days		

Source of Medication List

- Patient Medication List
- Patient/Family Recall
- Pharmacy
- Primary Care Physician List
- Previous Discharge Paperwork
- Reconciled from patient's Medication bottles
- Reconciliation Prescriber (MD/DO)

Medication List Recorded/Reviewed by RN/NP/DO/PA/NP/LPN/RPh

By: _____ Date: _____
 By: _____ Date: _____
 By: _____ Date: _____
 By: _____ Date: _____

Physician _____ Date _____
 Physician _____ Date _____

Revised 2/13

**EXHIBIT NO. B6F
PAGE: 101 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
ATTENDING:

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----
DATE OF NOTE: JAN 6, 2018@14:03 ENTRY DATE: JAN 7, 2018@14:03:49
AUTHOR: HALE, DIANNE M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 01/07/2018 14:04

**EXHIBIT NO. B6F
PAGE: 102 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006398531
 ADM: Jan 06, 2018 13:27

RURAL HEALTH CLINIC

Name: Nevae Adams Age: 2 DOB: 7-21-15
 Date/Time of Arrival: 1/6

Reason for Visit: Cough, congestion, watery matted eyes,
 runny nose, and tearing (7) ear

ALLERGIES Amoxicillin

Vitals: BP _____ HR 122 RR 22 Temp 98.2 Pulse Ox 98 % lpm
 Pain (0-10) _____ Location _____ Wt. 29 Ht. _____ LMP _____

Medical History:

Asthma Gout: CHF: COPD: CVA Diabetes
 HTN Hyperlipidemia: Psych: Renal: Seizures

Other: Turner Syndrome, Hypothyroidism, Heart

Date of last mammogram _____ Date of last papsmear _____

Date of last colonoscopy _____

Surgical History:

Appendix Cardiac/Stent Gallbladder Hysterectomy BTL
 Other: _____

Social History: smoker ____ ppd/never/quit drugs _____ alcohol none/recent/occassional

Primary Care Provider: _____

Nurse Signature: _____

******PATIENT REQUIRES HIGHER LEVEL OF CARE******

Focus assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider _____ Date _____ Time _____

Original 2-2017

**EXHIBIT NO. B6F
PAGE: 103 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
ATTENDING:

----- PRESCRIPTION COPY (SCANNED) -----
DATE OF NOTE: JAN 6, 2018@14:03 ENTRY DATE: JAN 7, 2018@14:04:04
AUTHOR: HALE, DIANNE M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned copy of Prescription(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 01/07/2018 14:04

EXHIBIT NO. B6F
PAGE: 104 OF 239

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006398531
 ADM: Jan 06, 2018 13:27

32975

WELCH COMMUNITY HOSPITAL
 SUPERVISOR MICHAEL KELLY, M.D.
 DANNY CLINE, P.A.-C

STATE AND CITY
 451 McDowell Street
 Welch, WV 24801

N	ADAMS, NEVAEH	ACT# : 000398531	Date
	NAME: IN0018	Med# : 138580	EXPIRES: JAN 2018
A	DOB : 7/21/2015	IC : CO	DRUGS FOR CHILDREN
	STX : 1	AGE : 2y	DRUGS FOR PREGNANCY
R	REC'D BY DR : OXCO, JOSH	CITY RX	

Erythromycin ophthalmic ointment

S: Apply 1cm To Conjunctival

S: Every 4 hrs for 7 days

Refill NR: 1 2 3 4 5

Amelia May Ric

Prescription is void if more than one (1) prescription is written per blank.

- 1-24
- 25-49
- 50-74
- 75-100
- 101-150
- 151 and over

EXHIBIT NO. B6F
PAGE: 105 OF 239

32976		WELCH COMMUNITY HOSPITAL	
		SUPERVISOR MICHAEL KELLY, M.D.	
		DANNY CLINE, P.A.-C	
		CASH 412-5416 454 McDowell Street Welch, WV 26801	
ADAMS, NEVAEH		ACT# : 040/198531	
ADM : 100519		MED# : 103560	
DOB : 11/21/2015		FE : CD	
SEX : F		AGE : 2 Y	
SER : YMCA		DR : DYC1, JOSE	
THIS IS A SECURITY RX			
<p>Rebitusin (Childress) Sg: 1/4 + 1/2 every 6 hrs PRN Disp: 40 units</p> <p><i>January 2016</i></p>			
<input type="checkbox"/> 1-24 <input type="checkbox"/> 25-49 <input type="checkbox"/> 50-74 <input type="checkbox"/> 75-100 <input type="checkbox"/> 101-150 <input type="checkbox"/> 151 and over			
Rx# NR 1 2 3 4 5			
Prescription is void if more than one (1) prescription is written on blank			

**EXHIBIT NO. B6F
PAGE: 106 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006398531
ADM: Jan 06,2018 13:27

*** END ***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

EXHIBIT NO. B6F
PAGE: 107 OF 239

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
ATTENDING:

***** CONFIDENTIAL ORDERS SUMMARY *****

Order Date: St: Requestor: Start Date: Stop Date:
Nature of Order: Signature:
Item Ordered:

*** END **** * CONFIDENTIAL ORDERS SUMMARY *

**EXHIBIT NO. B6F
PAGE: 108 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006398531
ADM: Jan 06,2018 13:27

***** CONFIDENTIAL LAB RESULTS SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL LAB RESULTS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 109 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006398531
ADM: Jan 06,2018 13:27

***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 110 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006398531
ADM: Jan 06,2018 13:27

***** CONFIDENTIAL DISCHARGE SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL DISCHARGE SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 111 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
ATTENDING:

***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 112 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006398531
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 06, 2018 13:27
ATTENDING:
=====

ADRs: No ADRs on file.

Allergies: PENICILLIN
=====

****NO MEDICATIONS FOUND****

*** END ***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

{{{ END }}} Patient Encounter(s) History Report Dec 28, 2018@14:22

**EXHIBIT NO. B6F
PAGE: 113 OF 239**

Patient Encounter(s) History Report Dec 28, 2018@14:31

(From: 08/09/18 --- Thru: 08/10/18)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006416081
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09, 2018 12:36
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]
 Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B6F
PAGE: 114 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006416081
ADM: Aug 09,2018 12:36

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 115 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09, 2018 12:36
ATTENDING:

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (MEDICAL RECORDS ASSISTANT)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J

Observed/Historical: Historical

==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 116 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006416081
ADM: Aug 09,2018 12:36

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 117 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09, 2018 12:36
ATTENDING:

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- CERTIFIED MAIL RECEIPT (SCANNED DOC) -----
DATE OF NOTE: AUG 17, 2018@13:05 ENTRY DATE: AUG 17, 2018@13:05:55
AUTHOR: STIMSON, MARLENA EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Certified mail receipt attached as scanned document. See attached image.

/es/ MARLENA STIMSON
OFFICE ASSISTANT
Signed: 08/17/2018 13:16

**EXHIBIT NO. B6F
PAGE: 118 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006416081
 ADM: Aug 09,2018 12:36

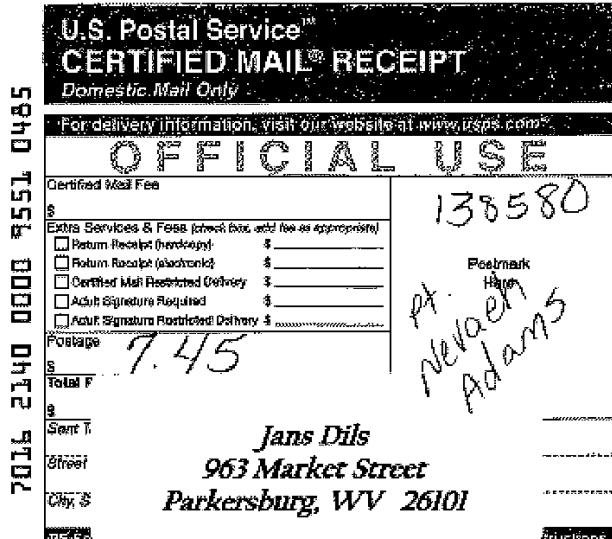


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PAGE: 119 OF 239

Certified Mail service provides the following benefits:

- A receipt (this portion of the Certified Mail label).
 - A unique identifier for your mailpiece.
 - Electronic verification of delivery or attempted delivery.
 - A record of delivery (including the recipient's signature) that is retained by the Postal Service™ for a specified period.
- Important Reminders:**
- You may purchase Certified Mail service with First-Class Mail®, First-Class Package Service®, or Priority Mail® service.
 - Certified Mail service is not available for International mail.
 - Insurance coverage is not available for purchase with Certified Mail service; however, the purchase of Certified Mail service does not change the insurance coverage automatically included with certain Priority Mail items.
 - For an additional fee, and with a proper endorsement on the mailpiece, you may request the following services:
 - Return receipt service, which provides a record of delivery (including the recipient's signature). You can request a hardcopy return receipt or an electronic version. For a hardcopy return receipt, complete PS Form 3811, Domestic Return Receipt; attach PS Form 3811 to your mailpiece;
- for an electronic return receipt, see a retail associate for assistance. To receive a duplicate return receipt for no additional fee, present this USPS®-postmarked Certified Mail receipt to the retail postmaster.
- Restricted delivery service, which provides delivery to the addressee specified by name, or to the addressee's authorized agent.
- Adult signature service, which requires the signer to be at least 21 years of age (not available at retail).
- Adult signature restricted delivery service, which requires the signer to be at least 21 years of age and provides delivery to the addressee specified by name, or to the addressee's authorized agent (not available at retail).
- To ensure that your Certified Mail receipt is accepted as legal proof of mailing, it should bear a USPS postmark. If you would like a postmark on this Certified Mail receipt, please present your Certified Mail item at a Post Office™ for postmarking. If you don't need a postmark on this Certified Mail receipt, detach the barcode portion of this label, affix it to the mailpiece, apply appropriate postage, and deposit the mailpiece.

IMPORTANT: Save this receipt for your records.

PS Form 3800, April 2015 (Revised) PSN 7590-02-000-2047

**EXHIBIT NO. B6F
PAGE: 120 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006416081
 ADM: Aug 09, 2018 12:36

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

Jans Dils
963 Market Street
Parkersburg, WV 26101



9590 9402 2259 6225 4576 18

2. Article Number (Transfer from service label)
 7016 2140 0000 9551 0485

COMPLETE THIS SECTION ON DELIVERY

A. Signature	<i>Cherylynn White</i>	<input type="checkbox"/> Agent
		<input type="checkbox"/> Addressee
B. Received by (Printed Name)	<i>Cherylynn White</i>	C. Date of Delivery
		<i>8-21-18</i>

D. Is delivery address different from item 1? Yes
 If YES, enter delivery address below: No

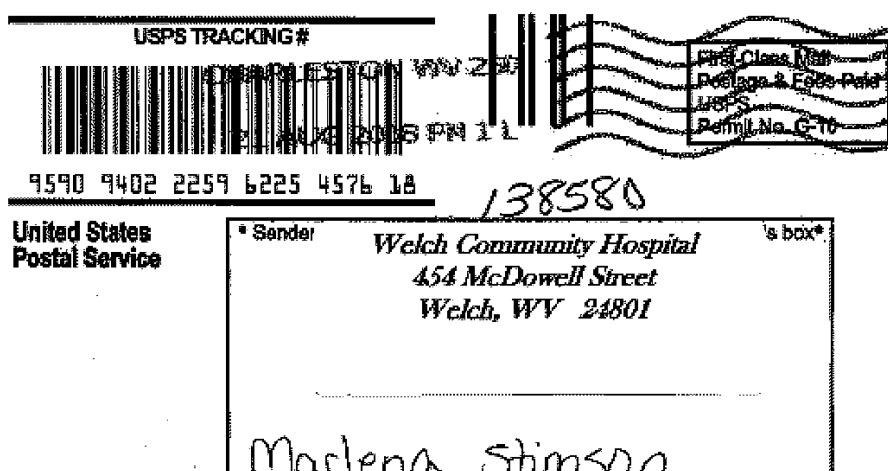
138580

3. Service Type
- | | |
|--|---|
| <input type="checkbox"/> Adult Signature | <input type="checkbox"/> Priority Mail Express® |
| <input type="checkbox"/> Adult Signature Restricted Delivery | <input type="checkbox"/> Registered Mail™ |
| <input checked="" type="checkbox"/> Certified Mail® | <input type="checkbox"/> Registered Mail Restricted Delivery |
| <input type="checkbox"/> Collect on Delivery | <input type="checkbox"/> Return Receipt for Merchandise |
| <input type="checkbox"/> Collect on Delivery Restricted Delivery | <input type="checkbox"/> Signature Confirmation™ |
| <input type="checkbox"/> Insured Mail | <input type="checkbox"/> Signature Confirmation Restricted Delivery |
| <input type="checkbox"/> Insured Mail Restricted Delivery (over \$500) | |

PS Form 3811, July 2015 PSN 7530-02-000-9069

Domestic Return Receipt

**EXHIBIT NO. B6F
PAGE: 121 OF 239**



**EXHIBIT NO. B6F
PAGE: 122 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006416081
ADM: Aug 09, 2018 12:36

----- AUTHORIZATION FOR RELEASE OF MEDICAL RECORD (SCANNED -----
DATE OF NOTE: AUG 17, 2018@13:04 ENTRY DATE: AUG 17, 2018@13:04:13
AUTHOR: STIMSON, MARLENA EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned document(s).

/es/ MARLENA STIMSON
OFFICE ASSISTANT
Signed: 08/17/2018 13:05

**EXHIBIT NO. B6F
PAGE: 123 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006416081
 ADM: Aug 09, 2018 12:36

NB

From: GFI FaxMaker To: 13044363389 Page: 1/4 Date: 8/17/2018 9:15:59 AM

MR# 138580
received
 08-17-2018



963 Market Street, Parkersburg, WV 26101
 Fax: 304-428-4500
 Email: records@jandils.com

To:	Welch Community Hospital *	From:	Jaime
	Attn: Medical Records		
	454 McDowell Street		
	Welch, WV 24801		
Fax:	(304) 436-3389	Pages:	
Re:	Ms. Nevaeh Hope Adams	Date:	August 17, 2018
DoB:	7/21/2015		

Request for Medical Records for Social Security Disability/ Supplemental Security Income Claim
DATES OF SERVICE ARE LISTED ON MEDICAL AUTHORIZATION.

PLEASE CALL OUR OFFICE IF ANY FEES ARE ASSOCIATED WITH THIS REQUEST PRIOR TO FULFILLING.

Also enclosed is a signed statement asking that all fees be waived per amendment §16-29-2 of the West Virginia Code.

If records are unavailable for the above-named patient, please check the appropriate box below and fax this cover sheet back to us at 304-428-4500. Thanks for your cooperation!

- No records for Dates of Service Requested (DATE LAST SEEN _____)
- Not a patient at this facility
- Records have been purged

Please forward records to our email: records@jandils.com or 304-428-4500

For Information on a no-cost, HIPAA-CERTIFIED way to deliver your medical records, contact Beverly at

51818
 11/18 8/19/18
 10/18 1CD
 11/18 M/S

**The information contained in this facsimile message is attorney privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the address indicated above. Thank you.

This fax was sent with GFI FaxMaker fax server. For more information visit: <http://www.gfi.com>

**EXHIBIT NO. B6F
PAGE: 124 OF 239**

From: GFI FaxMaker To: 13044363369 Page: 2/4 Date: 8/17/2018 9:15:59 AM

138580

~~CONFIDENTIALITY DOES NOT AFFECT THE LEGALITY OF THIS INFORMATION~~

Patient Name: Ms. Nevaeh Hope Adams Date of Birth: 7/21/2015

Address: Kelli Adams PO Box 491

City: Panther State: WV Zip: 24872

Telephone Number: (304)650-7454 SSN: (000)00-0000

I hereby authorize: Welch Community Hospital * to release my medical records to Jan Dils, Attorney at Law, LC, 963 Market Street, Parkersburg, WV 26101. This information is needed by my attorney and I in connection with a claim for disability benefits from the Social Security Administration.

Please forward records to: JAN DILS, ATTORNEY AT LAW, LC., 963 Market Street, Parkersburg, WV 26101. This information is needed by my attorney and I in connection with a claim for disability benefits from the Social Security Administration.

Information to be disclosed: Complete Health Record(s) Laboratory Test

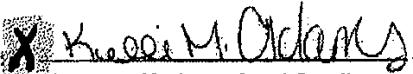
X-Ray Reports History & Physical Exam Consultation

Other (please specify) _____

For treatment date(s) if applicable: 01/07/2018 to present

A photocopy of this consent may be used as if it is the original. Refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enroll in a health plan. Unless otherwise revoked, this authorization will expire 180 days after the date of signature. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 963 Market Street, Parkersburg, WV, 26101.

Signed By:



Signature of Patient or Legal Guardian

Nevaeh Adams

Patient's Name

Kelli Adams

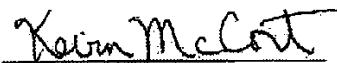
Print Name of Patient or Legal Guardian

Mother

Relationship to Patient

08/17/2018

Date



Witness

This form was sent with GFI FaxMaker fax server. For more information, visit <http://www.gfi.com>

EXHIBIT NO. B6F
PAGE: 125 OF 239

From: GFI FaxMaker TO: 13044363308 Page: 3/4 Date: 0/17/2018 9:10:38 AM

STATEMENT OF INABILITY TO AFFORD MEDICAL RECORD FEES
WEBCOM VINCENZA CLERK/INTO

I am unable to pay search fees and copying charges for medical records because:

138580

- a. I am unemployed
- b. I am disabled
- c. I and/or my household receive income below the federal poverty level, my household size is 6 persons
- d. I and/or my household receive state or federal income assistance. Specifically: _____

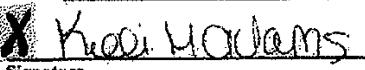
<input type="checkbox"/> Child Support	<input type="checkbox"/> Head Start
<input type="checkbox"/> Dymo 11/11/11/TANF Program	<input type="checkbox"/> TANF: Temporary Assistance for Needy Families / cash assistance
<input type="checkbox"/> Free or reduced school meals	<input type="checkbox"/> CNAAP: Supplemental Nutrition Assistance Program or food stamps
<input type="checkbox"/> Chafee: Children's assistance	<input type="checkbox"/> WIC: Special Supplemental Nutrition Program for Women, Infants, & Children
<input type="checkbox"/> Federal Pell Grants	<input type="checkbox"/> TEFAP: The Emergency Food Assistance Program
<input type="checkbox"/> Federal TRIO Programs	<input type="checkbox"/> Section 8 Project-Based Rental Assistance or Choice Vouchers
<input type="checkbox"/> HUD Housing Assistance	<input type="checkbox"/> LIHEAP: Low-Income Home Energy Assistance Program
<input type="checkbox"/> TANF employment and training	<input type="checkbox"/> Veteran Administration disability benefits
<input type="checkbox"/> Long term disability	<input type="checkbox"/> Emergency Food and Shelter Program
<input type="checkbox"/> Disability retirement benefits	<input type="checkbox"/> Title I Migrant Education Program
<input type="checkbox"/> Indian Education	<input type="checkbox"/> Indian Health Services
<input type="checkbox"/> Short term disability	<input type="checkbox"/> Federal Work – Study
<input type="checkbox"/> Unemployment benefits	<input type="checkbox"/> Head Start HHS
<input type="checkbox"/> Currently receiving SSI	

OTHER assistance from the government.

THEREFORE, I request that search fees and copying charges be waived for me and my authorized representative Jan Dilis, Attorney at Law, as provided by West Virginia Code § 16-29-2 as amended.

West Virginia Code § 16-29-2. Reasonable expenses to be reimbursed states:

- (b) Notwithstanding the provisions of subsection (a) of this section, a provider shall not impose a charge on an indigent person or his or her authorized representative if the medical records are necessary for the purpose of supporting a claim or appeal under provisions of the Social Security Act, 42 U.S.C. §301 et seq.
- (c) For purposes of this section, a person is considered indigent if her or she:
- (1) Is represented by an organization or affiliated pro bono program that provides legal assistance to indigents; or
 - (2) Verifies on a medical records request and release form that the records are requested for purposes of supporting a social security claim or appeal and submits with the release form reasonable proof that the person is financially unable to pay full copying charges by reason of unemployment, disability, income below the federal poverty level, or receipt of state or federal income assistance.


 Signature

08/17/2018
 Date

Ms. Kelli Adams OBO Ms. Nevach Hope Adams
 Printed Name

Search fees and copying charges shall be waived, as appropriate, described by the above code for the above referenced individual. If additional information is needed for this request please contact Jan Dilis Attorneys at Law, LC at (304)428-8900 and request to speak with Amanda Nolan. Invoices submitted with medical records for individuals who are entitled fees waiver under this law will not be honored unless the invoice is authorized by this firm in advance or a prior agreement regarding fees/charges has been made.

This fax was sent with GFI FaxMaker fax server. For more information, visit: <http://www.gfi.com>

EXHIBIT NO. B6F
PAGE: 126 OF 239

Name : ADAMS, NEVAEH H	MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE	ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL	ADM: Aug 09,2018 12:36
ATTENDING:	

----- CODING ABSTRACT FORM (SCANNED) -----
 DATE OF NOTE: AUG 15, 2018@13:42 ENTRY DATE: AUG 15, 2018@13:42:54
 AUTHOR: WELLMAN,MELISSA J EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

See attached scanned Coding Abstract Form(s).
 DATE: 08/15/2018 WELCH HOSPITAL TIME: 01:35 PM

PAGE: 1 OF 1 CODING SUMMARY

ADAMS, NEVAEH H MR #: 000138580 PAT #: 006416081

Sex: F Admitted: 8/09/18

Birthdate: 7/21/2015 Discharged: 8/09/18

Age at Admit: 003 LOS: 1

Attending Phys: 615553 KOBBAH, PIAYON UB92 Disp: 01

MR Coord Apprv: 1 - APP MR Apprv Date: 8/15/18

Outlier: 00 Current DRG:

Diagnoses POA MOD HAC Description

1. Z00.129 Encntr for routine child health exam w/o abnormal findings

2. Z28.9 Immunization not carried out for unspecified reason

Date CPT Modifiers Description

1. 08/09/18 36415 ROUTINE VENIPUNCTURE

2. 08/09/18 85025 COMPLETE CBC W/AUTO DIFF WBC

3. 08/09/18 96110 EP DEVELOPMENTAL TEST LIM

4. 08/09/18 99214 OFFICE/OUTPATIENT VISIT EST

5. 08/09/18 99392 PREV VISIT EST AGE 1-4

To Attending Physician: Please review the above diagnoses and procedures and notify Health Information Management if there are any discrepancies or any inaccuracies. Thank you !!

**EXHIBIT NO. B6F
PAGE: 127 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09,2018 12:36
ATTENDING:

/es/ MELISSA J WELLMAN
MEDICAL RECORDS ASSISTANT, LPN
Signed: 08/15/2018 13:42

----- IDENTIFICATION CARD/DRIVERS LICENCE -----
DATE OF NOTE: AUG 9,2018@13:48 ENTRY DATE: AUG 9,2018@13:48:13
AUTHOR: MULLINS,KARISA L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

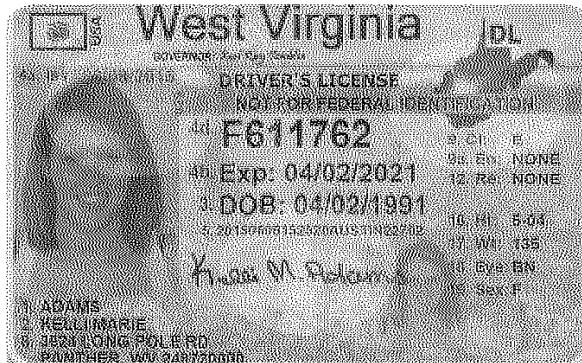
ID Card /Drivers License attached as scanned image.

/es/ KARISA L MULLINS
OFFICE ASSISTANT
Signed: 08/09/2018 13:48

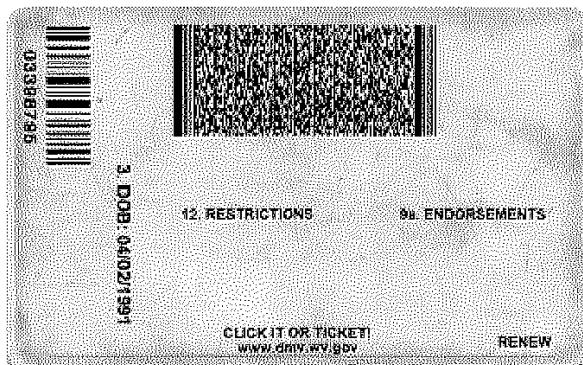
**EXHIBIT NO. B6F
PAGE: 128 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006416081
ADM: Aug 09,2018 12:36



**EXHIBIT NO. B6F
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**EXHIBIT NO. B6F
PAGE: 130 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006416081
ADM: Aug 09,2018 12:36

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----
DATE OF NOTE: AUG 9,2018@13:48 ENTRY DATE: AUG 9,2018@13:48:30
AUTHOR: MULLINS,KARISA L EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ KARISA L MULLINS
OFFICE ASSISTANT
Signed: 08/09/2018 13:48

**EXHIBIT NO. B6F
PAGE: 131 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006416081
 ADM: Aug 09, 2018 12:36



ADAMS, NEVAEH	
ADM : 010918	ACT# : 006416081
MED# : 139580	
DOB : 7/21/2015	FC : CD
SEX : F	AGE : 3 yr
SFR : PNC	DR : KIRRAH, PIAYON

WELCH COMMUNITY HOSPITAL
 454 McDOWELL STREET
 WELCH, WV 24801

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

**EXHIBIT NO. B6F
PAGE: 132 OF 239**

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

ADAMS, NEVAEH	ACT# : 608416081
ADM : 810918	MED# : 138580
DOB : 7/21/2015	FC : CB
SEX : F	AGE : 3 yr
SER : POC	DR : KOBBAH, PIYON

EXHIBIT NO. B6F
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7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

If you would like to Opt out of HIV testing, please initial the box to the left.

There may be some instances where patients are not allowed to opt out for further information please refer to the information sheet given to you upon registration.

8. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: K X

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

9. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

ADAMS, NEVAEH		ACT# : 006416081
ADM : 8/09/18		MED# : 139580
		FC : 00
DOB : 7/21/2015		AGE : 3 yr
SEX : F		
SER : PDC		DR : KOBRAK, PIYON

**EXHIBIT NO. B6F
PAGE: 134 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006416081
ADM: Aug 09,2018 12:36

----- INSURANCE CARD -----
DATE OF NOTE: AUG 9,2018@13:47 ENTRY DATE: AUG 9,2018@13:47:34
AUTHOR: MULLINS,KARISA L EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.
INSURANCE CARD BACK (SCANNED) :

/es/ KARISA L MULLINS
OFFICE ASSISTANT
Signed: 08/09/2018 13:48

**EXHIBIT NO. B6F
PAGE: 135 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006416081
 ADM: Aug 09, 2018 12:36

Eligibility Information

Page 1 of 2

Eligibility Verification

Form Entry Member Search Eligibility Verification

Eligibility Inquiry verifies whether a member was eligible for a covered program on the date(s) of service submitted in the request. This information does not guarantee eligibility or payment for the service rendered.

Member

Name	Date of Birth	Member ID	Gender
ADAMS NEVAEH	7/21/2015	00405164305	Female
Tracking Number	10221W000007295		

Eligibility Inquiry

Dates of Service

* From Date Of Service 8/9/2018

* To Date Of Service 8/9/2018

* Inquiry Type Date Span Only



N/A/MB RESET

Enrollments

Program/Benefit Name	Coverage Status	Coverage Level	Plan Type	Effective Date	Termination Date	Member ID
- WV Mountain Health Trust Benefit Plan	Active	Primary	Medical	05/01/2018		00405164305
Rate Code	Coverage	Effective Date	Termination Date			
FCMGMF	Categorically Needy	06/01/2018				
FCMGMF	Tier 3 Copay	06/01/2018				
- WVCHIP Premium Plan	Active	Secondary	Medical	05/01/2018		4051643051
Rate Code	Coverage	Effective Date	Termination Date			
PREMI	WVCHIP Premium	05/01/2018				

ADAMS, NEVAEH

ADM: 8/08/18 ACT#: 006416081
 DOB: 7/21/2015 MED#: 138580
 FC: CO SEX: F AGE: 3 yr
 SER: POC DR: KOBBAH, PIAYON

Other Insurance

No Coordination of Benefits information found

Copay

It is the member's responsibility to pay the copay to the provider at the time of the service. Copays are at the benefit level (individual service codes).

Beginning for claims with a Date of Service on or after August 09, 2018, copays for this member are:

Service	Copay Amount	Effective Date	Termination Date	Tier
DENTAL	\$25	08/01/2018		CHIP PREMIUM
ER	\$35	08/01/2018		CHIP PREMIUM
HOSPITAL INPATIENT	\$25	08/01/2018		CHIP PREMIUM
HOSPITAL OUTPATIENT	\$25	08/01/2018		CHIP PREMIUM
PHYSICIAN	\$20	08/01/2018		CHIP PREMIUM

PCP / Medical Home

Effective Date	Termination Date
PCP / Medical Home Name	UNICARE HEALTHPLAN OF WEST VIRGINIA, INC
Address	PO Box 91 Attn: Claims, Charleston, WV 25321-0091
Office Number	800-782-0095
	Coverage Status Active

<https://www.wvmmis.com/MyHealthPAS/Provider/Pages/PrvEligibilityVerification.aspx> 8/9/2018

**EXHIBIT NO. B6F
PAGE: 136 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09, 2018 12:36
ATTENDING:

----- PRESENTING SHEET (SCANNED) -----
DATE OF NOTE: AUG 9, 2018@13:47 ENTRY DATE: AUG 9, 2018@13:47:57
AUTHOR: MULLINS, KARISA L EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ KARISA L MULLINS
OFFICE ASSISTANT
Signed: 08/09/2018 13:48

EXHIBIT NO. B6F
PAGE: 137 OF 239

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

 MRN: WEL000138580
 ACT: WEL006416081
 ADM: Aug 09,2018 12:36

RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION FORM

PLEASE FILL OUT TOP PORTION ONLY

NAME: Nevaeh Adams TODAY'S DATE: 8-9-10
 TIME: 12:24 AGE: 2 BIRTHDAY: 7-21-15

TO BE FILLED OUT BY HOSPITAL STAFF

DISPOSITION: WIC PEDS IM

Registration Complaint: shots

NURSE: VB Henry TIME: 10:38

ADAMS, NEVAEH	
ADM: 006416081	ACT: 006416081
DOB: 7/21/2015	MC: CC
SEX: F	AGE: 3 yr
SER: POC	DR: KOBBAH, PIAYON

**EXHIBIT NO. B6F
PAGE: 138 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09, 2018 12:36
ATTENDING:

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----
DATE OF NOTE: AUG 9, 2018@09:22 ENTRY DATE: AUG 11, 2018@09:22:20
AUTHOR: VAUGHN,MEGHAN T EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ MEGHAN T VAUGHN
OFFICE ASSISTANT
Signed: 08/11/2018 09:23

**EXHIBIT NO. B6F
PAGE: 139 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006416081
 ADM: Aug 09, 2018 12:36

RURAL HEALTH CLINIC
 Name: Nevaeh Adams
 Date/Time of Arrival: 1230

ADAMS, NEVAEH
 ADM: 8/09/18 ACT: 008416081
 DOB: 7/21/2015 MEO#: 138580
 SEX: F FC: CO
 STB: PNP DR: KIRRAH PAYON AGE: 3 yr

Reason for Visit:
shots

ALLERGIES Amoxicillin

Vitals: BP _____ HR 120 RR 22 Temp 99.1 Pulse Ox 98 % lpm
 Pain (0-10) _____ Location _____ Wt 32.4 Ht. _____ LMP _____

Medical History:

Asthma Gout: CHF: COPD: CVA Diabetes
 HTN Hyperlipidemia: Psych: Renal: Seizures

Other: Turner's syndrome, Os tritaley valve, hip dysplasia

Date of last mammogram _____ Date of last papsmear _____

Date of last colonoscopy _____

Surgical History:

Appendix Cardiac/Stent Gallbladder Hysterectomy BTL
 Other: bil hip

Social History: smoker ppd/never/quit drugs alcohol none/recent/occassional

Primary Care Provider: J

Nurse Signature: B. Bentz

****PATIENT REQUIRES HIGHER LEVEL OF CARE****

Focus assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider _____ Date _____ Time _____

Original 2-2017

**EXHIBIT NO. B6F
PAGE: 140 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09, 2018 12:36
ATTENDING:

----- MEDICATION RECONCILIATION (SCANNED) -----
DATE OF NOTE: AUG 9, 2018@09:22 ENTRY DATE: AUG 11, 2018@09:22:35
AUTHOR: VAUGHN,MEGHAN T EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ MEGHAN T VAUGHN
OFFICE ASSISTANT
Signed: 08/11/2018 09:23

**EXHIBIT NO. B6F
PAGE: 141 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006416081
 ADM: Aug 09, 2018 12:36

**WELCH COMMUNITY HOSPITAL
MEDICATION RECONCILIATION FORM**

ADAMS, NEVAEH
 ADM: 80918 ACT #: 069416081
 MED#: 136580
 DOB: 7/21/2015 FC: CO
 SEX: F AGE: 3 yr
 CSD-DRG: 101 VANDAU DRUGS

Name: Allergies:		Patient is on no medications at this time						
LIST BELOW ALL OF THE PATIENT'S MEDICATION PRIOR TO ADMISSION (INCLUDING OVER-THE-COUNTER AND HERBAL MEDS)								
Name of Medication/Dose	Amount	Route	Frequency	Last Dose	Reason for Medication	Continue on Admission	Continue after Surgery or Transfer	Continue on Discharge
1. <i>Chromex Cori with Inj</i>		by mouth / topical Inject / Inhaler Injections / topical	1 times a day as needed			Y N	Y N	Y N
2.		Inject / Inhaler times a day			Y N	Y N	Y N
3.		by mouth / topical Inject / Inhaler times a day as needed			Y N	Y N	Y N
4.		by mouth / topical Inject / Inhaler times a day as needed			Y N	Y N	Y N
5.		by mouth / topical Inject / Inhaler times a day as needed			Y N	Y N	Y N
6.		by mouth / topical Inject / Inhaler times a day as needed			Y N	Y N	Y N
7.		by mouth / topical Inject / Inhaler times a day as needed			Y N	Y N	Y N
8.		by mouth / topical Inject / Inhaler times a day as needed			Y N	Y N	Y N
9.		by mouth / topical Inject / Inhaler times a day as needed			Y N	Y N	Y N
10.		by mouth / topical Inject / Inhaler times a day as needed			Y N	Y N	Y N

NEW MEDICATIONS ADDED								
Date	Name of Medication/Dose	Amount	Route	Frequency	Duration	Rasson	Provider Name	
			by mouth/topical/inject/inhale	times a day as needed	Days			
			by mouth/topical/inject/inhale	times a day as needed	Days			
			by mouth/topical/inject/inhale	times a day as needed	Days			
			by mouth/topical/inject/inhale	times a day as needed	Days			
			by mouth/topical/inject/inhale	times a day as needed	Days			
			by mouth/topical/inject/inhale	times a day as needed	Days			
			by mouth/topical/inject/inhale	times a day as needed	Days			
			by mouth/topical/inject/inhale	times a day as needed	Days			
			by mouth/topical/inject/inhale	times a day as needed	Days			

Source of Medication List:
 _____ Patient Medication List
 _____ Patient/Family Recall
 _____ Pharmacy: _____
 _____ Primary Care Physician List
 _____ Previous Discharge Paperwork
 _____ Reconciled from patient's Medication bottles
 _____ Reconciliation Prescriber (MD/DO)

Medication List Recorded/Reviewed by RN/ND/PA/LPN/RP
 By: *B. Sleeth* Date: 8/9/18
 By: _____ Date: _____
 By: _____ Date: _____
 By: _____ Date: _____

Physician _____ Date _____
 Physician _____ Date _____

Revised 2/13

**EXHIBIT NO. B6F
PAGE: 142 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09, 2018 12:36
ATTENDING:

----- CLINIC NOTE (SCANNED) -----
DATE OF NOTE: AUG 9, 2018@09:21 ENTRY DATE: AUG 11, 2018@09:22
AUTHOR: VAUGHN,MEGHAN T EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Clinic Note(s).

/es/ MEGHAN T VAUGHN
OFFICE ASSISTANT
Signed: 08/11/2018 09:23

**EXHIBIT NO. B6F
PAGE: 144 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

*** END ***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 145 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09, 2018 12:36
ATTENDING:
=====

***** CONFIDENTIAL ORDERS SUMMARY *****

Order Date: St: Requestor: Start Date: Stop Date:
Nature of Order: Signature:
Item Ordered:
=====

08/09/18 13:57 c KOBBAH, PIAYON E 08/09/18 14:26:30 08/09/18 14:34
ELECTRONICALLY ENTERED ELECTRONIC

Treating Specialty:

Ordering Location: PEDIATRIC CLINIC

- Activity:
- 08/09/2018 13:57 New Order entered by KOBBAH, PIAYON E (PHYSICIAN)
- Order Text: CBC-WEL BLOOD-LAV STAT I ONCE
- Nature of Order: ELECTRONICALLY ENTERED
- Elec Signature: KOBBAH, PIAYON E (PHYSICIAN) on 08/09/2018 13:57
-

*** END ***** CONFIDENTIAL ORDERS SUMMARY *****

EXHIBIT NO. B6F
PAGE: 146 OF 239

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006416081
 ADM: Aug 09,2018 12:36

***** CONFIDENTIAL LAB RESULTS SUMMARY *****

Report Released Date/Time: Aug 09, 2018@14:34

Provider: KOBBAH, PIAYON E

Specimen: BLOOD. WHEM 0809 59

Specimen Collection Date: Aug 09, 2018@14:26

Test name	Result	Flg	units	Ref.	range	Site	Result	Dt/Time
WBC-WEL	11.1	H	x10 3/uL	4.8	- 10.8	[68]	08/09/18 14:34	
NEU%-WEL	65.6	%		42.2	- 75.2	[68]	08/09/18 14:34	
LYM%-WEL	26.6	%		20.5	- 51.5	[68]	08/09/18 14:34	
MON%-WEL	5.9	%		5.5	- 11.7	[68]	08/09/18 14:34	
EOS%-WEL	1.1	%		0.9	- 2.9	[68]	08/09/18 14:34	
BAS%-WEL	0.8	%		0.2	- 1.0	[68]	08/09/18 14:34	
NEU#-WEL	7.2	H	#	1.4	- 6.5	[68]	08/09/18 14:34	
LYMPH #-WEL	3.0	#		1.2	- 3.4	[68]	08/09/18 14:34	
MON#-WEL	0.7	#		0.3	- 0.8	[68]	08/09/18 14:34	
EOS#-WEL	0.1	#		0.0	- 0.2	[68]	08/09/18 14:34	
BAS#-WEL	0.1	#		0.0	- 0.1	[68]	08/09/18 14:34	
RBC-WEL	4.48		x10 6/uL	4.20	- 5.40	[68]	08/09/18 14:34	
HEMOGLOBIN-WEL	12.8		g/dl	12.0	- 16.0	[68]	08/09/18 14:34	
HEMATOCRIT-WEL	37.9	%		37.0	- 47.0	[68]	08/09/18 14:34	
MCV-WEL	84.5	fL		81.0	- 99.0	[68]	08/09/18 14:34	
MCH-WEL	28.6	pg		27.0	- 31.0	[68]	08/09/18 14:34	
MCHC-WEL	33.8	g/dl		33.0	- 37.0	[68]	08/09/18 14:34	
RDW-WEL	11.3	L	%	11.5	- 14.5	[68]	08/09/18 14:34	
PLATELETS-WEL	117	L	x10 3/uL	130	- 400	[68]	08/09/18 14:34	
MPV-WEL	8.0	fL		7.4	- 10.4	[68]	08/09/18 14:34	

Comment: Collected by LG at 1434

Released by MGA at 1434

Performing Lab Sites

[68] WEL
 454 McDOWELL STREET WELCH, WV 24801

----- END -----

*** END ***** CONFIDENTIAL LAB RESULTS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 147 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09,2018 12:36
ATTENDING:

***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 148 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006416081
ADM: Aug 09,2018 12:36

***** CONFIDENTIAL DISCHARGE SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL DISCHARGE SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 149 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09, 2018 12:36
ATTENDING:

***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 150 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006416081
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 09, 2018 12:36
ATTENDING:

ADRs: No ADRs on file.

Allergies: PENICILLIN
=====

****NO MEDICATIONS FOUND****

*** END ***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

{{{ END }}} Patient Encounter(s) History Report Dec 28, 2018@14:31

**EXHIBIT NO. B6F
PAGE: 151 OF 239**

Patient Encounter(s) History Report Dec 28, 2018@14:32

(From: 08/28/18 --- Thru: 08/29/18)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006417682
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 28, 2018 13:07
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]
 Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B6F
PAGE: 152 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006417682
ADM: Aug 28,2018 13:07

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 153 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006417682
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 28, 2018 13:07
ATTENDING:

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (MEDICAL RECORDS ASSISTANT)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J
Observed/Historical: Historical
==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 154 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006417682
ADM: Aug 28,2018 13:07

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

EXHIBIT NO. B6F
PAGE: 155 OF 239

Name : ADAMS, NEVAEH H	MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE	ACT: WEL006417682
HOSP : WELCH COMMUNITY HOSPITAL	ADM: Aug 28,2018 13:07
ATTENDING:	

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- CODING ABSTRACT FORM (SCANNED) -----
 DATE OF NOTE: AUG 30,2018@14:11 ENTRY DATE: AUG 30,2018@14:11:53
 AUTHOR: WELLMAN,MELISSA J EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

See attached scanned Coding Abstract Form(s).
 DATE: 08/30/2018 WELCH HOSPITAL TIME: 02:04 PM

PAGE: 1 OF 1 CODING SUMMARY

ADAMS, NEVAEH H MR #: 000138580 PAT #: 006417682

Sex: F Admitted: 8/28/18

Birthdate: 7/21/2015 Discharged: 8/28/18

Age at Admit: 003 LOS: 1

Attending Phys: 615553 KOBBAH, PIAYON UB92 Disp: 01

MR Coord Apprv: 1 - APP MR Apprv Date: 8/30/18

Outlier: 00 Current DRG:

Diagnoses POA MOD HAC Description

- 1. H66.93 Otitis media, unspecified, bilateral
- 2. J06.9 Acute upper respiratory infection, unspecified

Date CPT Modifiers Description

- 1. 08/28/18 99214 OFFICE/OUTPATIENT VISIT EST

To Attending Physician: Please review the above diagnoses and procedures and notify Health Information Management if there are any discrepancies or any inaccuracies. Thank you !!

/es/ MELISSA J WELLMAN
 MEDICAL RECORDS ASSISTANT, LPN
 Signed: 08/30/2018 14:11

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----
 DATE OF NOTE: AUG 28,2018@15:55 ENTRY DATE: AUG 29,2018@15:55:11
 AUTHOR: HALE,DIANNE M EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

**EXHIBIT NO. B6F
PAGE: 156 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006417682
ADM: Aug 28,2018 13:07

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 08/29/2018 15:56

**EXHIBIT NO. B6F
PAGE: 157 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006417682
 ADM: Aug 28, 2018 13:07

RURAL HEALTH CLINIC
 Name: Nevaeh Adams
 Date/Time of Arrival: 8-28-18 1255

ADAMS, NEVAEH
 ADM: 082818 ACT#: 006417682
 MED#: 138580
 DOB: 7/21/2015 FC: MD
 SEX: F AGE: 3 yr
 CCO: CCR No. VNOODAU PREVNUA

Reason for Visit:
Runny nose, fever, cough, fever, pulling at ears
x 2 days.

Tylenol @ 1200

ALLERGIES Amoxicil

Vitals: BP _____ HR 148 RR 38 Temp 99.8 Pulse Ox 89 % lpm
 Pain (0-10) _____ Location _____ Wt. 32 Ht. _____ LMP _____

Medical History:

Asthma Gout: CHF: COPD: CVA Diabetes
 HTN Hyperlipidemia: Psych: Renal: Seizures

Other: G Turner's syndrome

Date of last mammogram _____ Date of last papsmear _____

Date of last colonoscopy _____

Surgical History:

Appendix Cardiac/Stent Gallbladder Hysterectomy BTL
 Other: G Bilateral hypo- Loring heart valve

Social History: smoker -ppd/never/quit drugs -alcohol none/recent/occassional

Primary Care Provider: Dr. Koffash

Nurse Signature: Carnestine Dow LPN

****PATIENT REQUIRES HIGHER LEVEL OF CARE****

Focus assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider _____ Date _____ Time _____

Original 2-2017

**EXHIBIT NO. B6F
PAGE: 158 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006417682
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 28, 2018 13:07
ATTENDING:

----- MEDICATION RECONCILIATION (SCANNED) -----
DATE OF NOTE: AUG 28, 2018@15:55 ENTRY DATE: AUG 29, 2018@15:55:28
AUTHOR: HALE, DIANNE M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 08/29/2018 15:56

EXHIBIT NO. B6F
PAGE: 159 OF 239

Name : ADAMS, NEVAEH H
DOB/SEX: JUL, 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL

MRN: WEL000138580
ACT: WEL006417682
ADM: Aug 28, 2018 13:07

Name: _____ Allergies: Anaphylactic Patient is on no medications at this time

LIST BELOW ALL OF THE PATIENT'S MEDICATION PRIOR TO ADMISSION, INCLUDING OVER-THE-COUNTER AND HERBAL MEDS								
Name of Medication/Dose	Amount	Route	Frequency	Last Dose	Reason for Medication	Continue on Admission	Continue after Surgery or Transfer	Continue on Discharge
1. Hormone Growth Inj.		by mouth / topical Inject / Inhaler	<input type="checkbox"/> times a day <input checked="" type="checkbox"/> as needed			Y N	Y N	Y N
2.		by mouth / topical Inject / Inhaler	<input type="checkbox"/> times a day <input checked="" type="checkbox"/> as needed			Y N	Y N	Y N
3.		by mouth / topical Inject / Inhaler	<input type="checkbox"/> times a day <input checked="" type="checkbox"/> as needed			Y N	Y N	Y N
4.		by mouth / topical Inject / Inhaler	<input type="checkbox"/> times a day <input checked="" type="checkbox"/> as needed			Y N	Y N	Y N
5.		by mouth / topical Inject / Inhaler	<input type="checkbox"/> times a day <input checked="" type="checkbox"/> as needed			Y N	Y N	Y N
6.		by mouth / topical Inject / Inhaler	<input type="checkbox"/> times a day <input checked="" type="checkbox"/> as needed			Y N	Y N	Y N
7.		by mouth / topical Inject / Inhaler	<input type="checkbox"/> times a day <input checked="" type="checkbox"/> as needed			Y N	Y N	Y N
8.		by mouth / topical Inject / Inhaler	<input type="checkbox"/> times a day <input checked="" type="checkbox"/> as needed			Y N	Y N	Y N
9.		by mouth / topical Inject / Inhaler	<input type="checkbox"/> times a day <input checked="" type="checkbox"/> as needed			Y N	Y N	Y N
10.		by mouth / topical Inject / Inhaler	<input type="checkbox"/> times a day <input checked="" type="checkbox"/> as needed			Y N	Y N	Y N

- Source of Medication List**

 - Patient Medication List
 - Patient/Family Recall
 - Pharmacy:
 - Primary Care Physician List
 - Previous Discharge Paperwork
 - Reconciled from patient's Medication bottles
 - Reconciliation Prescriber (MD/DN)

Medication List Recorded/Reviewed by RN/MD/DD/PAT/NP/APN/BSN

By: Farmer Jr LHD Date: 8-28-18

By: _____ Date: _____

By: _____ Date: _____
By: _____ Date: _____

By: _____ Date: _____

Date: _____

[View Details](#) | [Edit](#) | [Delete](#)

Physician _____ **Date** _____

Project No. _____ Date _____

Physician _____ **Date** _____

Date _____ Revised 2/13

Revised 2/13

Reviewed 2/13

**EXHIBIT NO. B6F
PAGE: 160 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006417682
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 28, 2018 13:07
ATTENDING:

----- PRESCRIPTION COPY (SCANNED) -----
DATE OF NOTE: AUG 28, 2018@15:55 ENTRY DATE: AUG 29, 2018@15:55:46
AUTHOR: HALE, DIANNE M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned copy of Prescription(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 08/29/2018 15:56

EXHIBIT NO. B6F
PAGE: 161 OF 239

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006417682
 ADM: Aug 28, 2018 13:07

8339 WELCH COMMUNITY HOSPITAL
 PIAYON E. KOBBAH, M.D.
 (304) 436-8461

Name Nevaeh Adams
 Address _____ Date 8/28/18

THIS PRESCRIPTION MAY BE FILLED WITH A PHARMACEUTICAL DRUG PRODUCT UNLESS THE WORDS "SWITCH TO GENERIC" OR THE WORDS "SWITCH TO ANOTHER DRUG PRODUCT" ARE WRITTEN IN INK OR MARKED WITH A STAMP ON THIS PRESCRIPTION FORM.

THIS IS A SECURITY TOL

claritin 5mg/5cc

DISP 8 oz

Six 1/2 tsp po Daily

Prescriber Kobba

- 1-24
- 25-49
- 50-74
- 75-100
- 101-150
- 151 and over

8338 WELCH COMMUNITY HOSPITAL
 PIAYON E. KOBBAH, M.D.
 (304) 436-8461

Name Nevaeh Adams
 Address _____ Date 8/28/18

THIS PRESCRIPTION MAY BE FILLED WITH A PHARMACEUTICAL DRUG PRODUCT UNLESS THE WORDS "SWITCH TO GENERIC" OR THE WORDS "SWITCH TO ANOTHER DRUG PRODUCT" ARE WRITTEN IN INK OR MARKED WITH A STAMP ON THIS PRESCRIPTION FORM.

THIS IS A SECURITY TOL

Zithromax 100ms/5cc

DISP Q3

Six 150 ms po D1

7.5 ms po D2-D5

Prescriber Kobba

- 1-24
- 25-49
- 50-74
- 75-100
- 101-150
- 151 and over

Prescription is valid if more than one (1) prescription is written per blank

ADAM, NEVAEH
 ADM: 08/28/18
 ACT: 08/28/18
 REC'D: 08/28/18
 MEDEX: 138580
 R00
 AGE: 34
 GENDER: M
 DOB: 07/21/15
 MRN: WEL000138580

**EXHIBIT NO. B6F
PAGE: 162 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

*** END ***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

EXHIBIT NO. B6F
PAGE: 163 OF 239

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006417682
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 28, 2018 13:07
ATTENDING:

***** CONFIDENTIAL ORDERS SUMMARY *****

Order Date: St: Requestor: Start Date: Stop Date:
Nature of Order: Signature:
Item Ordered:

***** END ***** CONFIDENTIAL ORDERS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 164 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006417682
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 28,2018 13:07
ATTENDING:

***** CONFIDENTIAL LAB RESULTS SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL LAB RESULTS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 165 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006417682
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 28,2018 13:07
ATTENDING:

***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 166 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006417682
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 28,2018 13:07
ATTENDING:

***** CONFIDENTIAL DISCHARGE SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL DISCHARGE SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 167 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006417682
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 28, 2018 13:07
ATTENDING:

***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 168 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006417682
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 28, 2018 13:07
ATTENDING:

ADRs: No ADRs on file.

Allergies: PENICILLIN
=====

****NO MEDICATIONS FOUND****

*** END ***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

{{{ END }}} Patient Encounter(s) History Report Dec 28, 2018@14:32

**EXHIBIT NO. B6F
PAGE: 169 OF 239**

Patient Encounter(s) History Report Dec 28, 2018@14:32

(From: 08/31/18 --- Thru: 09/01/18)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006418022
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 31, 2018 17:42
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]
 Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B6F
PAGE: 170 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006418022
ADM: Aug 31,2018 17:42

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 171 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006418022
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 31, 2018 17:42
ATTENDING:

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN,MELISSA J (MEDICAL RECORDS ASSISTANT)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN,MELISSA J

Observed/Historical: Historical

==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 172 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006418022
ADM: Aug 31,2018 17:42

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 173 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006418022
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 31, 2018 17:42
ATTENDING:

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- PRESENTING SHEET (SCANNED) -----
DATE OF NOTE: AUG 31, 2018@18:27 ENTRY DATE: AUG 31, 2018@18:27:17
AUTHOR: ENGLAND, AMANDA L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ AMANDA L ENGLAND
OFFICE ASSISTANT
Signed: 08/31/2018 18:28

EXHIBIT NO. B6F
PAGE: 174 OF 239

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006418022
 ADM: Aug 31,2018 17:42

RURAL HEALTH CLINIC (WALK IN CLINIC) REC		ADAMS, NEVAEH ADM: 8/31/18 ACT#: 006418022 DOB: 7/21/2015 MED#: 130580 SEX: F FC: MD SER: WAC DR: COWANS, RODNEY AGE: 3 YR	
PLEASE FILL OUT TOP PORTION ONLY			
NAME: <u>Nevaeh Adams</u>	TODAY'S DATE: <u>8/31/18</u>		
TIME: <u>5:30pm</u>	AGE: <u>3</u>	BIRTHDAY: <u>7/21/15</u>	
TO BE FILLED OUT BY HOSPITAL STAFF			
DISPOSITION: <u>WIC</u> <u>PEDS</u> <u>IM</u>			
Registration Complaint:	<u>Cough, runny nose, fever</u>		
NURSE: <u>Sherry R Westbury</u>	TIME: <u>5:30</u>		

**EXHIBIT NO. B6F
PAGE: 175 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006418022
ADM: Aug 31, 2018 17:42

----- INSURANCE CARD -----
DATE OF NOTE: AUG 31, 2018@18:27 ENTRY DATE: AUG 31, 2018@18:27:46
AUTHOR: ENGLAND, AMANDA L EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.
INSURANCE CARD BACK (SCANNED):

/es/ AMANDA L ENGLAND
OFFICE ASSISTANT
Signed: 08/31/2018 18:28

**EXHIBIT NO. B6F
PAGE: 176 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006418022
 ADM: Aug 31, 2018 17:42

Eligibility Information

Page 1 of 2

Eligibility Verification

Patient Search Member Search Eligibility Verification

Eligibility Inquiry verifies whether a member was eligible for a covered program on the date(s) of service submitted in the request. This information does not guarantee eligibility or payment for the service rendered.

Member

Name	Date of Birth	Member ID	Gender
ADAMS, NEVAEH H	07/21/2015	00405164305	Female
Tracking Number	18243W000009916		

Eligibility Inquiry

Date of Service	* From Date Of Service	8/31/2018	To Date Of Service	8/31/2018
-----------------	------------------------	-----------	--------------------	-----------

* Inquiry Type Date Span Only

SEARCH RISK

Enrollments

- Program/Benefit Name	Coverage Status	Coverage Level	Plan Type	Effective Date	Termination Date	Member ID
- WV Mountain Health Trust Benefit Plan	Active	Primary	Medical	05/01/2018		00405164305
Rate Code	Coverage	Effective Date	Termination Date			
FCMGKF	Categorically Need	05/01/2018				
FCMGKF	Tier 3 Copay	05/01/2018				
- WVCHP Premium Plan	Active	Secondary	Medical	05/01/2018		426164305
Rate Code	Coverage	Effective Date	Termination Date			
PRCM1	WVCHP Premium	05/01/2018				

ADAMS, NEVAEH

ADM: 8/31/18 ACT# : 008418015

MED# : 138580

FC : MD

SEX : F AGE : 3 yr

SER : ERM GR : SUTHERLAND, ROBERT

Other Insurance

No Co-ordination of Benefits information found.

Copay

It is the member's responsibility to pay the copay to the provider at the time of service. Copays are at the benefit level (individual service codes).

Beginning for claims with a Date of Service on or after August 31, 2018, copays for this member are:

Service	Copay Amount	Effective Date	Termination Date	Type
DENTAL	\$25	06/01/2018		CHIP PREMIUM
ER	\$35	06/01/2018		CHIP PREMIUM
HOSPITAL INPATIENT	\$25	06/01/2018		CHIP PREMIUM
HOSPITAL OUTPATIENT	\$25	06/01/2018		CHIP PREMIUM
PHYSICIAN	\$20	06/01/2019		CHIP PREMIUM

PCP / Medical Home

Effective Date	Termination Date		
PCP / Medical Home Name	Provider ID 9005002000		
Address			
Office Number	Coverage Status Active		

UNICARE HEALTHPLAN OF WEST VIRGINIA, INC.
 PO Box 91, Attn: Claims, Charleston, WV 25321-0091
 800-782-0066

<https://www.wvmmis.com/MyHealthPAS/Provider/Pages/PrvEligibilityVerification.aspx> 8/31/2018

**EXHIBIT NO. B6F
PAGE: 177 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006418022
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 31, 2018 17:42
ATTENDING:

----- IDENTIFICATION CARD/DRIVERS LICENCE -----
DATE OF NOTE: AUG 31, 2018@18:27 ENTRY DATE: AUG 31, 2018@18:27:56
AUTHOR: ENGLAND, AMANDA L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

ID Card /Drivers License attached as scanned image.
none

/es/ AMANDA L ENGLAND
OFFICE ASSISTANT
Signed: 08/31/2018 18:28

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----
DATE OF NOTE: AUG 31, 2018@18:26 ENTRY DATE: AUG 31, 2018@18:26:53
AUTHOR: ENGLAND, AMANDA L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ AMANDA L ENGLAND
OFFICE ASSISTANT
Signed: 08/31/2018 18:28

**EXHIBIT NO. B6F
PAGE: 178 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006418022
 ADM: Aug 31,2018 17:42



ADAMS, NEVAEH	
ADM: 8/31/18	ACT# : 008418022
DOB: 7/21/2015	MED#: 138580
SEX: F	FC: MD
SER: WIC	DR: COWANS, RODNEY
AGE: 3 yr	

WELCH COMMUNITY HOSPITAL
 454 MCDOWELL STREET
 WELCH, WV 24801

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby Irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

EXHIBIT NO. B6F
PAGE: 179 OF 239

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

- 5. HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
 - 6. OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

ADAMS, NEVAEH
ADM : 8/31/18 ACT# : 0064180322
DOB : 7/21/2015 MED# : 13B5530
SEX : F FC : MD
CPO : WIC AGE : 3 YR
DR : COWANS, RODNEY

EXHIBIT NO. B6F
PAGE: 180 OF 239

7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

If you would like to Opt out of HIV testing, please initial the box to the left.

There may be some instances where patients are not allowed to opt out for further information please refer to the information sheet given to you upon registration.

8. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: KAAA

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

9. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

ADAMS, NEVAEH	AGE: 006418722
ADM: 833118	MEDS: 10560
DOB: 7/21/2015	IC: MD
SEX: F	AGE: 3M
SER: 280	DR: CONNELL, ADRIENNE

EXHIBIT NO. B6F
PAGE: 181 OF 239

Name : ADAMS, NEVAEH H	MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE	ACT: WEL006418022
HOSP : WELCH COMMUNITY HOSPITAL	ADM: Aug 31,2018 17:42
ATTENDING:	

----- CODING ABSTRACT FORM (SCANNED) -----
 DATE OF NOTE: AUG 31,2018@15:22 ENTRY DATE: SEP 5,2018@15:22:29
 AUTHOR: JONES,NICHOLAS W EXP COSTIGNER:
 URGENCY: STATUS: COMPLETED

See attached scanned Coding Abstract Form(s).
 DATE: 09/05/2018 WELCH HOSPITAL TIME: 03:14 PM

PAGE: 1 OF 1 CODING SUMMARY

ADAMS, NEVAEH H MR #: 000138580 PAT #: 006418022

Sex: F Admitted: 8/31/18

Birthdate: 7/21/2015 Discharged: 8/31/18

Age at Admit: 003 LOS: 1

Attending Phys: 629574 COWANS, RODNEY UB92 Disp: 01

MR Coord Apprv: 1 - APP MR Apprv Date: 9/05/18

Outlier: 00 Current DRG:

Diagnoses POA MOD HAC Description

- 1. J30.2 Other seasonal allergic rhinitis
- 2. H66.93 Otitis media, unspecified, bilateral

Date CPT Modifiers Description

- 1. 08/31/18 99213 OFFICE/OUTPATIENT VISIT EST

To Attending Physician: Please review the above diagnoses and procedures and notify Health Information Management if there are any discrepancies or any inaccuracies. Thank you !!

/es/ NICHOLAS W JONES
 MEDICAL RECORDS ASSISTANT
 Signed: 09/05/2018 15:22

----- CLINIC NOTE (SCANNED) -----
 DATE OF NOTE: AUG 31,2018@12:54 ENTRY DATE: SEP 1,2018@12:54:09
 AUTHOR: COLLINS,LATISHA EXP COSTIGNER:
 URGENCY: STATUS: COMPLETED

See attached scanned Clinic Note(s).

**EXHIBIT NO. B6F
PAGE: 182 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006418022
ADM: Aug 31,2018 17:42

/es/ LATISHA COLLINS
OFFICE ASSISTANT
Signed: 09/01/2018 12:55

**EXHIBIT NO. B6F
PAGE: 183 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006418022
 ADM: Aug 31, 2018 17:42

Circle or check affirmatives, backslash (\) negatives. 14 Welch Community Hospital RHC URGENT CARE RECORD •Pediatric Illness•															
DATE: 8-31-18 TIME: 1815 ROOM: WIC															
HISTORIAN: patient parent caregiver. MODE OF ARRIVAL: ambulatory other. <u>chief complaint:</u> fever cough congested runny pulling ears not eating less active vomiting diarrhea rash ingestion <u>runny nose</u> <u>cough</u> <u>FU OM !</u> <u>not resolving</u>															
HPI <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;"><u>onset / duration:</u> _____ min / hrs / days ago</td> <td style="padding: 5px;"><u>continues in clinic</u></td> </tr> <tr> <td style="padding: 5px;"><u>5 days ago</u></td> <td style="padding: 5px;"><u>gone now / better</u></td> </tr> <tr> <td style="padding: 5px;"><u>context:</u> sick contacts home school other</td> <td style="padding: 5px;"><u>intermittent / worse</u></td> </tr> <tr> <td colspan="2" style="padding: 5px; vertical-align: top;"> <u>was diagnosed & O/H to med</u> <u>3 days ago</u> <u>Mother sister finished 4 days</u> <u>of azithromycin & there was</u> <u>no improvement. She stated</u> <u>OmniMed always helps</u> <u>Clear her infection</u> </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> <u>severity:</u> fever to <u>99.1°C</u> oral rectal axillary TM not measured - subjective none noted </td> </tr> <tr> <td colspan="2"> <u>associated symptoms:</u> acting differently <u>tired</u> <u>sleeping more</u> <u>not sleeping</u> <u>less active</u> <u>inconsolable</u> drinking <u>eating less</u> <u>not drinking</u> <u>lost feeding / liquids</u> <u>decreased urination</u> <u>lost urinated</u> <u>sleeping more</u> </td> </tr> <tr> <td colspan="2"> <u>Similar symptoms previously:</u> <u>Recently seen / treated by doctor / hospitalized:</u> </td> </tr> </table>		<u>onset / duration:</u> _____ min / hrs / days ago	<u>continues in clinic</u>	<u>5 days ago</u>	<u>gone now / better</u>	<u>context:</u> sick contacts home school other	<u>intermittent / worse</u>	<u>was diagnosed & O/H to med</u> <u>3 days ago</u> <u>Mother sister finished 4 days</u> <u>of azithromycin & there was</u> <u>no improvement. She stated</u> <u>OmniMed always helps</u> <u>Clear her infection</u>		<u>severity:</u> fever to <u>99.1°C</u> oral rectal axillary TM not measured - subjective none noted		<u>associated symptoms:</u> acting differently <u>tired</u> <u>sleeping more</u> <u>not sleeping</u> <u>less active</u> <u>inconsolable</u> drinking <u>eating less</u> <u>not drinking</u> <u>lost feeding / liquids</u> <u>decreased urination</u> <u>lost urinated</u> <u>sleeping more</u>		<u>Similar symptoms previously:</u> <u>Recently seen / treated by doctor / hospitalized:</u>	
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<u>5 days ago</u>	<u>gone now / better</u>														
<u>context:</u> sick contacts home school other	<u>intermittent / worse</u>														
<u>was diagnosed & O/H to med</u> <u>3 days ago</u> <u>Mother sister finished 4 days</u> <u>of azithromycin & there was</u> <u>no improvement. She stated</u> <u>OmniMed always helps</u> <u>Clear her infection</u>															
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ADAMS, NEVAEH ADM: 8/31/18 ACT#: 006418022 MED#: 138580 DOB: 7/21/2015 FC: MD SEX: F AGE: 3 yr SER: WIC DR: COWANS, RODNEY																																					
ROS <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50px; padding: 5px;"><u>ENT</u></td> <td style="padding: 5px;"><u>pulling at ears R/L</u></td> <td style="width: 50px; padding: 5px;"><u>CVS</u></td> <td style="padding: 5px;"><u>palpitations</u></td> </tr> <tr> <td style="padding: 5px;"><u>runny nose</u></td> <td style="padding: 5px;"><u>sore throat / mouth</u></td> <td style="padding: 5px;"><u>NEURO</u></td> <td style="padding: 5px;"><u>seizure</u></td> </tr> <tr> <td style="padding: 5px;"><u>red eyes / discharge</u></td> <td style="padding: 5px;"><u>EYES</u></td> <td style="padding: 5px;"><u>MS</u></td> <td style="padding: 5px;"><u>extremity pain / swelling</u></td> </tr> <tr> <td style="padding: 5px;"><u>cough</u></td> <td style="padding: 5px;"><u>RESPIRATORY</u></td> <td style="padding: 5px;"><u>SKIN</u></td> <td style="padding: 5px;"><u>rash</u></td> </tr> <tr> <td style="padding: 5px;"><u>trouble breathing</u></td> <td style="padding: 5px;"><u>G</u></td> <td style="padding: 5px;"><u>facial trunk extremities diffuse</u></td> <td style="padding: 5px;"><u>diaper rash</u></td> </tr> <tr> <td style="padding: 5px;"><u>vomiting / diarrhea</u></td> <td style="padding: 5px;"><u>GI</u></td> <td style="padding: 5px;"><u>LYMPH</u></td> <td style="padding: 5px;"><u>swollen glands</u></td> </tr> <tr> <td style="padding: 5px;"><u>abdominal distention</u></td> <td style="padding: 5px;"><u>GU</u></td> <td style="padding: 5px;"><u>PSYCH</u></td> <td style="padding: 5px;"><u>anxiety / depression</u></td> </tr> <tr> <td style="padding: 5px;"><u>blood in stool</u></td> <td style="padding: 5px;"><u>problems urinating</u></td> <td style="padding: 5px;"><u>LINMP</u></td> <td style="padding: 5px;"><u>preg premenstrual</u></td> </tr> <tr> <td colspan="4" style="padding: 5px;"> <input type="checkbox"/> except as marked positive, all systems above reviewed and found negative </td> </tr> </table>		<u>ENT</u>	<u>pulling at ears R/L</u>	<u>CVS</u>	<u>palpitations</u>	<u>runny nose</u>	<u>sore throat / mouth</u>	<u>NEURO</u>	<u>seizure</u>	<u>red eyes / discharge</u>	<u>EYES</u>	<u>MS</u>	<u>extremity pain / swelling</u>	<u>cough</u>	<u>RESPIRATORY</u>	<u>SKIN</u>	<u>rash</u>	<u>trouble breathing</u>	<u>G</u>	<u>facial trunk extremities diffuse</u>	<u>diaper rash</u>	<u>vomiting / diarrhea</u>	<u>GI</u>	<u>LYMPH</u>	<u>swollen glands</u>	<u>abdominal distention</u>	<u>GU</u>	<u>PSYCH</u>	<u>anxiety / depression</u>	<u>blood in stool</u>	<u>problems urinating</u>	<u>LINMP</u>	<u>preg premenstrual</u>	<input type="checkbox"/> except as marked positive, all systems above reviewed and found negative			
<u>ENT</u>	<u>pulling at ears R/L</u>	<u>CVS</u>	<u>palpitations</u>																																		
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<u>trouble breathing</u>	<u>G</u>	<u>facial trunk extremities diffuse</u>	<u>diaper rash</u>																																		
<u>vomiting / diarrhea</u>	<u>GI</u>	<u>LYMPH</u>	<u>swollen glands</u>																																		
<u>abdominal distention</u>	<u>GU</u>	<u>PSYCH</u>	<u>anxiety / depression</u>																																		
<u>blood in stool</u>	<u>problems urinating</u>	<u>LINMP</u>	<u>preg premenstrual</u>																																		
<input type="checkbox"/> except as marked positive, all systems above reviewed and found negative																																					
<u>• CONST components also addressed in HPI</u> <u>reviewed and updated: Past Hx Family Hx Social Hx</u> <u>Location: in chart Date:</u>																																					
PAST HX <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50px; padding: 5px;"><u>Birth Hx</u></td> <td style="padding: 5px;"><u>ear infection(s)</u></td> </tr> <tr> <td style="padding: 5px;"><u>complications at birth</u></td> <td style="padding: 5px;"><u>febrile seizure</u></td> </tr> <tr> <td style="padding: 5px;"><u>premature birth</u> _____ wks</td> <td style="padding: 5px;"><u>pharyngitis</u></td> </tr> <tr> <td style="padding: 5px;"><u>diabetes Type I insulin</u></td> <td style="padding: 5px;"><u>pneumonia</u></td> </tr> <tr> <td style="padding: 5px;"><u>asthma</u></td> <td style="padding: 5px;"><u>seizure disorder</u></td> </tr> <tr> <td style="padding: 5px;"><u>bronchitis / bronchiolitis</u></td> <td style="padding: 5px;"><u>sickle cell disease</u></td> </tr> <tr> <td style="padding: 5px;"><u>cardiac problems</u></td> <td style="padding: 5px;"><u>urinary tract infection(s)</u></td> </tr> <tr> <td style="padding: 5px;"><u>congenital heart disease</u></td> <td></td> </tr> <tr> <td colspan="2" style="padding: 5px;"> <u>development delay</u> <u>hip dysplasia</u> <u>heating ootric</u> <u>Turron + syndrome</u> <u>Value</u> </td> </tr> <tr> <td colspan="2"> <u>Surgeries / Procedures</u> <u>none</u> <u>VP shunt</u> <u>Spine ORIF</u> </td> </tr> <tr> <td colspan="2"> <u>Immunizations: UTD / referred to PCP</u> <u>Medications</u> <u>none</u> <u>see nurses note</u> aspirin ibuprofen acetaminophen last dose </td> </tr> <tr> <td colspan="2"> <u>Allergies</u> <u>NKDA</u> <u>see nurses note</u> <u>Amox</u> </td> </tr> <tr> <td colspan="2"> SOCIAL HX <u>smoker / 2nd hand exposure</u> <u>alcohol (recent / occasional)</u> <u>drugs</u> <u>attends daycare / school</u> <u>caretaker / foster care</u> </td> </tr> <tr> <td colspan="2"> FAMILY HX <u>adopted</u> </td> </tr> </table>		<u>Birth Hx</u>	<u>ear infection(s)</u>	<u>complications at birth</u>	<u>febrile seizure</u>	<u>premature birth</u> _____ wks	<u>pharyngitis</u>	<u>diabetes Type I insulin</u>	<u>pneumonia</u>	<u>asthma</u>	<u>seizure disorder</u>	<u>bronchitis / bronchiolitis</u>	<u>sickle cell disease</u>	<u>cardiac problems</u>	<u>urinary tract infection(s)</u>	<u>congenital heart disease</u>		<u>development delay</u> <u>hip dysplasia</u> <u>heating ootric</u> <u>Turron + syndrome</u> <u>Value</u>		<u>Surgeries / Procedures</u> <u>none</u> <u>VP shunt</u> <u>Spine ORIF</u>		<u>Immunizations: UTD / referred to PCP</u> <u>Medications</u> <u>none</u> <u>see nurses note</u> aspirin ibuprofen acetaminophen last dose		<u>Allergies</u> <u>NKDA</u> <u>see nurses note</u> <u>Amox</u>		SOCIAL HX <u>smoker / 2nd hand exposure</u> <u>alcohol (recent / occasional)</u> <u>drugs</u> <u>attends daycare / school</u> <u>caretaker / foster care</u>		FAMILY HX <u>adopted</u>									
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FAMILY HX <u>adopted</u>																																					
<small>SYSTEM © 1996 - 2016 T-System, Inc.</small>																																					

Rev. 09/16

**EXHIBIT NO. B6F
PAGE: 184 OF 239**
PHYSICAL EXAM**General Appearance**

no acute distress mild / moderate / severe distress
 active / playful / smiles fussy / crying / cries on exam / irritable
 attentive/niml lethargic / weak cry
 good eye contact
 sleeping/easily aroused

INFANTS:

nml consolability poor consolability / poor intake suck
 nml feeding / suck poor muscle tone
 flat anter. fontanel closed / bulging / sunken anter. fontanel

HEENT

conjunct. & lids nml tenderness / swelling
 PERRL scleral icterus / injected conjunctivae
 ears nml EOM palsy / anisocoria / conjunctival exudate
 ears sunken eyes / photophobia
 nose nml TM erythema / dullness (R/L)
 pharynx nml loss of TM landmarks (R/L)
 moist mucous membranes TM obscured by wax (R/L) *posterior*
 membranes

NECK

supple *Short Webbed neck*
 no masses

RESPIRATORY

no resp. distress respiratory distress
 breath sounds nml retractions / accessory muscle use
 prolonged expirations
 decreased air movement
 grunting (infants)

CVS

reg. rate & rhythm stridor
 heart sounds nml wheezes / rales / rhonchi
 strong periph pulses murmur grade /6 sys/dexs
 nml capillary refill peripheral pulses weak / thready
 slow cap refill sec

ABDOMEN

non-tender tenderness / guarding / rebound
 distention hepatomegaly / splenomegaly / mass
 no organomegaly abnml bowel sounds

GENITALIA

nml inspection discharge / erythema / swelling / tenderness
 circumcised (male) testes undescended
 uncircumcised (male) hernia

EXTREMITIES

non-tender tenderness
 nml ROM cyanosis / diaphoresis / pallor / icterus
 SKIN poor skin turgor
 no rash / lesions diaper rash / skin rash
 no petechiae urticarial edematous impetiginous vesiculariform
 normal color scabuliform monilial erythematous vesicular crusted
 warm, dry skin lesions

NEURO

tension nml facial asymmetry
 motor nml sensory loss / weakness
 CN's nml (2-10) depressed mood / affect

ADDITIONAL NOTES

Pediatric Illness - 14 Reportable Measure

ADAMS, NEVAEH

ADM: 8/31/18 ACT#: 008418022
DOB: 7/21/2015 MED#: 138580
SEX: F AGE: 3 yr
SER: WIC DR: COVANS, RODNEY

LABS & XRAYS

CBC	UA
BMP	Preg
XRAYS <input type="checkbox"/> Interp. by me <input type="checkbox"/> Viewed by me <input type="checkbox"/> Discard w/ radiologist	
CXR <input type="checkbox"/> nml / NAD <input type="checkbox"/> no infiltrates <input type="checkbox"/> nml heart size <input type="checkbox"/> nml mediastinum	
<i>Other</i>	

PROCEDURES

LP	discussed risks, benefits, alternatives: parent/guardian consents.
Time:	fluid color RBC WBC
bedside prep	glucose polys lymph
L3-4 L4-5	protein monos gm stt

PROGRESS

Time: unchanged improved re-examined

CLINICAL IMPRESSION

Fever	Menigitis
Vomiting / Diarrhea	FL <i>(circled)</i> Odd's Media - R/L
Dehydration	Pharyngitis - Sorep / Mono
Asthma / Reactive Airway Disease	Pneumonia (location)
acute exacer. status asthmaticus	Sepsis / SIRS - severe
Bronchitis / Bronchiolitis - RSV	Septic Shock
Croup	Sinusitis
Gastroenteritis / Enteritis	Upper Respiratory Infection
Hypoxemia	UTI / Pyelonephritis
Ingestion	Viral Syndrome
Influenza seasonal H1N1	<i>Allergic</i>

TREATMENT PLAN / DISCHARGE MEDICATION

<i>Cefdinir 250mg/5ml susp</i>	<i>Cordarone Chat fm</i>
Discussed with Dr. [initials]	
will see patient in office / clinic / hospital	
Counselled patient / family regarding	
lab results diagnosis need for follow-up smoking / drug / alcohol cessation	
for any concern	
Time spent counseling: minutes	Admit orders written
DISPOSITION: <input checked="" type="checkbox"/> Home <input type="checkbox"/> admn <input type="checkbox"/> transfer	<i>18:30</i>
FOLLOW-UP: <input type="checkbox"/> PCP <input type="checkbox"/> return to clinic	<i>if condition</i>
CONDITION: <input type="checkbox"/> unchanged <input type="checkbox"/> improved <input type="checkbox"/> stable	<i>Worsen</i>
total face-to-face time: minutes	

I have reviewed the chart and agree with the documentation as recorded by the MLP, including the assessment, treatment plan, and disposition.

I personally evaluated and examined the patient in conjunction with the MLP and agree with the management and disposition of the patient.

JH NP / PA C

MD / DO

Template Complete

Rev. 09 / 16

**EXHIBIT NO. B6F
PAGE: 185 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006418022
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 31, 2018 17:42
ATTENDING:

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----
DATE OF NOTE: AUG 31, 2018@12:54 ENTRY DATE: SEP 1, 2018@12:54:27
AUTHOR: COLLINS, LATISHA EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ LATISHA COLLINS
OFFICE ASSISTANT
Signed: 09/01/2018 12:55

**EXHIBIT NO. B6F
PAGE: 186 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006418022
 ADM: Aug 31, 2018 17:42

ADAMS, NEVAEH
 ADM: 8/31/18 ACT#: 006418022
 MED#: 138580
 DOB: 7/21/2015 FC: MD
 SEX: F AGE: 3 yr
 CCB: INC NO-COMM COMM

Name: Merach Adams Age: 3 DOB: 7/21/15
 Date/Time of Arrival: 8/31/18 at 5:30 pm

Reason for Visit: Cough, runny nose, fever.

ALLERGIES Amoxicillin.

Vitals: BP _____ HR _____ RR 24 Temp 99.4 Pulse Ox 97 % lpm
 Pain (0-10) _____ Location _____ Wt. 32 Ht. _____ LMP _____

Medical History:

Asthma Gout: CHF: COPD: CVA Diabetes

HTN

Hyperlipidemia: Psych: Renal: Seizures

Other: hip dysplasia, tumors, Leaking aortic valve.

Date of last mammogram _____ Date of last papsmear _____

Date of last colonoscopy _____

Surgical History:

Appendix Cardiac/Stent Gallbladder Hysterectomy BTL

Other: Hips

Social History: smoker q ppd/never/quit drugs q alcohol none/recent/occassional

Primary Care Provider:

Nurse Signature: Sherry R. Weston

****PATIENT REQUIRES HIGHER LEVEL OF CARE****

Focus assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider _____ Date _____ Time _____

Original 2-2017

**EXHIBIT NO. B6F
PAGE: 187 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006418022
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 31, 2018 17:42
ATTENDING:

----- MEDICATION RECONCILIATION (SCANNED) -----
DATE OF NOTE: AUG 31, 2018@12:54 ENTRY DATE: SEP 1, 2018@12:54:49
AUTHOR: COLLINS, LATISHA EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ LATISHA COLLINS
OFFICE ASSISTANT
Signed: 09/01/2018 12:55

**EXHIBIT NO. B6F
PAGE: 188 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX : JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WELI000138580
ACT: WELI006418022
ADM: AUG 31, 2018 17:42

**WELCH COMMUNITY HOSPITAL
MEDICATION RECONCILIATION FORM**

ADAMS, NEVAEH

ADM: 8/31/18 ACT#: 008418022
MED#: 138580
DOB: 7/21/2015 FC: MD
SEX: F AGE: 3 yr
SSN: WIC DR: COWANS, ROONEY

Name:	<input type="checkbox"/> Patient is on no medications at this time
Allergies:	

LIST BELOW ALL OF THE PATIENT'S MEDICATION PRIOR TO ADMISSION INCLUDING OVER-THE-COUNTER AND HERBAL MEDS

Name of Medication/Dose	Amount	Route	Frequency	Last Dose	Reason for Medication	Continue on Admission	Continue after Surgery or Transfer	Continue on Discharge
1. Tylenol		by mouth / topical Inject / inhale	___ times a day □ as needed			Y N	Y N	Y N
2. FES		by mouth / topical Inject / inhale	___ times a day □ as needed			Y N	Y N	Y N
3. Growth hormone		by mouth / topical Inject / inhale	___ times a day □ as needed			Y N	Y N	Y N
4.		by mouth / topical Inject / inhale	___ times a day □ as needed			Y N	Y N	Y N
5.		by mouth / topical Inject / inhale	___ times a day □ as needed			Y N	Y N	Y N
6.		by mouth / topical Inject / inhale	___ times a day □ as needed			Y N	Y N	Y N
7.		by mouth / topical Inject / inhale	___ times a day □ as needed			Y N	Y N	Y N
8.		by mouth / topical Inject / inhale	___ times a day □ as needed			Y N	Y N	Y N
9.		by mouth / topical Inject / inhale	___ times a day □ as needed			Y N	Y N	Y N
10.		by mouth / topical Inject / inhale	___ times a day □ as needed			Y N	Y N	Y N

NEW MEDICATIONS ADDED

Date	Name of Medication/Dose	Amount	Route	Frequency	Duration	Reason	Provider Name
8/31/18	Cetaditur	2.50 ml	by mouth/topical/inject/inhale	times a day □ as needed	Days		
			by mouth/topical/inject/inhale	times a day □ as needed	Days		
			by mouth/topical/inject/inhale	times a day □ as needed	Days		
			by mouth/topical/inject/inhale	times a day □ as needed	Days		
			by mouth/topical/inject/inhale	times a day □ as needed	Days		
			by mouth/topical/inject/inhale	times a day □ as needed	Days		
			by mouth/topical/inject/inhale	times a day □ as needed	Days		
			by mouth/topical/inject/inhale	times a day □ as needed	Days		

Source of Medication List

 Patient Medication List Patient/Family Recall Pharmacy: Primary Care Physician List Previous Discharge Paperwork Reconciled from patient's Medication bottles Reconciliation Prescriber (MD/DO)

Medication List Recorded/Borrowed by RN/MD/DO/PA/NP/LPN/RPH

By: Merry R DeStefano Date: 8/31/18

By: _____ Date: _____

By: _____ Date: _____

By: _____ Date: _____

Physician _____ Date _____

Physician _____ Date _____

Revised 2/13

**EXHIBIT NO. B6F
PAGE: 189 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006418022
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 31, 2018 17:42
ATTENDING:

----- PRESCRIPTION COPY (SCANNED) -----
DATE OF NOTE: AUG 31, 2018@12:54 ENTRY DATE: SEP 1, 2018@12:55:08
AUTHOR: COLLINS, LATISHA EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned copy of Prescription(s).

/es/ LATISHA COLLINS
OFFICE ASSISTANT
Signed: 09/01/2018 12:55

EXHIBIT NO. B6F
PAGE: 190 OF 239

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006418022
 ADM: Aug 31, 2018 17:42

39520 WELCH COMMUNITY HOSPITAL	
Supervisor, Jose L. Gyco MD	Julietta Sison, PA-C
WV Lic# Exp.	LIC# 058 454 McDowell St., Welch, WV 24801 NPI# 1300863921 (304) 436-8161 DEAM MS2130716

Name Nevaeh Adams
 Address _____ Date 8-31-18
 THIS PRESCRIPTION MAY BE FILLED WITH A GENERICALLY EQUIVALENT DRUG PRODUCT UNLESS THE WORDS "BRAND NECESSARY" OR THE WORDS "THIS PRESCRIPTION MUST BE FILLED WITH THE PRESCRIBED BRAND NAME PRODUCT" ARE WRITTEN ON THE PRESCRIPTION ITSELF.
 THIS IS A SECURITY RX
 Cefadroxil 250 mg 15 ml sup^{sup}
 Sig 2 ml PO q 12h
 x 10 days
 day 40 ml
 Rel# NR 1 2 3 4 5
 1-24
 25-49
 50-74
 75-100
 101-150
 151 and over
 JH

Prescription is valid if more than one (1) prescription is written per blank

**EXHIBIT NO. B6F
PAGE: 191 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

*** END ***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

EXHIBIT NO. B6F
PAGE: 192 OF 239

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006418022
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 31, 2018 17:42
ATTENDING:

Order Date: St: Requestor: Start Date: Stop Date:
Nature of Order: Signature:
Item Ordered:

***** END ***** CONFIDENTIAL ORDERS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 193 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006418022
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 31,2018 17:42
ATTENDING:

***** CONFIDENTIAL LAB RESULTS SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL LAB RESULTS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 194 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006418022
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 31,2018 17:42
ATTENDING:

***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 195 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006418022
ADM: Aug 31,2018 17:42

***** CONFIDENTIAL DISCHARGE SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL DISCHARGE SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 196 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006418022
HOSp : WELCH COMMUNITY HOSPITAL ADM: Aug 31, 2018 17:42
ATTENDING:

***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 197 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006418022
HOSPT : WELCH COMMUNITY HOSPITAL ADM: Aug 31, 2018 17:42
ATTENDING:
=====

ADRs: No ADRs on file.

Allergies: PENICILLIN
=====

****NO MEDICATIONS FOUND****

*** END ***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

{{{ END }}} Patient Encounter(s) History Report Dec 28, 2018@14:32

**EXHIBIT NO. B6F
PAGE: 198 OF 239**

Patient Encounter(s) History Report Dec 28, 2018@14:20

(From: 12/11/17 --- Thru: 12/12/17)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B6F
PAGE: 199 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006396563
ADM: Dec 11, 2017 21:50

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 200 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006396563
ADM: Dec 11, 2017 21:50

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (MEDICAL RECORDS ASSISTANT)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J

Observed/Historical: Historical

==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 201 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006396563
ADM: Dec 11,2017 21:50

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

EXHIBIT NO. B6F
PAGE: 202 OF 239

Name : ADAMS, NEVAEH H	MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE	ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL	ADM: Dec 11, 2017 21:50
ATTENDING:	

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- CODING ABSTRACT FORM (SCANNED) -----
 DATE OF NOTE: DEC 19, 2017@14:43 ENTRY DATE: DEC 19, 2017@14:44:02
 AUTHOR: HARRISON, NAOMI EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

See attached scanned Coding Abstract Form(s).
 DATE: 12/19/2017 WELCH HOSPITAL TIME: 02:35 PM

PAGE: 1 OF 1 CODING SUMMARY - INPT

Patient Name: ADAMS, NEVAEH H MR #: 000138580 PAT #: 006396563

 Sex: F Admitted: 12/11/17

Birthdate: 7/21/2015 Discharged: 12/12/17

Age at Admit: 002 LOS: 1

Attending Phys: 619410 LEO, SHERWOOD UB92 Disp: 01

Current DRG: Outlier: 0

 Diagnoses POA MOD HAC Description

-
- 1. H66.91 Otitis media, unspecified, right ear
- 2. J02.9 Acute pharyngitis, unspecified
- 3. J06.9 Acute upper respiratory infection, unspecified

Date CPT Modifiers Description

-
- 1. 12/11/17 36415 ROUTINE VENIPUNCTURE
- 2. 12/11/17 36415 ROUTINE VENIPUNCTURE
- 3. 12/11/17 36415 ROUTINE VENIPUNCTURE
- 4. 12/11/17 71020 TC CHEST X-RAY
- 5. 12/11/17 85025 COMPLETE CBC W/AUTO DIFF WBC
- 6. 12/11/17 86403 PARTICLE AGGLUTINATION TEST
- 7. 12/11/17 87430 STREP A AG EIA
- 8. 12/11/17 87804 INFLUENZA ASSAY W/OPTIC

EXHIBIT NO. B6F
PAGE: 203 OF 239

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
 ATTENDING:

9. 12/11/17 94640 AIRWAY INHALATION TREATMENT

10. 12/11/17 99282 25 EMERGENCY DEPT VISIT

To Attending Physician: Please review the above diagnoses and procedures and notify Health Information Management if there are any discrepancies or any inaccuracies. Thank you !!

/es/ NAOMI HARRISON
 MEDICAL RECORDS ASSISTANT
 Signed: 12/19/2017 14:44

----- ER DISCHARGE SHEET
 DATE OF NOTE: DEC 12, 2017@00:05 ENTRY DATE: DEC 12, 2017@02:34:25
 AUTHOR: LEWIS,MARTHA L EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

Welch Community Hospital
 ER DISCHARGE SHEET

Patient Name: ADAMS,NEVAEH H DOB: JUL 21, 2015 Age: 2
 Sex: FEMALE Race: WHITE MR#: WEL000138580

DISCHARGED/TRANSFERRED:

Patient's Outcome: Improved

To: Home []Referred to Social Services
 []Nursing Home:

[]Cobra Form completed
 []Copy of Transfer Form
 []Labs/X-ray/Notes given

Via: Released with adult

EDUCATION: Discharge with written instruction on:
 Upper Respiratory Infection

Voiced understanding of instructions, Rx given with med teaching,
 Copy of Med Rec Sheet

DISCHARGE:

Discharge: Date/Time: 12-Dec-2017 00:05

/es/ MARTHA L LEWIS, RN

Signed: 12/12/2017 02:34

----- ER NURSING FLOW SHEET
 DATE OF NOTE: DEC 11, 2017@23:45 ENTRY DATE: DEC 12, 2017@00:12:49
 AUTHOR: LEWIS,MARTHA L EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

Welch Community Hospital
 ER NURSING FLOW SHEET

EXHIBIT NO. B6F
PAGE: 204 OF 239

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
ATTENDING:

Patient Name: ADAMS, NEVAEH H DOB: JUL 21, 2015 Age: 2
Sex: FEMALE Race: WHITE MR#: WEL000138580
Physician: Leo, Sherwood P., MD

Date/Time: 11-Dec-2017 23:45

CHIEF COMPLAINT:
Mom reports fever, vomiting and pulling at rt. ear. Pt. has history of Turner's Syndrome.

VISUAL: No complaints
NEUROLOGICAL: No complaints
EARS:
[X] Pain Right
[] Drainage
[] Ringing
[] Blood

Comments:

NOSE: No complaints
MOUTH: No complaints
THROAT: No complaints
MUSCULOSKELETAL: No complaints
RESPIRATORY: No complaints
CARDIOVASCULAR: No complaints
Comments:
history of Turner's Syndrome

GI/GU: Nausea, Vomiting
Bowel Sounds: Active
Abdomen: Soft, Non-tender
Quadrant: [] N/A
Urinary Problems: No

If Yes, S/S:

[X] N/A FHT:

/es/ MARTHA L LEWIS, RN

Signed: 12/12/2017 00:14

----- NURSING PROGRESS NOTE -----
DATE OF NOTE: DEC 11, 2017@23:25 ENTRY DATE: DEC 12, 2017@02:35:12
AUTHOR: LEWIS, MARTHA L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

**EXHIBIT NO. B6F
PAGE: 205 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006396563
ADM: Dec 11, 2017 21:50

2325. This pt. received to ER #1 with c/o running a fever with vomiting today. Pt. also pulling at rt. ear. Labs and x-ray have been done prior to pt. coming to ER.

2330. Dr. Leo at bedside to assess pt.

2354. Have received d/c order for this pt.

0005. Pt. discharged to home at this time with mom. Prescription given. Info sheet on URI given to mom. Pt. is to follow up with Dr. Bailey Friday as scheduled. Understanding verbalized.

/es/ MARTHA L LEWIS, RN

Signed: 12/12/2017 02:37

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----
DATE OF NOTE: DEC 11, 2017@22:10 ENTRY DATE: DEC 11, 2017@22:10:23
AUTHOR: THOMAS, KEVIN W EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ KEVIN W THOMAS
OFFICE ASSISTANT
Signed: 12/11/2017 22:11

**EXHIBIT NO. B6F
PAGE: 206 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006396563
 ADM: Dec 11, 2017 21:50



KT
12/11/17

ADAMS, NEVAEH	ACT# : 006396563
ADM : 12/11/17	MED# : 138580
DOB : 7/21/2015	FC : CD
SEX : F	AGE : 2 yr
SIR : ERM	DR : LEO SHERWOOD

WELCH COMMUNITY HOSPITAL
 454 McDOWELL STREET
 WELCH, WV 24801

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

**EXHIBIT NO. B6F
PAGE: 207 OF 239**

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

ADAMS, NEVAEH	ACT# : 006386563
ADM : 12/11/17	MED# : 138580
DOB : 7/21/2015	FC : CO
SEX : F	AGE : 2 yr
SER : ERM	DR : LEO, SHERWOOD

EXHIBIT NO. B6F
PAGE: 208 OF 239

7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

If you would like to Opt out of HIV testing, please initial the box to the left.
 There may be some instances where patients are not allowed to opt out for further information please refer to the information sheet given to you upon registration.

8. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: 

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

9. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

ADAMS, NEVAEH	
ADM : 12/13/17	ACT# : 006398563
	MED# : 138580
DOB : 7/21/2015	FC : CO
SEX : F	AGE : 2 yr
SER : ERM	DR : LEO, SHERWOOD

**EXHIBIT NO. B6F
PAGE: 209 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
ATTENDING:

----- PRESENTING SHEET (SCANNED) -----
DATE OF NOTE: DEC 11, 2017@22:10 ENTRY DATE: DEC 11, 2017@22:10:37
AUTHOR: THOMAS, KEVIN W EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ KEVIN W THOMAS
OFFICE ASSISTANT
Signed: 12/11/2017 22:11

EXHIBIT NO. B6F
PAGE: 210 OF 239

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006396563
 ADM: Dec 11,2017 21:50

Presenting Complaint Registration Form
Emergency Room

Name: Nevaeh Adams Today's Date: 12-11-17
 Time: 9:20 Age: 2 Birthdate: 07-21-15

Chief Complaint (tell why you are here):
Never had a cold before now it's high

Hospital Use Only:

ADAMS, NEVAEH	
ADM: 12/11/17	ACT# : 006396563
MED# : 136580	
DOB: 07/21/2015	FC: C0
SEX: F	AGE: 2 yr
SER: ERM	OB: 100, SHERWOOD

Disposition: ER

Registration Complaint: None

Initials: W Intake/Inriage Timer: 2:49

EXHIBIT NO. B6F
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**EXHIBIT NO. B6F
PAGE: 212 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006396563
ADM: Dec 11, 2017 21:50

----- INSURANCE CARD -----
DATE OF NOTE: DEC 11, 2017@22:10 ENTRY DATE: DEC 11, 2017@22:10:49
AUTHOR: THOMAS, KEVIN W EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.
INSURANCE CARD BACK (SCANNED):

/es/ KEVIN W THOMAS
OFFICE ASSISTANT
Signed: 12/11/2017 22:11

**EXHIBIT NO. B6F
PAGE: 213 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSPT : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006396563
ADM: Dec 11, 2017 21:50

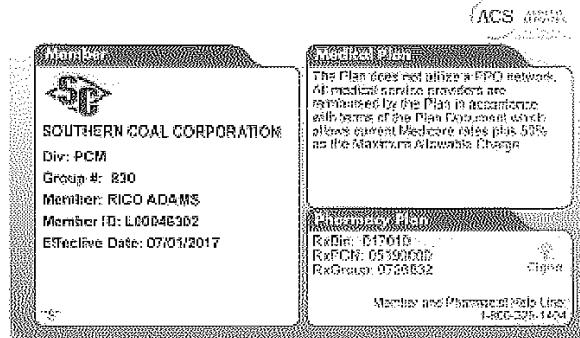


EXHIBIT NO. B6F
PAGE: 214 OF 239

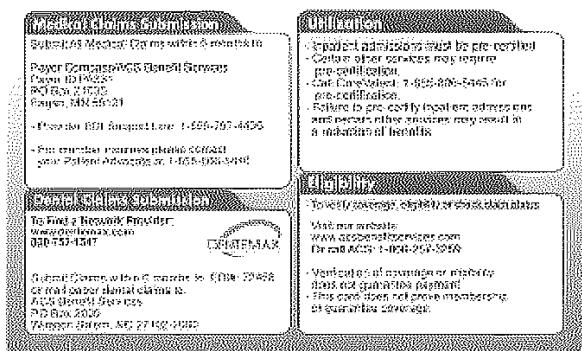


EXHIBIT NO. B6F
PAGE: 215 OF 239

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006396563
 ADM: Dec 11, 2017 21:50

Eligibility Information

Page 1 of 1

Eligibility Verification
[Form Entry](#) | [Member Search](#) | [Eligible Verification](#)

Eligibility Inquiry verifies whether a member was eligible for a covered program on the date(s) of service submitted in the request. This information does not guarantee eligibility or payment for the service rendered.

Member

Name	Date of Birth	Member ID	Gender
ADAMS, NEVAEH	2015-07-21	WEL000138580	Female
Tracking Number: 15022W000007567			

Eligibility Inquiry

Dates of Service: *From Date Of Service *To Date Of Service
 *Facility Type:

SEARCH | RESET

Enrollments

Program/Benefit Name	Coverage Status	Coverage Level	Plan Type	Effective Date	Termination Date	Member ID
- Medicaid Benefit Plan	Active	Primary	Market	05/01/2018	05/31/2018	00405164305
Rate Code	Coverage	Effective Date	Termination Date			
FCMGKF	Categorically Needy	05/01/2018	05/31/2018			
FCMGKF	Tier 1 Copay	05/01/2018	05/31/2018			

No enrollments were found for the search criteria.

Other Insurance

No Co-insurance or Benefits information found.

Copay

It is the member's responsibility to pay the copay to the provider at the time of the service. Copays are at the benefit level individual service charges.

Beginning for claims with a Date of Service on or after May 08, 2018, copays for this member are:

Service	Copay Amount	Effective Date	Termination Date	Tier
N/A	\$0	05/08/2018	05/31/2018	Member is exempt

No Copay information found for the member.

PCP / Medical Home

No PCP / Medical Home information found for the member.

Lock-In

No Lock-In information found for DGR range requested.

Spend Down

No Spend Down information found at this time.

PRINT RESULTS

**EXHIBIT NO. B6F
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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
ATTENDING:

----- IDENTIFICATION CARD/DRIVERS LICENCE -----
DATE OF NOTE: DEC 11, 2017@22:10 ENTRY DATE: DEC 11, 2017@22:11:02
AUTHOR: THOMAS, KEVIN W EXP COSIGNER:
URGENCY: STATUS: COMPLETED

minor..no ID

/es/ KEVIN W THOMAS
OFFICE ASSISTANT
Signed: 12/11/2017 22:11

----- PATIENT EDUCATION DOCUMENTATION RECORD (SCANNED) -----
DATE OF NOTE: DEC 11, 2017@08:21 ENTRY DATE: DEC 13, 2017@08:21:27
AUTHOR: DILLON, LISA M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Patient Education Documentation Record(s).

/es/ LISA M DILLON
OFFICE ASSISTANT
Signed: 12/13/2017 08:22

**EXHIBIT NO. B6F
PAGE: 217 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006396563
ADM: Dec 11, 2017 21:50

Welch Community Hospital

**Patient Education for
UPPER RESPIRATORY INFECTION**

I acknowledge that I have received a teaching packet for Upper Respiratory Infection. I will also receive education about any medications needed of discharge.

Kate M Adams
Patient's Signature

12/11/17 0005
Date/Time

Matthew Lawson
Nurse's Signature

ADAMS, NEVAEH
ADM: 12/11/17 ACT#: 006396563
MED#: 138580
DOB: 7/21/2015 FC: CO
SEX: F AGE: 2 yr
SER: ERM DR: LEO, SHERWOOD

**EXHIBIT NO. B6F
PAGE: 218 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
ATTENDING:

----- PRESCRIPTION COPY (SCANNED) -----
DATE OF NOTE: DEC 11, 2017@08:20 ENTRY DATE: DEC 13, 2017@08:20:42
AUTHOR: DILLON,LISA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned copy of Prescription(s).

/es/ LISA M DILLON
OFFICE ASSISTANT
Signed: 12/13/2017 08:22

EXHIBIT NO. B6F
PAGE: 219 OF 239

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006396563
ADM: Dec 11, 2017 21:50

30393	WELCH COMMUNITY HOSPITAL
WV License # 18472	Sherwood Lee, M.D.
404 McDowell St.	DEA# B14670889 WV-1, WV 26001
Name: <i>Welch Adam</i>	Date: <i>2/11/10</i>
Address:	
THE PRESCRIPTION MAY BE FILLED WITH A PHARMACEUTICALLY EQUIVALENT DRUG PRODUCT UNLESS SPECIFICALLY REQUESTED ON THIS PRESCRIPTION FORM.	
<p style="text-align: center;">This is a security Rx</p> <p style="text-align: center;"><i>On a. ext 12/1/10 80 + 10 DAYS</i></p> <p style="text-align: right;"> <input type="checkbox"/> 1-24 <input type="checkbox"/> 25-49 <input type="checkbox"/> 50-74 <input type="checkbox"/> 75-100 <input type="checkbox"/> 101-150 <input type="checkbox"/> 151 and over </p>	
Refill NR <i>(circle)</i> 2 3 4 5	
<p style="text-align: center;">Prescription is valid if more than one (1) prescription is written per blank</p>	

ADAMS, NEVAEH
ADM : 12/11/17 ACT# : 006386563
DOB : 7/21/2015 MED# : 138580
SEX : F FC : CD
SER LERN : DR : LEO SHERWIN AGE : 2 yr

**EXHIBIT NO. B6F
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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
ATTENDING:

----- TRIAGE (SCANNED) -----
DATE OF NOTE: DEC 11, 2017@08:19 ENTRY DATE: DEC 13, 2017@08:19:17
AUTHOR: DILLON,LISA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

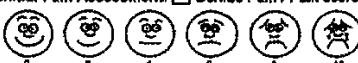
See attached scanned Triage document(s).

/es/ LISA M DILLON
OFFICE ASSISTANT
Signed: 12/13/2017 08:22

**EXHIBIT NO. B6F
PAGE: 221 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006396563
 ADM: Dec 11, 2017 21:50

Room	Time	Date: 12/11/17	Arrival Time: 2130	Triage Time: 2149	
Patient Name:	Nevaeh Adams	Age: 2	DOB: 7-21-15	Primary Care Physician: Bailey (Pineville)	
Arrival Mode:	<input checked="" type="checkbox"/> Walked <input type="checkbox"/> W/C <input type="checkbox"/> Carried <input type="checkbox"/> EMS	Treatment prior to arrival: HSO Motrin 2030			
Stated Complaint:	Jaw, vomiting today. Pulling @ ear & 2 days 4 km + 0.5 center of chest hurting.				
Temp: 98.8	B/P: _____	P: 134	R: 32	SpO ₂ : 97% <input type="checkbox"/> Room Air <input type="checkbox"/> O ₂ @ _____	Weight: Pounds 28 lbs. Weight: Kilograms _____
Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> PCN <input type="checkbox"/> ASA <input type="checkbox"/> Sulf <input type="checkbox"/> Codeine <input type="checkbox"/> Latex <input type="checkbox"/> Iodine <input type="checkbox"/> Other: Amoxil (nash)	SOCIAL HX: smoker _____ ppd / never / past / quit: _____ ago drugs: alcohol (recent / heavy / occasional)				
Medications: <input type="checkbox"/> None <input type="checkbox"/> See Medication List <input type="checkbox"/> Reviewed <input type="checkbox"/> Medical History <input type="checkbox"/> Denies <input type="checkbox"/> Cardiac <input type="checkbox"/> HTN <input type="checkbox"/> Cancer <input type="checkbox"/> Pulmonary/Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Liver Disease <input type="checkbox"/> CHF <input type="checkbox"/> Renal <input type="checkbox"/> Ulcers <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Thyroid <input type="checkbox"/> Seizures <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> Depression/Anxiety Other: Leaking valve. Hives / hives	Initial Pain Assessment: <input type="checkbox"/> Denies Pain / Pain score: /10 				
Previous Surgeries: <input type="checkbox"/> Denies <input type="checkbox"/> Appendectomy <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Cardiac/Stents <input type="checkbox"/> C-Section <input type="checkbox"/> Hysterectomy <input type="checkbox"/> BTL Other: Bil hives (dysplasia)	Pain location: _____ <input type="checkbox"/> constant <input type="checkbox"/> intermittent <input type="checkbox"/> radiates to: _____ Pain characteristics: <input type="checkbox"/> stabbing <input type="checkbox"/> pressure <input type="checkbox"/> burning <input type="checkbox"/> sharp <input type="checkbox"/> throbbing <input type="checkbox"/> dull Comments: _____				
Last Menstrual Period: 12/14	SKIN: <input checked="" type="checkbox"/> color nml, no rash <input checked="" type="checkbox"/> warm, dry <input type="checkbox"/> skin rash _____				
GENERAL APPEARANCE: <input checked="" type="checkbox"/> no acute distress <input checked="" type="checkbox"/> Alert <input type="checkbox"/> anxious	EXTREMITIES: <input type="checkbox"/> non-tender <input checked="" type="checkbox"/> full ROM <input checked="" type="checkbox"/> nml appearance <input type="checkbox"/> no pedal edema <input type="checkbox"/> call tenderness <input type="checkbox"/> pedal edema _____				
EENT: <input type="checkbox"/> eyes nml <input checked="" type="checkbox"/> ENT inspection nml <input type="checkbox"/> pharynx nml <input type="checkbox"/> nasal drainage <input checked="" type="checkbox"/> IM trachea.	NEUROPSYCH: <input checked="" type="checkbox"/> oriented x3 <input type="checkbox"/> sensation nml <input type="checkbox"/> motor nml <input checked="" type="checkbox"/> mood/affect nml <input type="checkbox"/> disoriented to: person / place / time <input type="checkbox"/> slurred / abnl speech <input type="checkbox"/> weakness / sensory loss <input type="checkbox"/> facial droop <input type="checkbox"/> depressed mood / affect Comment: _____				
RESPIRATORY: <input type="checkbox"/> no respiratory distress <input checked="" type="checkbox"/> breath sound nml <input type="checkbox"/> wheeze / rhonchi / rales					
CARDIOVASCULAR: <input checked="" type="checkbox"/> regular rate & rhythm <input type="checkbox"/> no murmur <input type="checkbox"/> no gallop <input type="checkbox"/> irregularly irregular rhythm <input type="checkbox"/> tachycardia <input type="checkbox"/> bradycardia					
ABDOMEN: <input checked="" type="checkbox"/> non-tender <input type="checkbox"/> no organomegaly <input checked="" type="checkbox"/> abnl bowel sounds <input type="checkbox"/> no distension <input type="checkbox"/> tenderness/guarding/rebound <input type="checkbox"/> abnl bowel sounds					
BACK: <input type="checkbox"/> nml inspection <input type="checkbox"/> CVA tenderness					

Medical Screening Examination Initiated By Qualified Medical Provider (QMP):

Continue evaluation in emergency department
 ESI Triage Level: 1 2 3 4 5

QMP Signature: Ashley Daugler FNP-C Date: 12/11/17 Time: 2155

EMERGENCY DEPARTMENT INTAKE/TRIAGE MSE FLOW SHEET
 Welch Community Hospital

Page 1

ADAMS, NEVAEH
 ADM: 12/11/17 ACT#: 006396563
 MED#: 138580
 DOB: 7/21/2015 FC: CO
 SEX: F AGE: 2 yr
 SER: ERN DR: LEB. SHERWOOD

Original 9-2016 revised 2-2017, 3-2017

**EXHIBIT NO. B6F
PAGE: 222 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
ATTENDING:

----- ER DISCHARGE INSTRUCTIONS (SCANNED) -----
DATE OF NOTE: DEC 11, 2017@08:19 ENTRY DATE: DEC 13, 2017@08:19:35
AUTHOR: DILLON,LISA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Discharge Instructions.

/es/ LISA M DILLON
OFFICE ASSISTANT
Signed: 12/13/2017 08:22

**EXHIBIT NO. B6F
PAGE: 223 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006396563
 ADM: Dec 11, 2017 21:50

ADAMS, NEVAEH	ACT# : 000366563
ADM : 12/11/17	MED# : 138580
DOB : 7/21/2015	FC : CO
SEX : F	AGE : 2 yr
SER : FBM	DR : LEO SHERWOOD

Welch Community Hospital Discharge Instructions

Date: 12/12/17Time: 12⁰⁵/pmDiagnosis: Acute Right Otitis Media, Upper Respiratory Infection

Procedures Performed During Visit:

- Venipuncture/IV Placement
- IV Fluids
- Urinary Catheterization
- Breathing Treatment
- Medications: _____
- Other: _____

 N/A

- EKG
- Laceration Repair
- Wound Care
- Eye Exam
- Splint/Immobilization
- Cardiac Monitoring
- Oxygen Therapy
- Ear Exam

Labs Performed During Visit:

- Complete Blood Count
- Comprehensive Metabolic Profile
- Basic Metabolic Profile
- Cardiac Enzymes
- Amylase
- Lipase
- Other: Mono

 N/A

- PT/INR-PTT
- D-Dimer
- Urinalysis
- Urine Drug Screen
- Pregnancy Test
- Arterial Blood Gas
- Strep Screen
- RSV Screen
- Flu A&B Screen
- Urine Culture
- Wound Culture

Radiology Test Performed During Visit:

- Chest X-Ray
- Abdominal X-Ray
- Extremity: _____
- Other: _____

 N/A

- Spine: _____
- CT Scan: _____
- Ultrasound/Doppler: _____

Return to ER for: Any concerns

Follow-up with:

- Primary Care Provider in _____ Days
- Surgical Clinic on _____
- Walk in Clinic in _____ Days
- OB/GYN in _____ Days

- Dentist in _____ Days
- Ortho in _____ Days
- Peds in _____ Days
- Other: _____
- Medical Clinic On _____
- Eye Dr. in _____ Days
- ENT in _____ Days

 Medication Reconciliation Form Given Prescription given: Fill and take as DirectedSpecial Instructions to Follow: Take meds as prescribed. Follow up with Dr. Bailey Friday 12/15/17 for recheck of Upper Respiratory Infection, Right Otitis MediaBP 110 P 110 R 1 Temp 97° Sat 95% Rad 1

I have had these discharge instructions reviewed with me, and I understand them. I will call my doctor or return to the hospital if my condition does not improve or becomes worse.

Karen M. Adams

Patient/Representative Signature

Martha Dawson

Nurse's Signature

**EXHIBIT NO. B6F
PAGE: 224 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
ATTENDING:

----- MEDICATION RECONCILIATION (SCANNED) -----
DATE OF NOTE: DEC 11, 2017@08:17 ENTRY DATE: DEC 13, 2017@08:18:40
AUTHOR: DILLON, LISA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ LISA M DILLON
OFFICE ASSISTANT
Signed: 12/13/2017 08:22

**EXHIBIT NO. B6F
PAGE: 225 OF 239**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006396563
 ADM: Dec 11, 2017 21:50

ADAMS, NEVAEH
 ADM: 12/11/17 ACT# : 006396563
 DOB : 7/21/2015 MED# : 138580
 SEX : F FC : CO
 SER : ERN AGE : 2 yr
 DR : LEO, SHERWOOD

**WELCH COMMUNITY HOSPITAL
MEDICATION RECONCILIATION FORM**

Name: <i>Nevaeh Adams</i>	DOB:	Patient is on no medications at this time	
Allergies: <i>None</i>			

LIST BELOW ALL OF THE PATIENT'S MEDICATION PRIOR TO ADMISSION, INCLUDING OVER-THE-COUNTER AND HERBAL MEDS

Name of Medication/Dose	Amount	Route	Frequency	Last Dose	Reason for Medication	Continue on admission	Continue After surgery or transfer	Continue on Discharge
1. <i>Hormone Growth Shot</i>		by mouth/topical inject/inhale	— Times daily	<i>3x week</i>		<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> Y
2.		by mouth/topical inject/inhale	— Times daily			<input type="checkbox"/> Y	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
3.		by mouth/topical inject/inhale	— Times daily			<input type="checkbox"/> Y	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
4.		by mouth/topical inject/inhale	— Times daily			<input type="checkbox"/> Y	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
5.		by mouth/topical inject/inhale	— Times daily			<input type="checkbox"/> Y	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
6.		by mouth/topical inject/inhale	— Times daily			<input type="checkbox"/> Y	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
7.		by mouth/topical inject/inhale	— Times daily			<input type="checkbox"/> Y	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
8.		by mouth/topical inject/inhale	— Times daily			<input type="checkbox"/> Y	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
9.		by mouth/topical inject/inhale	— Times daily			<input type="checkbox"/> Y	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y
10.		by mouth/topical inject/inhale	— Times daily			<input type="checkbox"/> Y	<input checked="" type="checkbox"/> N	<input type="checkbox"/> Y

NEW MEDICATIONS ADDED

Date	Name of Medication/Dose	Amount	Route	Frequency	Duration	Reason	Provider Name
12/11/17	<i>Omnicef 25mg/5ml</i>	50 mL	by mouth/topical/inject/inhale	1 times daily	10 Days	<i>Antibiotic</i>	<i>Dr. Adams</i>
			by mouth/topical/inject/inhale	times daily	Days		
			by mouth/topical/inject/inhale	times daily	Days		
			by mouth/topical/inject/inhale	times daily	Days		
			by mouth/topical/inject/inhale	times daily	Days		
			by mouth/topical/inject/inhale	times daily	Days		
			by mouth/topical/inject/inhale	times daily	Days		
			by mouth/topical/inject/inhale	times daily	Days		

Source of Medication List

- Patient Medication List
- Patient/Family Recall
- Pharmacy _____
- Primary Care Physician List
- Previous Discharge Paperwork
- Reconciled from patient's Medication bottles
- Recalculating Prescriber (MD/DO)

Medication List Recorded/Reviewed by RN/MD/DO/PA/NP/LPN/RPN:

By: _____ Date: _____
 By: _____ Date: _____
 By: _____ Date: _____
 By: *Dr. Adams* Date: *12/11/17*

Physician: _____ Date: _____

Physician: _____ Date: _____

**EXHIBIT NO. B6F
PAGE: 226 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
ATTENDING:

----- ER T-SHEET (SCANNED) -----
DATE OF NOTE: DEC 11, 2017@08:04 ENTRY DATE: DEC 13, 2017@08:04:49
AUTHOR: DILLON, LISA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned ER T-Sheet document(s).

/es/ LISA M DILLON
OFFICE ASSISTANT
Signed: 12/13/2017 08:22

EXHIBIT NO. B6F
PAGE: 227 OF 239

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSPT : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006396563
ADM: Dec 11, 2017 21:50

Circle or check affirmatives, checkmark (✓) negatives.	
14 Welch Community Hospital EMERGENCY PROVIDER RECORD + Pediatric Illness +	
Septic / Meningitis / Pneumonia / UTI / Mycoplasma / Dehydration / Kawasaki's Disease / Tick Born Disease	
TIME SEEN: 2230 ROOM: _____ EMS Arrived HISTORIAN: patient parent guardian custodian EMS other	
UNABLE TO OBTAIN HISTORY DUE TO: HPI	
chief complaint: fever <input checked="" type="checkbox"/> congested <input checked="" type="checkbox"/> fussy <input checked="" type="checkbox"/> pulling ears not eating <input checked="" type="checkbox"/> less active <input checked="" type="checkbox"/> vomiting <input checked="" type="checkbox"/> diarrhea <input checked="" type="checkbox"/> rash <input checked="" type="checkbox"/> ingestion <i>fussy nose</i>	
onset/duration: min / hrs / days ago <input checked="" type="checkbox"/> constant sudden-onset <input checked="" type="checkbox"/> intermittent episodes <input checked="" type="checkbox"/> lasting <input checked="" type="checkbox"/> worse / persistent since	
context: sick contacts <input checked="" type="checkbox"/> home <input checked="" type="checkbox"/> school <input checked="" type="checkbox"/> other recent travel outside US <input checked="" type="checkbox"/>	
C2 <i>(Handwritten: Recently runny nose X-rayed at ER/Clinic)</i>	
severity: fever to <input checked="" type="checkbox"/> °F / <input checked="" type="checkbox"/> °C and rectal axillary TM not measured - subjective <input checked="" type="checkbox"/> none noted	
associated symptoms: acting differently <input checked="" type="checkbox"/> fussy <input checked="" type="checkbox"/> crying more <input checked="" type="checkbox"/> not sleeping <input checked="" type="checkbox"/> less active <input checked="" type="checkbox"/> inconsolable drinking /eating less <input checked="" type="checkbox"/> not drinking <input checked="" type="checkbox"/> lost feeding / liquids <input checked="" type="checkbox"/> decreased urination <input checked="" type="checkbox"/> lost urinated <input checked="" type="checkbox"/> sleeping more <input checked="" type="checkbox"/>	
Similar symptoms previously: <i>no</i>	
Recently seen / treated by doctor / hospitalized: <i>no</i>	

ADAMS, NEVAEH ADM: 12/11/17 ACT#: 006396563 DOB: 7/21/2015 MED#: 138580 SEX: F FC: 00 SER: ERM AGE: 2 yr DR: LEO, SHERWOOD	
ROS	
<p>ENT: <input checked="" type="checkbox"/> pulling at ears <input checked="" type="checkbox"/> DA/L <input checked="" type="checkbox"/> RA/R <input checked="" type="checkbox"/> respiratory <input checked="" type="checkbox"/> voice throat / mouth <input checked="" type="checkbox"/> seizure <input checked="" type="checkbox"/> MS <input checked="" type="checkbox"/> red eyes / discharge <input checked="" type="checkbox"/> extremity pain / swelling (R/L) <input checked="" type="checkbox"/> SICK RESPIRATORY: <input checked="" type="checkbox"/> cough <input checked="" type="checkbox"/> SOB <input checked="" type="checkbox"/> rash <input checked="" type="checkbox"/> facial trunk extremities diffuse <input checked="" type="checkbox"/> double breathing <input checked="" type="checkbox"/> petechiae <input checked="" type="checkbox"/> diaper rash <input checked="" type="checkbox"/> LYMPH <input checked="" type="checkbox"/> GI: <i>x only</i> <input checked="" type="checkbox"/> vomiting / diarrhea <input checked="" type="checkbox"/> abdominal distension <input checked="" type="checkbox"/> blood in stool <input checked="" type="checkbox"/> swollen glands <input checked="" type="checkbox"/> GU: <input checked="" type="checkbox"/> painful / swollen genital area <input checked="" type="checkbox"/> PSYCH: <input checked="" type="checkbox"/> problems urinating <input checked="" type="checkbox"/> anxiety / depression <input checked="" type="checkbox"/> LNHP: <input checked="" type="checkbox"/> preg <input checked="" type="checkbox"/> premenstrual <input checked="" type="checkbox"/> all systems neg except as marked</p>	<p>CVS: <input checked="" type="checkbox"/> palpitations <input checked="" type="checkbox"/> NEURO: <input checked="" type="checkbox"/> seizure <input checked="" type="checkbox"/> MS <input checked="" type="checkbox"/> heart <input checked="" type="checkbox"/> skin <input checked="" type="checkbox"/> vertigo <input checked="" type="checkbox"/> rash <input checked="" type="checkbox"/> facial palsy <input checked="" type="checkbox"/> EYES: <input checked="" type="checkbox"/> red eyes / discharge <input checked="" type="checkbox"/> conjunctivitis <input checked="" type="checkbox"/> eye pain <input checked="" type="checkbox"/> eye swelling <input checked="" type="checkbox"/> eye floaters <input checked="" type="checkbox"/> eye redness <input checked="" type="checkbox"/> RESPIRATORY: <input checked="" type="checkbox"/> cough <input checked="" type="checkbox"/> SOB <input checked="" type="checkbox"/> rash <input checked="" type="checkbox"/> facial trunk extremities diffuse <input checked="" type="checkbox"/> double breathing <input checked="" type="checkbox"/> petechiae <input checked="" type="checkbox"/> diaper rash <input checked="" type="checkbox"/> LYMPH <input checked="" type="checkbox"/> GI: <input checked="" type="checkbox"/> vomiting / diarrhea <input checked="" type="checkbox"/> abdominal distension <input checked="" type="checkbox"/> blood in stool <input checked="" type="checkbox"/> swollen glands <input checked="" type="checkbox"/> GU: <input checked="" type="checkbox"/> painful / swollen genital area <input checked="" type="checkbox"/> PSYCH: <input checked="" type="checkbox"/> problems urinating <input checked="" type="checkbox"/> anxiety / depression <input checked="" type="checkbox"/> LNHP: <input checked="" type="checkbox"/> preg <input checked="" type="checkbox"/> premenstrual <input checked="" type="checkbox"/> all systems neg except as marked</p>
• CONST symptoms also addressed in HPI	
PAST HX	
Birth HX: birth wt. <input checked="" type="checkbox"/> complications at birth <input checked="" type="checkbox"/> problems in utero <input checked="" type="checkbox"/> premature birth <input checked="" type="checkbox"/> wks <input checked="" type="checkbox"/> perinatal exposure <input checked="" type="checkbox"/> bronchitis / bronchiolitis <input checked="" type="checkbox"/> cardiac problems <input checked="" type="checkbox"/> congenital heart disease <input checked="" type="checkbox"/> development delay <input checked="" type="checkbox"/> diabetes Type I <input checked="" type="checkbox"/> insulin <input checked="" type="checkbox"/> old records reviewed / summary: <i>runny nose</i>	
ear infection (R/L) <input checked="" type="checkbox"/> febrile seizure <input checked="" type="checkbox"/> lung disease asthma <input checked="" type="checkbox"/> pharyngitis <input checked="" type="checkbox"/> pneumonia <input checked="" type="checkbox"/> seizure disorder <input checked="" type="checkbox"/> sickle cell disease <input checked="" type="checkbox"/> urinary tract infection <input checked="" type="checkbox"/>	
Surgery / Procedures: <input checked="" type="checkbox"/> none <input checked="" type="checkbox"/> VP shunt <input checked="" type="checkbox"/>	
Immunization UTD: <input checked="" type="checkbox"/>	
Medications: <input checked="" type="checkbox"/> none <input checked="" type="checkbox"/> ASA <input checked="" type="checkbox"/> ibuprofen <input checked="" type="checkbox"/> acetaminophen <input checked="" type="checkbox"/> last dose: <input checked="" type="checkbox"/> Allergies: <input checked="" type="checkbox"/> NKDA <input checked="" type="checkbox"/> see further note <input checked="" type="checkbox"/> see further note	
SOCIAL HX: attends: daycare / school <input checked="" type="checkbox"/> caregiver / foster care <input checked="" type="checkbox"/> 2nd hand smoke exposure / smoker: <input checked="" type="checkbox"/> ppd / never / past / quit: <input checked="" type="checkbox"/> ago <input checked="" type="checkbox"/> ETOH / substance abuse: <input checked="" type="checkbox"/> FAMILY HX: <input checked="" type="checkbox"/> reviewed, not relevant <input checked="" type="checkbox"/> adopted <input checked="" type="checkbox"/>	

EXHIBIT NO. B6F
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<input checked="" type="checkbox"/> Nursing Assessment Reviewed	<input checked="" type="checkbox"/> Initial Vital Signs Reviewed
BP _____	HR _____
Pulse Ox _____ %	RA _____
O ₂ Introp. _____	Temp. _____
hypoxic _____	
PHYSICAL EXAM	
EXAM LIMITED BY: _____	
General Appearance	
appears well	mild / moderate / severe distress
active / playful / smiles	fussy / crying / cries on exam / irritable
attentiveness nm	lethargic / weak cry
good eye contact	_____
sleeping/safely aroused	_____
INFANTS	
nm consolability	poor consolability / poor intake suck
nm feeding / suck	poor muscle tone
flat ant. fontanel	closed / bulging / sunken ant. fontanel
HEENT	
Head straumatic	tenderness / swelling
Conjunct. & lids nm	scalar icterus / injected conjunctiva
EYES	
EOM palsy (R/L)	amblyopia
conjunctival exudate (R/L)	sunken eyes / photophobia
ears nm	TM obscured by debris (R/L)
loss of TM landmarks (R/L)	TM obscured by wax (R/L)
NOSE nm	
pharynx nm	rhinorrhea / purulent nasal drainage
moist mucous membranes	pharyngeal erythema / tonsillar exudate
membranes	ulcerations / vesicles
dry mucous membranes	drooling / trismus / mass
NECK	
supple	meningismus / Brudzinski / Kernig's
no masses	lymphadenopathy
RESPIRATORY	
no resp. distress	respiratory distress
breath sounds nm	wheezes / rales / rhonchi (R/L)
_____	retractions / accessory muscle use
_____	prolonged expiration
_____	decreased air movement
_____	grunting (infants)
_____	stridor

ADAMS, NEVAEH
ADM: 12/11/17
ACT#: 005338563
MED#: 138580
DOB: 7/21/2015
FC: CO
SEX: F
AGE: 2 yr
SER: ERN DR: LEO SHERWOOD

CVS
 rate & rhythm murmur grade ____/6 sys / dia
 heart sounds nm peripheral pulses weak / thready
 strong peripheral pulses slow capillary refill ____ sec
 nm capillary refill

ABDOMEN / GI
 non-tender tenderness / guarding / rebound :
 po distension generalized RUQ LUQ RLQ LLQ
 no organomegaly hepatomegaly / splenomegaly / mass
 abdominal bowel sounds

GENITALIA
 nm inspection discharge / erythema / swelling / tenderness
 circumcised (male) testes undescended
 uncircumcised (male) hernia (R/L)

EXTREMITIES
 non-tender tenderness (R/L)
 nm ROM

SKIN
 normal color cyanosis / diaphoresis / pallor / icterus
 warm, dry poor skin turgor
 no rash / lesions diaper rash / skin rash
 no petechiae urticarial exanthemata impigmentos varicelliform
 scutoidiform monifid erythematous vesicular crusted skin lesions

NEURO
 motor nm sensory loss / weakness
 sensation nm facial asymmetry
 CN's nm (2-12) paresis at baseline

PROCEDURES
 removal of cerumen from ear (R/L) with ear canette / irrigation

PROGRESS see additional template: # 94 51a
 time _____ unchanged Improved re-examined

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EXHIBIT NO. B6F
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XRATS / CT

head chest abdomen pelvis	Interpreted by ED provider unless noted otherwise
mm / NAD	no infiltrates mm heart size mm mediastinum absent

Interpreted by ED provider unless noted otherwise
mm / NAD
absent

mm / NAD
absent

LABS *Normal lab value ranges are included on the original lab report.		
CBC	Chemistries	UA
normal except	normal except	CRP normal except
WBC	Glu.	RSV
Hgb	BUN	Rotavirus
Hct	Creat.	Flu Screen
Platelets	Na	Strep Screen
sgot	K	Mono Spot
bands		Cultures sent
lymph		blood x
Pulse Ox	% on RA/ LO ₂ Intarg: amf / hypoxic	Time:

PROCEDURES

LP	discussed risks, benefits, options; patient / parent / guardian consents	
Time:	open press: _____	
stting / lying (R/L)	fluid color:	ABC monos
sterile technique	glucose	WBC lymph
L3-4 L4-5	protein	polys gm atm

PROGRESS - Continued

see additional template # 94 51a
Time: unchanged *improved re-examined*

- able to take food / fluid in emergency department.
 - EGDT for sepsis considered.
 - ♦ Persistent Asthma - >3y / long term control med / alternative med
 - ♦ Pharyngitis - 2y - 18y / strep A test / antibiotic
 - ♦ URG - 3m - 18y / No antibiotic
 - measure exclusions: refused / not indicated / indicated / contraindicated / not available / dispersed
 - patient ambulating / mentating at pre-event baseline
- Discharge VS: BP _____ HR _____ RR _____ Temp _____

ADAMS, NEVAEH

ADM: 12/11/17 ACT# : 006306563
MED# : 139580
DOB: 7/21/2015 FC: CO
SEX: F AGE: 2 yr
SER: ERM OR: LEO, SHERWOOD

Discussed with Dr. _____ Time: _____

all no patient to ED / hospital / office
Counselled patient directly regarding: Additional history from
lab / red results obtained and for follow-up family consider paramedics
prior recognition ordered holding orders written
 Rx given

CRITICAL CARE (excluding time for other separate services)
TIME 30-74 min 75-104 min min

Initial visit unless marked:

subsequent sequelae

CLINICAL IMPRESSION**Respiratory**

- ♦ Asthma / Reactive airway dz : acute exacerbation status asthmatics : tx of mild / mod / severe dz : intermittent persistent Bronchospasm, acute Bronchitis: acute RSV chronic simple mucopurulent Bronchiolitis: acute RSV Cold (nasopharyngitis) Group Epiglottitis: acute w/ obstruction Influenza: HINI A/B Other: R/L : acute recurrent chronic : serious suppurative w/ TM perf central marginal
- ♦ Pharyngitis: acute Strep Pneumonia: interstitial atypical bronchopneumonia lobar aspiration virus: RSV influenza: A/B bacterial:

Skin

- Sinusitis: acute recurrent chronic : maxillary frontal ethmoid Other: 110°
- UTI: cystitis: acute chronic : w/ hematuria Viral syndrome

Gastroenteritis

- Abd pain: RUQ LUQ RLQ LLQ generalized acute abd w/ rebound tenderness Nausea / Vomiting / Diarrhea Fever Headache Hypotension

Neurology

- Deposition Time: 11:00 AM DISPOSITION: home admitted OBS AMA (see AHA template #73) transferred CONDITION: unchanged improved stable Care transferred to: MD / DO / MLP Time: _____

I have reviewed the chart and agree with the documentation as recorded by the MLP, including assessment, treatment plan, and disposition.

I personally evaluated and examined the patient in conjunction with the MLP and agree with the findings and disposition of the patient.

FNP (Date/Time) IDX #: *5670*

Template Complete See Addendum (Dictated / Template #): _____

General Pediatric Illness - 14 Pg 3 of 4 Rev. 08/13 * Reportable Measure

2014-2015 T-System, Inc. Transact Version 3.0-2014

**EXHIBIT NO. B6F
PAGE: 230 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

*** END ***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

EXHIBIT NO. B6F
PAGE: 231 OF 239

Name : ADAMS, NEVAEH H	MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE	ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL	ADM: Dec 11, 2017 21:50
ATTENDING:	

***** CONFIDENTIAL ORDERS SUMMARY *****

Order Date:	St:	Requestor:	Start Date:	Stop Date:
Nature of Order:		Signature:		
Item Ordered:				

12/11/17 23:54	a	LEO, SHERWOOD	12/11/17 23:54	
ELECTRONICALLY ENTERED		ELECTRONIC		
Treating Specialty:				
Ordering Location: ER				
- Activity:				
- 12/11/2017 23:54 New Order entered by LEO, SHERWOOD (PHYSICIAN)				
- Order Text: Dist inst: take meds as presc, FU dr. Bailey as sched on Fri for recheck of				
- URI/Otitis of R ear				
- Nature of Order: ELECTRONICALLY ENTERED				
- Elec Signature: LEO, SHERWOOD (PHYSICIAN) on 12/11/2017 23:54				
-				

12/11/17 22:56:33	p	DARAGO, ASHLEY N	12/11/17 22:56	
ELECTRONICALLY ENTERED		ELECTRONIC		
Treating Specialty:				
Ordering Location: ER				
- Activity:				
- 12/11/2017 22:56 New Order entered by DARAGO, ASHLEY N (FAMILY NURSE PR)				
- Order Text: MICROSCOPIC URINE-WEL URINE, RANDOM STAT I ONCE				
- Nature of Order: ELECTRONICALLY ENTERED				
- Elec Signature: DARAGO, ASHLEY N (FAMILY NURSE PR) on 12/11/2017 22:56				
-				

12/11/17 22:56:33	p	DARAGO, ASHLEY N	12/11/17 22:56	
ELECTRONICALLY ENTERED		ELECTRONIC		
Treating Specialty:				
Ordering Location: ER				
- Activity:				
- 12/11/2017 22:56 New Order entered by DARAGO, ASHLEY N (FAMILY NURSE PR)				
- Order Text: URINALYSIS COMPLETE-WEL URINE, RANDOM STAT WC ONCE				
- Nature of Order: ELECTRONICALLY ENTERED				
- Elec Signature: DARAGO, ASHLEY N (FAMILY NURSE PR) on 12/11/2017 22:56				
-				

12/11/17 22:56:33	p	DARAGO, ASHLEY N	12/11/17 22:56	
ELECTRONICALLY ENTERED		ELECTRONIC		
Treating Specialty:				
Ordering Location: ER				
- Activity:				
- 12/11/2017 22:56 New Order entered by DARAGO, ASHLEY N (FAMILY NURSE PR)				
- Order Text: COMPREHENSIVE METABOLIC PROFILE-WEL PLASMA-GRNL STAT I ONCE				
- Nature of Order: ELECTRONICALLY ENTERED				
- Elec Signature: DARAGO, ASHLEY N (FAMILY NURSE PR) on 12/11/2017 22:56				
-				

EXHIBIT NO. B6F
PAGE: 232 OF 239

Name : ADAMS, NEVAEH H	MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE	ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL	ADM: Dec 11, 2017 21:50
ATTENDING:	

12/11/17 22:56:33 c DARAGO,ASHLEY N 12/11/17 23:38:42 12/11/17 23:51
 ELECTRONICALLY ENTERED ELECTRONIC

Treating Specialty:

Ordering Location: ER

- Activity:
- 12/11/2017 22:56 New Order entered by DARAGO,ASHLEY N (FAMILY NURSE PR)
- Order Text: CBC-WEL BLOOD-LAV STAT I ONCE
- Nature of Order: ELECTRONICALLY ENTERED
- Elec Signature: DARAGO,ASHLEY N (FAMILY NURSE PR) on 12/11/2017 22:56

-

12/11/17 22:56 c DARAGO,ASHLEY N 12/11/17 23:38:42 12/12/17 00:04
 ELECTRONICALLY ENTERED ELECTRONIC

Treating Specialty:

Ordering Location: ER

- Activity:
- 12/11/2017 22:56 New Order entered by DARAGO,ASHLEY N (FAMILY NURSE PR)
- Order Text: MONO SPOT-WEL BLOOD-LAV STAT I ONCE
- Nature of Order: ELECTRONICALLY ENTERED
- Elec Signature: DARAGO,ASHLEY N (FAMILY NURSE PR) on 12/11/2017 22:56

-

12/11/17 22:56 c DARAGO,ASHLEY N 12/11/17 23:38:42 12/12/17 00:03
 ELECTRONICALLY ENTERED ELECTRONIC

Treating Specialty:

Ordering Location: ER

- Activity:
- 12/11/2017 22:56 New Order entered by DARAGO,ASHLEY N (FAMILY NURSE PR)
- Order Text: FLU A B PANEL-WEL NP WASH NASOPHARYNX STAT I ONCE
- Nature of Order: ELECTRONICALLY ENTERED
- Elec Signature: DARAGO,ASHLEY N (FAMILY NURSE PR) on 12/11/2017 22:56

-

12/11/17 22:56 c DARAGO,ASHLEY N 12/11/17 23:38:14 12/11/17 23:59
 ELECTRONICALLY ENTERED ELECTRONIC

Treating Specialty:

Ordering Location: ER

- Activity:
- 12/11/2017 22:56 New Order entered by DARAGO,ASHLEY N (FAMILY NURSE PR)
- Order Text: STREP SCREEN GROUP A-WEL SWAB-TH PHARYNX STAT WC ONCE
- Nature of Order: ELECTRONICALLY ENTERED
- Elec Signature: DARAGO,ASHLEY N (FAMILY NURSE PR) on 12/11/2017 22:56

-

12/11/17 22:56 c DARAGO,ASHLEY N 12/11/17 22:56 12/13/17 00:17

**EXHIBIT NO. B6F
PAGE: 233 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006396563
ADM: Dec 11, 2017 21:50

ELECTRONICALLY ENTERED

ELECTRONIC

Treating Specialty:

Ordering Location: ER

History and Reason for Exam:

- Activity:
- 12/11/2017 22:56 New Order entered by DARAGO,ASHLEY N (FAMILY NURSE PR)
- Order Text: CHEST, 2 VIEWS PA & LAT STAT
- Nature of Order: ELECTRONICALLY ENTERED
- Elec Signature: DARAGO,ASHLEY N (FAMILY NURSE PR) on 12/11/2017 22:56

-

*** END ***** CONFIDENTIAL ORDERS SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 234 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006396563
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
 ATTENDING:

***** CONFIDENTIAL LAB RESULTS SUMMARY *****

Report Released Date/Time: Dec 12, 2017@00:04

Provider: DARAGO,ASHLEY N

Specimen: BLOOD. WHEM 1211 104

Specimen Collection Date: Dec 11, 2017@23:38

Test name	Result	Flg	units	Ref.	range	Site	Result	Dt/Time
MONO SPOT-WEL	NEGATIVE					[68]	12/12/17	00:04

Comment: collected by mbb @ 2315-released by jle @0000

Performing Lab Sites

[68] WEL
 454 McDOWELL STREET WELCH, WV 24801

----- END -----

Report Released Date/Time: Dec 11, 2017@23:51

Provider: DARAGO,ASHLEY N

Specimen: BLOOD. WHEM 1211 105

Specimen Collection Date: Dec 11, 2017@23:38

Test name	Result	Flg	units	Ref.	range	Site	Result	Dt/Time
WBC-WEL	7.3	x10 3/uL		4.8 - 10.8		[68]	12/11/17	23:51
NEU%-WEL	60.8	%		42.2 - 75.2		[68]	12/11/17	23:51
LYM%-WEL	25.3	%		20.5 - 51.5		[68]	12/11/17	23:51
MON%-WEL	11.9	H	%	5.5 - 11.7		[68]	12/11/17	23:51
EOS%-WEL	1.1	%		0.9 - 2.9		[68]	12/11/17	23:51
BAS%-WEL	0.9	%		0.2 - 1.0		[68]	12/11/17	23:51
NEU#-WEL	4.4	#		1.4 - 6.5		[68]	12/11/17	23:51
LYMPH #-WEL	1.8	#		1.2 - 3.4		[68]	12/11/17	23:51
MON#-WEL	0.9	H	#	0.3 - 0.8		[68]	12/11/17	23:51
EOS#-WEL	0.1	#		0.0 - 0.2		[68]	12/11/17	23:51
BAS#-WEL	0.1	#		0.0 - 0.1		[68]	12/11/17	23:51
RBC-WEL	4.61	x10 6/uL		4.20 - 5.40		[68]	12/11/17	23:51
HEMOGLOBIN-WEL	12.7	g/dL		12.0 - 16.0		[68]	12/11/17	23:51
HEMATOCRIT-WEL	40.1	%		37.0 - 47.0		[68]	12/11/17	23:51
MCV-WEL	87.0	fL		81.0 - 99.0		[68]	12/11/17	23:51
MCH-WEL	27.6	pg		27.0 - 31.0		[68]	12/11/17	23:51
MCHC-WEL	31.7	L	g/dL	33.0 - 37.0		[68]	12/11/17	23:51
RDW-WEL	11.8	%		11.5 - 14.5		[68]	12/11/17	23:51
PLATELETS-WEL	100	L	x10 3/uL	130 - 400		[68]	12/11/17	23:51
MPV-WEL	9.0	fL		7.4 - 10.4		[68]	12/11/17	23:51

Comment: plt estimation was counted manually due to QNS in blood.
 collected by mbb @ 2315-released by jle @ 2351

Performing Lab Sites

[68] WEL
 454 McDowell Street Welch, WV 24801

----- END -----

Report Released Date/Time: Dec 12, 2017@00:03

Provider: DARAGO,ASHLEY N

Specimen: NASOPHARYNX. WHEM 1211 103

Specimen Collection Date: Dec 11, 2017@23:38

EXHIBIT NO. B6F
PAGE: 235 OF 239

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

Test name	Result	Flg	units	Ref.	range	Site	Result	Dt/Time
FLU A-WEL	NEGATIVE					[68]	12/12/17	00:03
FLU B-WEL	NEGATIVE					[68]	12/12/17	00:03

Comment: collected by tw @ 2300-released by jle @ 0000

Performing Lab Sites
 [68] WEL
 454 McDOWELL STREET WELCH, WV 24801
 ----- END -----

Report Released Date/Time: Dec 11, 2017@23:59
 Provider: DARAGO,ASHLEY N
 Specimen: PHARYNX. WHEM 1211 102
 Specimen Collection Date: Dec 11, 2017@23:38

Test name	Result	Flg	units	Ref.	range	Site	Result	Dt/Time
STREP W	NEGATIVE					[68]	12/11/17	23:59

Comment: collected by tw @2300-released by jle @ 2359

Performing Lab Sites
 [68] WEL
 454 McDOWELL STREET WELCH, WV 24801
 ----- END -----

*** END ***** CONFIDENTIAL LAB RESULTS SUMMARY *****

EXHIBIT NO. B6F
PAGE: 236 OF 239

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
ATTENDING:

***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

----- CHEST, 2 VIEWS PA & LAT -----

Exm Date: DEC 11, 2017@22:58
Req Phys: DARAGO,ASHLEY N Pat Loc: ER (Req'g Loc)
Img Loc: WEL X-RAY
Service: Unknown

(Case 699 COMPLETE) CHEST, 2 VIEWS PA & LAT (RAD Inactive) CPT:71020
Reason for Study: fever

Reason for Study: fever

Clinical History:

Report Status: Verified

Date Reported: DEC 12, 2017

Date Verified: DEC 13, 2017

Verifier E-Sig:/ES/ALAN M LINTALA, MD

Report;

Examination: two-view chest

Clinical history: Fever.

Frontal and lateral chest x-ray performed at 11:15 PM on 12/11/2017: Previous study of 8/29/2017 was reviewed. No evidence of pulmonary consolidation, pneumothorax, large pleural effusions. Unremarkable cardiothymic shadow. Pulmonary vascularity is within normal limits. Bony thorax appears intact.

Impression:

No evidence of pulmonary consolidation, cardiomegaly, or pulmonary vascular congestion.

Dictated: 12/12/2017 12:09:01 AM Dictated By: Alan Lintala
M.D. Transcribed By Dragon Medical Practice Edition

Primary Diagnostic Code:

Primary Interpreting Staff:
ALAN M LINTALA, MD, Staff Physician (Verifier)
/SP

*** END ***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 237 OF 239**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006396563
ADM: Dec 11,2017 21:50

***** CONFIDENTIAL DISCHARGE SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL DISCHARGE SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 238 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
ATTENDING:

***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

**EXHIBIT NO. B6F
PAGE: 239 OF 239**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006396563
HOSPT : WELCH COMMUNITY HOSPITAL ADM: Dec 11, 2017 21:50
ATTENDING:
=====

ADRs: No ADRs on file.

Allergies: PENICILLIN
=====

****NO MEDICATIONS FOUND****

*** END ***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

{{{ END }}} Patient Encounter(s) History Report Dec 28, 2018@14:20

From: <ScanSTAT Technologies> To: S55 WV DDS CHARLESTON Page: 5/10 Date: 1/19/2019 12:46:51 AM

PATIENT NAME Nerath AdamsEXHIBIT NO. B7F
DOB 7-20-15 DATE 1/19/19 PAGE 1 OF 5**PEDIATRIC PATIENT & FAMILY HISTORY**

PLEASE INDICATE ANY ILLNESS OR CONDITIONS EXPERIENCED BY THE PATIENT OR THEIR FAMILY MEMBERS

	PATIENT	FAMILY	NO		PATIENT	FAMILY	NO
DIABETES		✓		ASTHMA		✓	✓
THYROID			✓	SLEEP APNEA			✓
AUTOIMMUNE DISEASE			✓	SEIZURES			
MIGRAINES				HEARING LOSS		✓	
HEART	✓			CANCER			✓
HYPERTENSION			✓	KIDNEY DISEASE			
BLEEDING DISORDER			✓	JAUNDICE/HEPATITIS/LIVER			✓
BIRTH DEFECTS	✓			ACID REFLUX			

CHILD'S PAST HISTORY

Allergies:

Anx

Hospitalizations:

Surgeries: check if your child has had any of the following

- Tonsillectomy
- Adenoectomy
- Ear tubes
- Appendectomy
- Dental
- Heart
- Eye
- Other please list hips

CHILD'S SOCIAL HISTORY

DAYTIME ENVIRONMENT:

HOME DAYCARE () BABYSITTER () SCHOOL () OTHER ()

PETS? Cat () Dog () Birds () Hamsters/Rodents () Cow () Horse ()

DOES ANYONE SMOKE IN THE HOME? Y N DOES ANYONE SMOKE IN THE CHILD'S OTHER ENVIRONMENT?

Y N

Brothers & Sisters? Y N How many? _____

Do both parents live in the home? Y N

BIRTH HISTORY:

Turnes Syndrome, heart problem.

OFFICE USE ONLY

9/25/18 BM

8BCF5D69ADBC456BAFA8, ADAMS, 5

From: <ScanSTAT Technologies>

To: S55 WV DDS CHARLESTON

Page: 6/10

Date: 1/19/2019 12:46:51 AM

7F

PEDIATRIC NEW PATIENT EVALUATION

Name: Nevrek AdamsDOB: 7/10/15DRAGE: 2 OF 5

Accompanied by:

Referred by:

Chief

Complaint: has had 18 ear infections

Review of Systems

Negative unless indicated

Const: Fever Weightloss/Gaining Fatigue Chills Developmental Delays
 Ears: Hearing Loss Tinnitus Pain Drainage Odor Itching Fullness
 Nose: Obstruction Discharge Allergy Injury Congestion Sneezing Itching Bleeding
 Throat: Hoarseness Sore Throat Swelling Bad Breath Difficulty Swallowing
 Eyes: Watery Drainage Crusting Itching texture disorder
 Sleep: Snoring Mouth Breathing Sleep Pauses Restless Sleep high palate
 Cardiac: Palpitations Chest Pain
 Heme/Lymph: Bruising Swollen Glands
 GI: Heartburn Diarrhea Constipation Stomach Pains Vomiting
 GU: Frequency Difficulty Urination Bed Wetting
 Respiratory: Cough Wheezing Shortness of Breath
 Psych: Anxiety Depression Behavior Problems
 Neuro: Numbness Tingling Loss of Balance Speech Delays Headache
 Musculoskeletal: Difficulty walking Jaw/Facial pain Neck pain
 Endocrine: Growth Problems
 Integument: Rash Lesions Open Wounds/sores

Pertinent Social History: Daycare Smoking Environment OtherAllergy Testing? Y N When _____ Where _____Pertinent ENT Surgeries/Injuries noneFamily History of Bleeding Disorder? Y NNurse: BW Adams

History of Present Illness: (location, severity, duration, timing, context, modifying factors, associated symptoms)

3 yrs of presents to E Recent
poop. Hx of tinner's
Paschal w/ B45, + poope
Vache. Has 18 ear infections
comes b/w. last course
Sped of abt. 6 days at beginning of each month

Age 1st infection: _____ # Infections/year _____ # Courses of Antibiotics _____

Antibiotic History: Amoxicillin Augmentin Bactrim Biaxin Ceclor Cefitin Cefzil Cipro
 Omnicef Rocephin Penicillin Zithromax Other: _____

Antihistamines _____ Nasal Sprays _____
 Ear Drops _____ Other Treatment _____

Scribed by _____ Provider [Signature]

From: <ScanSTAT Technologies>

To: S55 WV DDS CHARLESTON

Page: 7/10

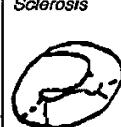
Date: 1/19/2019 12:46:51 AM

EXHIBIT NO. B7F
PAGE: 3 OF 5
PATIENT EXAMINATION
PT NAME Nevaeh Adams **DOB** 7/21/15 **Date** 9-25-18
HISTORY REVIEWED: CHIEF COMPLAINT _____ **HPI** _____ **ROS** _____ **PFSH** _____ **MED LIST** _____

- General Appearance: normal
- Mood & Affect: normal
- Communication: normal
- overweight
- obese
- underwt
- malnourished
- agitated
- nervous
- detached
- hrg impaired
- hearing aids
- speech imp.
- assistance

• BP	PULSE	RESP	16	TEMP	99.0	HT/WT	321bs			
HEART	normal	murmur	irregular	other	LUNGS	normal	labored	wheezes	rales	other

- Neuro Exam: cranial II-XII grossly intact A+0x3

HEAD & NECK	• NOSE	• ORAL CAVITY
<ul style="list-style-type: none"> • Lesions () <u>None</u> • Scars () <u>None</u> • Facial Function () <u>Normal</u> • Parotid Gland <u>Normal</u> Submandibular Gland () <u>Normal</u> • TMJ Normal 	<ul style="list-style-type: none"> WNL Septal Deviation (Hyperemic) Mucopus Fracture <p>KB Bleed Polyp(s) Hypertrophic Obstruction Allergy</p>	<ul style="list-style-type: none"> Gums, Lips, Teeth () <u>Normal</u> Oropharynx () <u>Normal</u> <p><i>See Lying Palate</i></p>
<ul style="list-style-type: none"> • () None Masses • () None Tenderness <p>PHOTOS</p>	<ul style="list-style-type: none"> JVD Bruit <p>Endoscopy: Y N Findings: + -- See Scope Form / Diagnostic Testing</p>	<p>Tonsils: Size Debris Odor</p> <p>Cryptic Inflamed</p>
• RIGHT EAR	• LEFT EAR	LARYNX
<ul style="list-style-type: none"> WNL Wax Perf Sclerosis 	<ul style="list-style-type: none"> Cholest. Monomer Fungus Atel. Fluid <p>WNL</p> <p>External Ear Inspection () <u>Normal</u></p>	<ul style="list-style-type: none"> Cholest. Monomer Fungus Atel. Fluid <p>WNL</p> <p>Paralytic</p> <p>External Ear Inspection () <u>Normal</u></p>
		<p>Fl Laryngoscopy: Y N Findings: + -- See Scope Form / Diagnostic Testing</p> 

DIAGNOSTIC TESTS REVIEWED (tests dated today unless otherwise noted):

CT/XRAY	SKIN TSTG
AUDIO	PATHS/CULTURE
DIAGNOSIS: 1. <u>Recent runny nose</u> 2. <u>congestion</u> 3. <u></u> 4. <u></u>	
Treatment/Management: <u>Facetime with Patient</u>	
<p>- ✓ VPT</p> <p>- Pneumonia VPT</p>	
Scribed By <u>DR</u> Physician's Signature <u>DR</u> Date <u>3/20/18</u>	

RTC ____ Days ____ Wks ____ Months ____ W/ ____ Audio ____ CT ____ Sk Tstg ____ Scoping ____ Other

Informational Handouts: Sleep Apnea/Snoring Reflux Nosebleed Cholesteatoma Swimmers Ear TMJ
Allergy Precautions

Informational Videos Viewed: Tubes T&A Septoplasty Ear Surgery Laser Surgery Sinus Surgery 2456BAFA8, ADAMS 7

From: <ScanSTAT Technologies> To: S55 WV DDS CHARLESTON Page: 8/10 Date: 1/19/2019 12:46:51 AM
ENT QUALITY PAYMENT PROGRAM MEASURES.

DOB: 7/21/15 Patient Name: Nevach Adams Date of Service PAGE 4 OF 5 EXHIBIT NO. B7F

Quality Measure:	PATIENT EXCLUDED	PERFORMANCE NOT MET	PERFORMANCE MET
#130 Medication list Reconciliation all patients 18 and over HIGH PRIORITY		<input type="checkbox"/> G8428 Medication list NOT Reconciled for NO Reason For NO reason	<input checked="" type="checkbox"/> G8427 Meds list reconciled. <input type="checkbox"/> G8430 Meds list not reconciled for good reason
#91 Acute Otitis Externa age 2 and over treated with topical prep (RX or OTC) (each occurrence defined as a 30 day period, only count one instance of reporting in that 30 day period)	<input type="checkbox"/> No AOE <input type="checkbox"/> Under age 2. <input type="checkbox"/> those with AOE already seen for that diagnosis within the last 30 days.	<input type="checkbox"/> 4130F-8P Topical prep NOT in use or NOT given for NO reason	<input type="checkbox"/> 4130F Topical prep in use or given <input type="checkbox"/> 4130F-1P Topical prep not in use or NOT given WITH reason: coexisting AOM, TM perf. <input type="checkbox"/> 4130F-2P PATIENT reason for NOT prescribing topical
#93 Acute Otitis Externa age 2 and over: Use of inappropriate Systemic antimicrobial. (each occurrence defined as a 30 day period, only count one instance of reporting in that 30 day period)	<input type="checkbox"/> Less than age 2 <input type="checkbox"/> no AOE <input type="checkbox"/> seen for AOE within the last 30 days.	<input type="checkbox"/> 4131F Systemic Antimicrobial prescribed with NO reason given	<input type="checkbox"/> 4132F Systemic antimicrobial NOT prescribed <input type="checkbox"/> 4131F-1P Systemic antimicrobial prescribed for medical reason (coexisting AOM, Perforated TM, Diabetes, immune deficiency)
#331 Adult Sinusitis 18 and older: INVERSE MEASURE Use of antibiotic within 10 days of onset of symptoms (each occurrence)	<input type="checkbox"/> Date of dx of sinusitis	<input type="checkbox"/> G9287 Antibiotic NOT prescribed within 10 days of onset of symptoms <input type="checkbox"/> G9505 Antibiotic prescribed but reason given _____	<input type="checkbox"/> G9286 Antibiotic prescribed within 10 days of onset of symptoms without reason

WEITZEL

8BCF5D69ADBC456BAFA8, ADAMS, 8

From: <ScanSTAT Technologies>

To: S55 WV DDS CHARLESTON

Page: 9/10

Date: 1/19/2019 12:46:51 AM

EXHIBIT NO. B7F**PAGE: 5 OF 5**

#332 Appropriate Choice of antibiotic in Adult acute bacterial sinusitis for more than 10 days age 18 and over (once per performance period)		<input type="checkbox"/> G9314 NOT given Amoxicillin with or without clavulanate as first line drug for no reason	<input type="checkbox"/> G9315 Prescribed Amoxicillin with or without clavulanate as first line <input type="checkbox"/> G9313 Prescribed a different antibiotic first line for medical reasons: cystic fibrosis, immotile cilia disorder/dyskinesis, immune deficiency, sinus surgery with in 12mths, anatomic abn such as deviated septum, resistant organisms, Allergy to meds, recurrent sinusitis, chronic sinusitis, other reason.
#333 Adult Sinusitis: CT done within 28 days of dx of acute sinusitis in patients 18 and over. (each Occurrence) INVERSE MEASURE: Closer to 0% is good.	<input type="checkbox"/> Date of diagnosis of Acute Sinusitis.	<input type="checkbox"/> G9350 CT scan NOT done within 28 days of dx. <input type="checkbox"/> G9348 CT done within 28 days of dx for documented reason (Sinusitis >7- 10d??, antibiotic resistance, immunocompromised, recurrent sinusitis, acute frontal sinusitis, acute sphenoid sinusitis, periorbital sinusitis, or other medical reason	<input type="checkbox"/> G9349 CT scan done within 28 days of diagnosis

EXHIBIT NO. B8F
PAGE: 1 OF 26

Health Information Technology (HIT) Medical Report

NOTE: The following displays data transmitted to the SSA from the health IT partner using standards-based computer transactions and is reformatted to assist with navigating through the clinical details of the record. Known duplicative information will be struck-through (e.g. sample).

Summarization of Episode Note Continuity of Care Document

Received From: WVU Medicine

MEGAHIT sent a request for electronic medical records from the following claimant-provided source(s):

Source Type: Doctor/Therapist
 Source Name: CAMC WOMENS & CHILDRENS HOSPITAL
 Address: 800 PENNSYLVANIA AVE
 CHARLESTON, WV 25302

Creation Date:	Date Range Requested:	Type of Request:
12/20/2018	07/21/2014 - 12/20/2018	MEGAHIT Triggered

Nevaeh Hope Adams SSN: 794-01-8055	DOB: 07/21/2015	Sex: Female
--	------------------------	--------------------

Partner Medical Record Demographics:		
Name: Nevaeh Adams	DOB: 07/21/2015	Sex: Female

Table of Contents

- Problems List [PROB LIST]
- Encounters [ENC]
- Procedures [PROCED]
- Laboratory Results [LABS]
- Vital Signs [VITALS]
- Medication Information [MEDS]
- Plan of Care [CARE PLAN]
- Healthcare Providers [PROV LIST]

EXHIBIT NO. B8F
PAGE 2 OF 26

PROB LIST

Problems List

<u>Problem [Code]</u>	<u>Occurrences</u>	<u>First Date</u>	<u>Last Date</u>	<u>Associated Types</u>	<u>Last Prognosis Value</u>	<u>Last Prognosis Date</u>
Aortic valve regurgitation [60234000]	1	05/09/2018	-	Disease		
Nonrheumatic aortic (valve) insufficiency [I35.1]						
Aortic valve disorder [424.1]						
Aortic valve insufficiency [38490]						
Esotropia [16596007]	1	05/09/2018	-	Disease		
Unspecified esotropia [H50.00]						
Esotropia NOS [378.00]						
Esotropia [80576]						
H/O: congenital anomaly [161572004]	1	05/09/2018	-	Disease		
Personal history of (corrected) congenital malformations of integument, limbs and musculoskeletal system [Z87.76]						
Hx-congenital malfor NEC [V13.69]						
Personal history of congenital hip dysplasia [734539]						
Turner syndrome [38804009]	1	05/09/2018	-	Disease		
Karyotype 45, X [Q96.0]						
Gonadal dysgenesis [758.6]						
Turner syndrome karyotype 45, x [41312017]						

Narrative Text

Problem	Noted Date
Turner syndrome karyotype 45, x	05/09/2018
Esotropia	05/09/2018
Aortic valve insufficiency	05/09/2018
Personal history of congenital hip dysplasia	05/09/2018
Overview:	
S/p open reduction	

ENC

**EXHIBIT NO. B8F
PAGE: 3 OF 26**

Encounters

Date	Type	Specialty	Care Team	Description
11/21/2018	Documentation Only		Wriston, Alyssa, PA	
11/13/2018	Telephone		Dye, Amanda, MD	Has Questions; Has Questions; Has Questions

CHILDRENS MEDICAL OFFICE BLDG-WVUPC

11/13/2018

Telephone Encounter - Carroll, Brittany A - 11/13/2018 10:41 AM EST

Mom said she spoke to the insurance company regarding Nevaeh's hormone shots, and they said they faxed everything to our office.

Has Nevaeh been approved for these?

Thanks

Electronically Signed by Carroll, Brittany A on 11/13/2018 10:41 AM EST

Telephone Encounter - Tinney, Pamela S - 11/14/2018 9:44 AM EST

Mom said she has not heard from anyone

Electronically Signed by Tinney, Pamela S on 11/14/2018 9:44 AM EST

Telephone Encounter - Harris, Marsha A - 11/14/2018 10:38 AM EST

I called Mom.

Informed her that we are waiting to get clearance from Shriner's.

I do not see anything in her chart from them.

She said she would call them and see what she could do.

Electronically Signed by Harris, Marsha A on 11/14/2018 10:38 AM EST

Telephone Encounter - Pauley, Alexus, MA - 11/14/2018 1:59 PM EST

----- Message from Alyssa Wriston, PA sent at 10/26/2018 2:46 PM EDT -----

Can you all see if we can get my note sent to Shriner's orthopedics to have them give clearance for growth hormone? I can write up another letter if I need to for that. Also can you see if Carilion Clinic in Roanoke has her renal ultrasound results please? Thanks

Electronically Signed by Pauley, Alexus, MA on 11/14/2018 1:59 PM EST

Telephone Encounter - Pauley, Alexus, MA - 11/14/2018 1:59 PM EST

Faxed information to shriners 18592685780

Electronically Signed by Pauley, Alexus, MA on 11/14/2018 1:59 PM EST

Telephone Encounter - Pauley, Alexus, MA - 11/14/2018 3:01 PM EST

----- Message from Alyssa Wriston, PA sent at 10/26/2018 2:46 PM EDT -----

Can you all see if we can get my note sent to Shriner's orthopedics to have them give clearance for growth hormone? I can write up another letter if I need to for that. Also can you see if Carilion Clinic in Roanoke has her renal ultrasound results please? Thanks

Electronically Signed by Pauley, Alexus, MA on 11/14/2018 3:01 PM EST

Date	Type	Specialty	Care Team	Description
	Telephone Encounter - Pauley, Alexus, MA - 11/14/2018 3:01 PM EST			EXHIBIT NO. B8F PAGE: 4 OF 26
	Never had renal US, faxed papers and forms to ortho, waiting on response have fax confirmation			
	Electronically Signed by Pauley, Alexus, MA on 11/14/2018 3:01 PM EST			
	Telephone Encounter - Pauley, Alexus, MA - 11/16/2018 10:33 AM EST			
	shriners received fax, waiting on response for clearance			
	Electronically Signed by Pauley, Alexus, MA on 11/16/2018 10:33 AM EST			
	Telephone Encounter - Tinney, Pamela S - 12/04/2018 10:43 AM EST			
	Mom is upset saying this has taken way too long, mom said she has already received a letter from Shriners stating everything has been approved, please check into and call mom with update			
	Electronically Signed by Tinney, Pamela S on 12/04/2018 10:43 AM EST			
	Telephone Encounter - Wriston, Alyssa, PA - 12/04/2018 3:28 PM EST			
	Spoke with mother to make her aware that this process for approval of growth hormone could take up to 3 months. She is upset that the form did not get sent to Shriner's for a month but we did not get clearance from Shriner's until November 20th. Now that we have that clearance, her chart is now in the process for insurance approval. She states she may switch to Cincinnati's Turner Syndrome Clinic because they could get approval in 1 month. I advised mother that if she needs anything else to give us a call and then she hung up on me.			
	Electronically Signed by Wriston, Alyssa, PA on 12/04/2018 3:28 PM EST			
	Telephone Encounter - Midkiff, Tammy - 12/17/2018 3:34 PM EST			
	Spoke with Alyssa. She still feels like mom wants to move forward with growth hormone with our clinic. Alyssa and I Talked with Liz and asked her to move forward with the process.			
	Tammy - just so you are aware, this mother says she contacted administration because she is frustrated that the insurance approval for growth hormone is taking as long as it has. I discussed the whole process with her and that we were having issues at the beginning trying to get Shriner's fax number for clearance from their clinic. I told her that this can take up to 3 months for approval. She states she may just go up to Cincinnati instead.. Just FYI. I tried to calm her down. (Routing comment)			
10/10/2018	Electronically Signed by Midkiff, Tammy on 12/17/2018 3:34 PM EST			
	Telephone		Wriston, Alyssa, PA	Test <u>Results</u>

**CHILDRENS MEDICAL OFFICE BLDG-WVUPC
10/10/2018**

Telephone Encounter - Tinney, Pamela S - 10/10/2018 2:08 PM EDT

Mom is wanting to know if results are back and she is wanting to speak with someone about growth hormone

Electronically Signed by Tinney, Pamela S on 10/10/2018 2:08 PM EDT

Telephone Encounter - Carroll, Brittany A - 10/11/2018 1:32 PM EDT

Mom calling back about results.

She also has questions about her visit last week.

She won't be home this afternoons so please call her back tomorrow.

Thanks

Electronically Signed by Carroll, Brittany A on 10/11/2018 1:32 PM EDT

Telephone Encounter - Wriston, Alyssa, PA - 10/11/2018 1:47 PM EDT

Spoke with mother regarding growth hormone and labs. She has follow up with ortho at Shriner's in January. She has

EXHIBIT NO. B8F
PAGE: 5 OF 26

Date	Type	Specialty	Care Team	Description
10/04/2018	Office Visit	discussed GH injections with her doctor and says that it is a risk to take but it may even help hip issues. Mother would like to start this process. I will obtain clearance from ortho before we start. Bone age normal. All other labs normal. Mother requests GI referral for frequent, loose stools that she has up to 8-9x/day sometimes.	Wriston, Alyssa, PA	Turner syndrome karyotype 45, x (Primary Dx)

CHILDRENS MEDICAL OFFICE BLDG-WVUPC

10/04/2018

Progress Notes - Bdre, Sachin, MD - 10/04/2018 11:00 AM EDT

Formatting of this note might be different from the original.

CHILDRENS MEDICAL OFFICE BLDG-WVUPC
 WVUPC-PEDS ENDOCRINE
 830 Pennsylvania Ave
 Charleston WV 25302-3302
 304-388-1552

Name: Nevaeh Adams Referring Provider: Rahmet Muzaffer, MD

MRN: E2228804 **PCP**: Rahmet Muzaffer, MD

Date of Birth: 7/21/2015 Date of Service: 10/04/18

Informant: patient and grandparents; discussed with mother over the phone

History of Present Illness: Nevaeh Adams is a 3 y.o. female who presents with Turner Syndrome, 45-XO and short stature. Nevaeh was diagnosed in utero with Turner Syndrome and confirmed with **chromosome analysis** after birth. She has started to fall off the growth curve for height per her **PCP**. Mother states Nevaeh has been essentially the same weight for about 1.5 years now. She has been following with a geneticist in Roanoke annually and also sees a cardiologist and ophthalmologist. Nevaeh is also followed by ortho at Shriner's for hip dysplasia s/p open reduction and her right leg is slightly longer than her left. Last year, mother states Nevaeh had been awake for 48 hours when she took her to Welch ED and was presumably diagnosed with thyroid storm. She was admitted for 2 days and given IVF and potassium. She then came to W&C for further workup. Nevaeh has had some caps placed secondary to dental caries.

Interval History: Recently Nevaeh's ears have been bothering her. She has history of recurrent AOM. She will be having an audiology appointment to test her hearing and soon will have tympanostomy tubes placed. She is currently not toilet trained but is working on it. Nevaeh previously followed with Birth to Three for occupational **therapy** but has phased out and will be starting school next year. Nevaeh has not grown in height at all so height has gone from 14%tile to 3%tile. She has gained 0.8 kg in 5 months. Mother states renal ultrasound was performed at Carilion Clinic in Roanoke and she reports that Nevaeh does have horseshoe kidneys but no **results** in EPIC were found.

Nevaeh's Medical Team:

Dr. Lori Miller - cardiologist, Roanoke
 Dr. Doherty - Geneticist, Roanoke
 Ortho at Shriners
 Vista Star - ophthalmology, Roanoke
 Developmental specialist with BTT

No current outpatient prescriptions on file.

No current facility-administered medications for this visit.

Past Medical History:

Diagnosis Date

- Bicuspid aortic valve
- Developmental delay
- Heart defect
- Otitis media
- Turner syndrome
- 45, XO
- Visual impairment
- esotropia

Date	Type	Specialty	Care Team	Description
		Family Medical History: Problem Relation (Age of Onset) No Known Problems Mother, Father		EXHIBIT NO. B8F PAGE: 6 OF 26

Review of Systems:

Constitutional: negative for fever or weight loss
 Eyes: + esotropia, negative for diplopia, blurry vision, or scotoma
 HEENT: + recurrent AOM
 Cardiovascular: + bicuspid aortic valve, mild aortic narrowing
 Respiratory: negative for wheezing, dyspnea, or cough
 Gastrointestinal: negative for constipation, diarrhea, hematochezia, or abdominal pain
 GU: + horseshoe kidneys
 Endocrine: +Turner syndrome
 Musculoskeletal: negative for back pain, joint pain, or trauma
 Neurologic: negative for paresthesias, headaches, or dizziness
 Integument: negative for rashes, bruising, or hyperpigmentation

Physical Exam:

Vitals:
 10/04/18 1129
 BP: (l) 135/78
 Pulse: (l) 133
 Weight: 14.5 kg (32 lb)
 Height: 0.883 m (2' 10.76")
 BMI: 18.66

97 %ile (Z= 1.85) based on CDC 2-20 Years BMI-for-age data using vitals from 10/4/2018.

General: well appearing, no distress
 Eyes: pupils equal and reactive to light and accomodation, no nystagmus
 HEENT: + esotropia, clear nasal drainage, moist mucous membranes, no lymphadenopathy
 Chest: broad chest with widely spaced nipples
 Cardiovascular: regular rate and rhythm, no murmur, +2 peripheral pulses
 Respiratory: clear to auscultation bilaterally, no wheezing, no crackles or rales
 Abdomen: soft, non-tender, non-distended, no masses or organomegaly
 Musculoskeletal: moves all four extremities well, no joint edema, warmth, or tenderness
 Neurologic: cranial nerves II-XII grossly intact, no focal deficits
 Integument: no rashes, hyperpigmentation, or discoloration
 Neck: webbing of neck, thyroid normal to palpation, no lymphadenopathy

Assessment: Nevaeh Adams is a 3 y.o. female with Turner Syndrome, 45-XO and short stature.

Plan:

1. Turner Syndrome: Follows with cardiology every 2 years - appointment coming up November 2018. Shriner's orthopedic follow up in January 2019. Unable to find renal ultrasound report but will try to find documentation.
2. Short stature: Labs and bone age reviewed - all normal. Will obtain clearance from orthopedics to initiate GH injection **therapy.**
3. Cerumen impaction, bilateral: Follow with **PCP**. Advised to not use Q-tips.

Total time spent with patient/family was 15 minutes with more than 50% in counseling.

Alyssa Wriston, PA-C
 Pediatric Endocrinology

I, Alyssa Wriston, attest and affirm that the above-referenced note was authored by me and accurately reflects the services that I personally rendered to the patient on such date.

Alyssa Wriston, PA-C
 Pediatric Endocrinology
 11/16/18

Electronically Signed by Bendre, Sachin, MD on 10/04/2018 11:00 AM EDT
 07/24/2018 Documentation Only Lewis, Kevin R, APRN

Date	Type	Specialty	Care Team	Description
		MEDICAL STAFF OFFICE BLDG-WVUPC		EXHIBIT NO. B8F PAGE: 7 OF 26
	07/24/2018			
		Progress Notes - McCallister, Tim D - 07/24/2018 11:59 PM EDT		
		Records uploaded to Jan Dils secure portal.		
05/14/2018	Telephone	Electronically Signed by McCallister, Tim D on 07/24/2018 11:59 PM EDT	Dye, Amanda, MD	Results ; Results
		CHILDRENS MEDICAL OFFICE BLDG-WVUPC		
	05/14/2018			
		Telephone Encounter - Tinney, Pamela S - 05/14/2018 9:16 AM EDT		
		Mom checking to see if lab results are back		
		Electronically Signed by Tinney, Pamela S on 05/14/2018 9:16 AM EDT		
		Telephone Encounter - Tinney, Pamela S - 05/14/2018 2:34 PM EDT		
		Mom calling again to see if results are back		
		Electronically Signed by Tinney, Pamela S on 05/14/2018 2:34 PM EDT		
		Telephone Encounter - Pauley, Alexus, MA - 05/14/2018 4:19 PM EDT		
		Not all results are back. Will send to Dr. Dye when all back, dad aware		
		Electronically Signed by Pauley, Alexus, MA on 05/14/2018 4:19 PM EDT		
		Telephone Encounter - Carroll, Brittany A - 05/15/2018 2:59 PM EDT		
		Mom calling to see if lab results are back.		
		Electronically Signed by Carroll, Brittany A on 05/15/2018 2:59 PM EDT		
		Telephone Encounter - Pauley, Alexus, MA - 05/15/2018 3:41 PM EDT		
		Could be a week before labs are back,		
		Electronically Signed by Pauley, Alexus, MA on 05/15/2018 3:41 PM EDT		
		Telephone Encounter - Carroll, Brittany A - 05/24/2018 9:43 AM EDT		
		Mom wants to know if labs are back yet.		
		Thanks		
		Mom says if she doesn't answer you can leave details on the voicemail.		
05/11/2018	Orders Only	Electronically Signed by Carroll, Brittany A on 05/24/2018 9:43 AM EDT	Dye, Amanda, MD	
05/09/2018	Office Visit	Telephone Encounter - Wriston, Alyssa, PA - 05/25/2018 2:59 PM EDT	Wriston, Alyssa, PA	Turner syndrome karyotype 45, x (Primary Dx); Polyuria; Esotropia; Nonrheumatic aortic valve insufficiency; Personal history of congenital hip

Date	Type	Specialty	Care Team	Description
				dysplasia EXHIBIT NO. B8F PAGE: 8 OF 26

CHILDRENS MEDICAL OFFICE BLDG-WVUPC**05/09/2018**Progress Notes - Dye, Amanda, MD - 05/09/2018 1:30 PM EDT

Formatting of this note might be different from the original.

CHILDRENS MEDICAL OFFICE BLDG-WVUPC
WVUPC-PEDS ENDOCRINE
830 Pennsylvania Ave
Charleston WV 25302-3302
304-388-1552

Name: Nevaeh Adams Referring Provider: Rahmet Muzaffer, MD
MRN: E2228804 PCP: Rahmet Muzaffer, MD
Date of Birth: 7/21/2015 Date of Service: 05/11/18

Informant: patient and mother

History of Present Illness: Nevaeh Adams is a 2 y.o. female who presents with Turner Syndrome, 45-XO and short stature. Nevaeh was diagnosed in utero with Turner Syndrome and confirmed with chromosome analysis after birth. She has started to fall off the growth curve for height per her PCP. Mother states Nevaeh has been essentially the same weight for about 1.5 years now. She has been following with a geneticist in Roanoke annually and also sees a cardiologist and ophthalmologist. Nevaeh is also followed by ortho at Shriner's for hip dysplasia s/p open reduction and her right leg is slightly longer than her left. Mother reports an elevated TSH level recently. Mother reports that Nevaeh has hand swelling on and off and also drinks about 12-15 sippy cups a day. Last year, mother states Nevaeh had been awake for 48 hours when she took her to Welch ED and was presumably diagnosed with thyroid storm. She was admitted for 2 days and given IVF and potassium. She then came to W&C for further workup. Nevaeh has had some caps placed secondary to dental caries and has been told she needs ear tubes as she has recurrent AOM but mother refuses this at this time.

Nevaeh's Medical Team:
Dr. Lori Miller - cardiologist, Roanoke
Dr. Doherty - Geneticist, Roanoke
Ortho at Shriners
Vista Star - ophthalmology, Roanoke
Developmental specialist with BTT

No current outpatient prescriptions on file.

No current facility-administered medications for this visit.

Past Medical History:

Diagnosis Date

- Bicuspid aortic valve
 - Developmental delay
 - Heart defect
 - Otitis media
 - Turner syndrome
- 45, XO
- Visual impairment
- esotropia

Family Medical History

Problem Relation (Age of Onset)

No Known Problems Mother, Father

Review of Systems:

Constitutional: negative for fever or weight loss

Eyes: + esotropia, negative for diplopia, blurry vision, or scotoma

HEENT: + recurrent AOM

Cardiovascular: + bicuspid aortic valve, mild aortic narrowing

Date	Type	Specialty	Care Team	Description
		Respiratory: negative for wheezing, dyspnea, or cough Gastrointestinal: negative for constipation, diarrhea, hematochezia, or abdominal pain GU: negative for dysuria, nephrolithiasis, or hematuria Endocrine: +Turner syndrome Musculoskeletal: negative for back pain, joint pain, or trauma Neurologic: negative for paresthesias, headaches, or dizziness Integument: negative for rashes, bruising, or hyperpigmentation		EXHIBIT NO. B8F PAGE: 9 OF 26

Physical Exam:
 Ht 0.883 m (2' 10.76") | Wt 13.7 kg (30 lb 3.3 oz) | BMI 17.57 kg/m2
 General: well appearing, no distress
 Eyes: pupils equal and reactive to light and accomodation, no nystagmus
 HEENT: + esotropia, clear nasal drainage, moist mucous membranes, no lymphadenopathy
 Chest: broad chest with widely spaced nipples
 Cardiovascular: regular rate and rhythm, no murmur, +2 peripheral pulses
 Respiratory: clear to auscultation bilaterally, no wheezing, no crackles or rales
 Abdomen: soft, non-tender, non-distended, no masses or organomegaly
 Musculoskeletal: moves all four extremities well, no joint edema, warmth, or tenderness
 Neurologic: cranial nerves II-XII grossly intact, no focal deficits
 Integument: no rashes, hyperpigmentation, or discoloration
 Neck: webbing of neck, thyroid normal to palpation, no lymphadenopathy

Assessment: Nevaeh Adams is a 2 y.o. female with Turner Syndrome, 45-XO and short stature.

Plan:

1. Turner Syndrome: Labs ordered as well as bone age study.
2. Short stature: Will work up for GH deficiency.

Total time spent with patient/family was 40 minutes with more than 50% in counseling.

Alyssa Wriston, PA-C
 Pediatric Endocrinology

Electronically Signed by Dye, Amanda, MD on 05/09/2018 1:30 PM EDT

06/08/2017

Documentation Only

Lewis, Kevin R, APRN

06/07/2017

Telephone

Lewis, Kevin R, APRN

Has Questions

CHILDRENS MEDICAL OFFICE BLDG-WVUPC

06/07/2017

Telephone Encounter - Withrow, Tabitha - 06/07/2017 1:19 PM EDT

MOM SPOKE WITH LEWIS AND WAS GOING TO FAX PAPERS OVER TO HIM SO HE COULD TELL HER WHAT SHE NEEDS TO DO . HER NP APT IS NOT UNTIL July 7

Electronically Signed by Withrow, Tabitha on 06/07/2017 1:19 PM EDT

Telephone Encounter - Withrow, Tabitha - 06/07/2017 2:25 PM EDT

Mom said she is coming to the er here

Electronically Signed by Withrow, Tabitha on 06/07/2017 2:25 PM EDT

Telephone Encounter - Withrow, Tabitha - 06/07/2017 2:34 PM EDT

Mom calling back saying if lewis cant talk to her now she is going to er . Pulled fax showed lewis and he took call and spoke with mom

Electronically Signed by Withrow, Tabitha on 06/07/2017 2:34 PM EDT

Telephone Encounter - Lewis, Kevin R - 06/14/2017 8:23 AM EDT

Mother was taking to ER

Electronically Signed by Lewis, Kevin R on 06/14/2017 8:23 AM EDT

Date	Type	Specialty	Care Team	Description
05/08/2017	Telephone		Lewis, Kevin R, APRN	Staff Documentation EXHIBIT NO. B8F PAGE: 10 OF 26
CHILDRENS MEDICAL OFFICE BLDG-WVUPC				
05/08/2017				

Telephone Encounter - Drake, April - 05/08/2017 3:02 PM EDT

REFERRAL TO US WAS BY ALATTAR PER DR DAUGHERTY REQUEST. THEY NEED TO SEND US RECORDS FOR UPCOMING APPT. MOM CANT GO IN AND SIGN RELEASE SHE WOULD LIKE US TO FAX ON LETTERHEAD STATING WE ARE REQUESTING RECORDS WITH PTS DOB AND NAME. FAX TO 540.342.1244

Electronically Signed by Drake, April on 05/08/2017 3:02 PM EDT

Telephone Encounter - Parsons, Ashley V - 05/09/2017 9:47 AM EDT

CALLED DR.AL-ATTAR'S OFFICE. NURSE WILL FAX RECORDS. DUE TO PATIENT BEING REFERRED TO OUR OFFICE BY DR.AL-ATTAR, LETTERHEAD IS NOT NECESSARY.

Electronically Signed by Parsons, Ashley V on 05/09/2017 9:47 AM EDT
from 07/20/2014 to 12/20/2018

PROCED

Procedures

Non-identified Provider

Date	Procedure/Encounter Type [Code]
05/15/2018	ANTI-MULLERIAN HORMONE [10242619]
05/15/2018	INSULIN-LIKE GROWTH FACTOR-1 (IGF-1) - ESOTERIX [10244916]
05/14/2018	IMMUNOGLOBULIN A [794]
05/11/2018	X-ray of hand and wrist for bone age [428603007]
05/10/2018	TISSUE TRANSGLUTAMINASE (TTG) ANTIBODY, IGA, SERUM [10250495]
05/09/2018	THYROID STIMULATING HORMONE (SENSITIVE TSH) [906]
05/09/2018	HGA1C (HEMOGLOBIN A1C WITH EST AVG GLUCOSE) [828]
05/09/2018	THYROPEROXIDASE (TPO) ANTIBODIES, SERUM [10221564]
05/09/2018	THYROGLOBULIN ANTIBODY, SERUM [10232921]
05/09/2018	THYROXINE, FREE (FREE T4) [902]

Narrative Text

Procedure Name	Priority	Date/Time	Associated Diagnosis	Comments
ANTI-MULLERIAN HORMONE	Routine	05/15/2018 4:35 PM EDT	Turner syndrome karyotype 45, x	<u>Results</u> for this procedure are in the <u>results</u> section
INSULIN-LIKE GROWTH FACTOR-1 (IGF-1) - REFERENCE LAB	Routine	05/15/2018 4:35 PM EDT	Turner syndrome karyotype 45, x	<u>Results</u> for this procedure are in the <u>results</u> section

Procedure Name	Priority	Date/Time	Associated Diagnosis	Comments
IMMUNOGLOBULIN A (IGA), SERUM	Routine	05/14/2018 5:57 PM EDT	Turner syndrome karyotype 45, x	<u>Results</u> for this procedure are in the EXHIBIT NO. B8F PAGE: 11 OF 26 results section
XR BONE AGE HAND AND WRIST	Routine	05/11/2018		
TISSUE TRANSGLUTAMINASE (TTG) ANTIBODY, IGA, SERUM	Routine	05/10/2018 2:42 PM EDT	Turner syndrome karyotype 45, x	<u>Results</u> for this procedure are in the results section
THYROID STIMULATING HORMONE (SENSITIVE TSH)	Routine	05/09/2018 6:41 PM EDT	Turner syndrome karyotype 45, x	<u>Results</u> for this procedure are in the results section
HGA1C (HEMOGLOBIN A1C WITH EST AVG GLUCOSE)	Routine	05/09/2018 5:49 PM EDT	Polyuria	<u>Results</u> for this procedure are in the results section
THYROPEROXIDASE (TPO) ANTIBODIES, SERUM	Routine	05/09/2018 5:32 PM EDT	Turner syndrome karyotype 45, x	<u>Results</u> for this procedure are in the results section
THYROGLOBULIN ANTIBODY, SERUM	Routine	05/09/2018 5:32 PM EDT	Turner syndrome karyotype 45, x	<u>Results</u> for this procedure are in the results section
THYROXINE, FREE (FREE T4)	Routine	05/09/2018 5:32 PM EDT	Turner syndrome karyotype 45, x	<u>Results</u> for this procedure are in the results section

from 07/20/2014 to 12/20/2018

LABS

Laboratory Results

Date	Test
05/15/2018	10242619
Associated Procedure:	Text:

Date	Test	ANTI-MULLERIAN HORMONE (05/15/2018 4:35 PM EDT)			EXHIBIT NO. B8F PAGE: 12 OF 26		
		Component	Value	Ref Range	Performed At Pathologist Signature		
	#Result206953267Procedure	ANTI-MULLERIAN HORMONE	<0.1	<8.8 ng/mL	CHARLESTON AREA MEDICAL CENTER		
		Comment: -----ADDITIONAL INFORMATION----- The testing method is a manual immunoenzymatic assay manufactured by Ansh Labs. Values obtained with different assay methods or kits may be different and cannot be used interchangeably. If this test is being ordered as a tumor marker, results cannot be interpreted as absolute evidence for the presence or absence of malignant disease. This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration. Test Performed by: Mayo Clinic Laboratories - Rochester Superior Drive 3050 Superior Drive NW, Rochester, MN 55901					
		Specimen					
		Blood - Blood	Performing Organization		Address	City/State/Zipcode	Phone Number
			CHARLESTON AREA MEDICAL CENTER		3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
	ANTI-MULLERIAN HORMONE	Value: <0.1 Ref Range: <8.8 ng/mL Text:					

Date	Test																																																																											
	<p>ANTI-MULLERIAN HORMONE <0.1 ng/mL</p> <p>Comment:</p> <p>-----ADDITIONAL INFORMATION-----</p> <p>The testing method is a manual immunoenzymatic assay manufactured by Ansh Labs. Values obtained with different assay methods or kits may be different and cannot be used interchangeably. If this test is being ordered as a tumor marker, results cannot be interpreted as absolute evidence for the presence or absence of malignant disease.</p> <p>This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration.</p> <p>Test Performed by: Mayo Clinic Laboratories - Rochester Superior Drive 3050 Superior Drive NW, Rochester, MN 55901</p>																																																																											
05/15/2018	<p>10244916</p> <p>Associated Procedure: #Result206953264Procedure</p> <p>Text: INSULIN-LIKE GROWTH FACTOR-1 (IGF-1) - ESOTERIX (05/15/2018 4:35 PM EDT)</p> <table> <thead> <tr> <th>Component</th> <th>Value</th> <th>Ref Range</th> <th>Performed At</th> <th>Pathologist Signature</th> </tr> </thead> <tbody> <tr> <td>IGF-1, LC/MS, S</td> <td>49</td> <td>ng/mL</td> <td>CHARLESTON AREA MEDICAL CENTER</td> <td></td> </tr> <tr> <td></td> <td>Comment:</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>-----REFERENCE VALUE-----</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>28-256</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>Tanner stages Females:</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>I 86-323</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>II 118-451</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>III 258-529</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>IV 224-586</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>V 188-512</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>Z-SCORE -0.67</td> <td>-2.0 - 2.0</td> <td>CHARLESTON AREA MEDICAL CENTER</td> <td></td> </tr> <tr> <td></td> <td>Comment:</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>-----ADDITIONAL INFORMATION-----</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Component	Value	Ref Range	Performed At	Pathologist Signature	IGF-1, LC/MS, S	49	ng/mL	CHARLESTON AREA MEDICAL CENTER			Comment:					-----REFERENCE VALUE-----					28-256					Tanner stages Females:					I 86-323					II 118-451					III 258-529					IV 224-586					V 188-512					Z-SCORE -0.67	-2.0 - 2.0	CHARLESTON AREA MEDICAL CENTER			Comment:					-----ADDITIONAL INFORMATION-----					This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by			
Component	Value	Ref Range	Performed At	Pathologist Signature																																																																								
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EXHIBIT NO. B8F
PAGE: 13 OF 26

Date	Test	the U.S. Food and Drug Administration. Test Performed by: Mayo Clinic Laboratories - Rochester Superior Drive 3050 Superior Drive NW, Rochester, MN 55901				EXHIBIT NO. B8F PAGE: 14 OF 26
		Specimen Blood - Blood Performing Organization Address City/State/Zipcode Phone Number				
		CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304		
	IGF-1, LC/MS, S	Value: 49 ng/mL Text: IGF-1, 49 LC/MS, S ng/mL CHARLESTON AREA MEDICAL CENTER Comment: -----REFERENCE VALUE----- ----- 28-256 Tanner stages Females: I 86-323 II 118-451 III 258-529 IV 224-586 V 188-512				
	Z-SCORE	Value: -0.67 Ref Range: -2.0 - 2.0 Text: Z- -0.67 -2.0 - CHARLESTON AREA SCORE 2.0 MEDICAL CENTER Comment: -----ADDITIONAL INFORMATION----- This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration. Test Performed by: Mayo Clinic Laboratories - Rochester Superior Drive 3050 Superior Drive NW, Rochester, MN 55901				
05/14/2018	IgA SerPl-mCnc					
	IMMUNOGLOBULIN A	Value: 58.5 mg/dL Ref Range: 20.0 - 100.0 mg/dL Text: IMMUNOGLOBULIN A 58.5 20.0 - 100.0 mg/dL CHARLESTON AREA MEDICAL CENTER				
	Associated Procedure: IgA SerPl-mCnc	Text: IMMUNOGLOBULIN A (05/14/2018 5:57 PM EDT)				
		Component Value Ref Range	Performed At		Pathologist Signature	
		IMMUNOGLOBULIN A 58.5 20.0 - 100.0 mg/dL	CHARLESTON AREA MEDICAL CENTER			

Date	Test	Specimen				EXHIBIT NO. B8F PAGE: 15 OF 26 Performed At
		Blood - Blood				CHARLESTON AREA MEDICAL CENTER
		Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304				MEDICAL CENTER
		Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432				
		Performing Organization	Address	City/State/Zipcode	Phone Number	
		CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304		
05/11/2018	X-ray of hand and wrist for bone age					
	Unknown	Text: XR BONE AGE HAND AND WRIST (05/11/2018) Narrative This result has an attachment that is not available.		Performed At		
		EXTERNAL LAB				
	Associated Procedure: X-ray of hand and wrist for bone age					
05/10/2018	10250495					
	Associated Procedure: #Result206953262Procedure	Text: TISSUE TRANSGLUTAMINASE (TTG) ANTIBODY, IGA, SERUM (05/10/2018 2:42 PM EDT)				
		Component	Value	Ref Range	Performed At	Pathologist Signature
		TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGA, SERUM	<2.4	0.1 - 7.0 EU/mL	CHARLESTON AREA MEDICAL CENTER	
		Blood - Blood			Specimen	
		Narrative		Performed At		
		Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304		CHARLESTON AREA MEDICAL CENTER		
		Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432				
		Performing Organization	Address	City/State/Zipcode	Phone Number	
		CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304		
	TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGA, SERUM	Value: <2.4 Ref Range: 0.1 - 7.0 EU/mL Text: TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGA, SERUM		<2.4 0.1 - 7.0 EU/mL	CHARLESTON AREA MEDICAL CENTER	
05/09/2018	906					
	Associated Procedure: #Result206953258Procedure	Text: THYROID STIMULATING HORMONE (SENSITIVE TSH) (05/09/2018 6:41 PM EDT)				

Date	Test	EXHIBIT NO. B8F <small>77 CHARLESTON 114 AREA MEDICAL mg/dL CENTER</small> <small>PAGE: 17 OF 26</small>			
	ESTIMATED AVERAGE GLUCOSE	88	Comment: Formula 28.7 X A1C - 46.7 = Estimated Avg. Glucose(eAG). Reference: ^a b Nathan DM, Kuenen J, Borg R,Zheng H, Schoenfeld D, Heine RJ (2008)."Translating the A1C assay into estimated average glucose values". Diabetes Care 31(8):1473-8. doi:10.2337/dc08-0545.PMC 2742903.PMID 18540046. http://care.diabetesjournals.org/content/31/8/1473.full . Estimation of average glucose levels over approximately the preceding 120 days, as measured by HbA1c, should not be used in patients with abnormal RBC turnover. This reference range is obtained from the calculated glucose using a reference range of 4.3 - 5.6% HbA1C.	%	CHARLESTON AREA MEDICAL CENTER
Hgb A1c MFr Bld	Value: 4.7 % Text: HEMOGLOBIN A1C4.7			%	CHARLESTON AREA MEDICAL CENTER
Associated Procedure: Hgb A1c MFr Bld	Text: HGA1C (HEMOGLOBIN A1C WITH EST AVG GLUCOSE) (05/09/2018 5:49 PM EDT)	Component	Value	Ref Range	Performed At Pathologist Signature
	HEMOGLOBIN4.7 A1C			%	CHARLESTON AREA MEDICAL CENTER
	Comment: Normal: <5.7% PreDiabetes: 5.7% - 6.4% Diabetes: 6.5% or higher Diabetic Goal: <7%				
	ESTIMATED AVERAGE GLUCOSE	88	Comment: Formula 28.7 X A1C - 46.7 = Estimated Avg. Glucose(eAG). Reference: ^a b Nathan DM, Kuenen J, Borg R,Zheng H, Schoenfeld D, Heine RJ (2008)."Translating the A1C assay into estimated average glucose values". Diabetes Care 31(8):1473-8. doi:10.2337/dc08-0545.PMC 2742903.PMID 18540046. http://care.diabetesjournals.org/content/31/8/1473.full . Estimation of average glucose levels over approximately the preceding 120	77 - 114 mg/dL	CHARLESTON AREA MEDICAL CENTER

Date	Test	<p>days, as measured by HbA1c, should not be used in patients with abnormal RBC turnover. This reference range is obtained from the calculated glucose using a reference range of 4.3 - 5.6% HbA1C.</p> <p>Specimen</p> <p>Blood - Blood</p> <table border="0"> <tr> <td>Narrative</td><td>Performed At</td></tr> <tr> <td>Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle CHARLESTON AREA Ave SE, Charleston, WV 25304</td><td>CHARLESTON AREA MEDICAL CENTER</td></tr> </table> <p>Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432</p> <table border="0"> <tr> <td>Performing Organization</td><td>Address</td><td>City/State/Zipcode</td><td>Phone Number</td></tr> <tr> <td>CHARLESTON AREA MEDICAL CENTER</td><td>3200 MacCorkle Avenue, S.E.</td><td>Charleston, PA</td><td>25304</td></tr> </table>	Narrative	Performed At	Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle CHARLESTON AREA Ave SE, Charleston, WV 25304	CHARLESTON AREA MEDICAL CENTER	Performing Organization	Address	City/State/Zipcode	Phone Number	CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA	25304	EXHIBIT NO. B8F PAGE: 18 OF 26													
Narrative	Performed At																											
Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle CHARLESTON AREA Ave SE, Charleston, WV 25304	CHARLESTON AREA MEDICAL CENTER																											
Performing Organization	Address	City/State/Zipcode	Phone Number																									
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA	25304																									
05/09/2018	10221564																											
	Associated Procedure: #Result206953260Procedure	<p>Text: THYROPEROXIDASE (TPO) ANTIBODIES, SERUM (05/09/2018 5:32 PM EDT)</p> <table border="0"> <tr> <td>Component</td><td>Value</td><td>Ref Range</td><td>Performed At</td><td>Pathologist Signature</td></tr> <tr> <td>THYROID PEROXIDASE AB</td><td><28.0</td><td>unit/mL</td><td>CHARLESTON AREA MEDICAL CENTER</td><td></td></tr> </table> <p>Comment:</p> <p>Thyroid Peroxidase AB Negative <=60.0 U/mL Thyroid Peroxidase AB Positive >60.0 U/mL</p> <p>Specimen</p> <p>Blood - Blood</p> <table border="0"> <tr> <td>Narrative</td><td>Performed At</td></tr> <tr> <td>Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle CHARLESTON AREA Ave SE, Charleston, WV 25304</td><td>CHARLESTON AREA MEDICAL CENTER</td></tr> </table> <p>Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432</p> <table border="0"> <tr> <td>Performing Organization</td><td>Address</td><td>City/State/Zipcode</td><td>Phone Number</td></tr> <tr> <td>CHARLESTON AREA MEDICAL CENTER</td><td>3200 MacCorkle Avenue, S.E.</td><td>Charleston, PA</td><td>25304</td></tr> </table>					Component	Value	Ref Range	Performed At	Pathologist Signature	THYROID PEROXIDASE AB	<28.0	unit/mL	CHARLESTON AREA MEDICAL CENTER		Narrative	Performed At	Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle CHARLESTON AREA Ave SE, Charleston, WV 25304	CHARLESTON AREA MEDICAL CENTER	Performing Organization	Address	City/State/Zipcode	Phone Number	CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA	25304
Component	Value	Ref Range	Performed At	Pathologist Signature																								
THYROID PEROXIDASE AB	<28.0	unit/mL	CHARLESTON AREA MEDICAL CENTER																									
Narrative	Performed At																											
Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle CHARLESTON AREA Ave SE, Charleston, WV 25304	CHARLESTON AREA MEDICAL CENTER																											
Performing Organization	Address	City/State/Zipcode	Phone Number																									
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA	25304																									
	THYROID PEROXIDASE AB	<p>Value: <28.0</p> <p>Text:</p> <table border="0"> <tr> <td>THYROID PEROXIDASE AB</td><td><28.0</td><td>unit/mL</td><td>CHARLESTON AREA MEDICAL CENTER</td></tr> </table> <p>Comment:</p> <p>Thyroid Peroxidase AB Negative <=60.0 U/mL Thyroid Peroxidase AB Positive >60.0 U/mL</p>						THYROID PEROXIDASE AB	<28.0	unit/mL	CHARLESTON AREA MEDICAL CENTER																	
THYROID PEROXIDASE AB	<28.0	unit/mL	CHARLESTON AREA MEDICAL CENTER																									
05/09/2018	10232921																											
	Associated Procedure: #Result206953261Procedure	<p>Text: THYROGLOBULIN ANTIBODY, SERUM (05/09/2018 5:32 PM EDT)</p>																										

Date	Test	Component	Value	Ref Range	Performed At	Pathologist Signature
		ANTI-THYROGLOBULIN	<15.0	unit/mL	CHARLESTON AREA MEDICAL CENTER	EXHIBIT NO. B PAGE: 19 OF 26
			Comment:			
			Thyroglobulin Antibody Negative <=60.0 U/mL			
			Thyroglobulin Antibody Positive > 60.0 U/mL			
				Specimen		
			Blood - Blood			
				Narrative	Performed At	
				Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304	CHARLESTON AREA MEDICAL CENTER	
				Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432		
		Performing Organization		Address	City/State/Zipcode	Phone Number
		CHARLESTON AREA MEDICAL CENTER		3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
	ANTI-THYROGLOBULIN	Value: <15.0 Text: ANTI-THYROGLOBULIN	<15.0	unit/mL	CHARLESTON AREA MEDICAL CENTER	
			Comment:			
			Thyroglobulin Antibody Negative <=60.0 U/mL			
			Thyroglobulin Antibody Positive > 60.0 U/mL			
05/09/2018	T4 Free SerPI-mCnc	Associated Procedure: T4 Free SerPI-mCnc	Text: Free T4 (05/09/2018 5:32 PM EDT)			
			Component	Value	Ref Range	Performed At
		THYROXINE, FREE (FREE T4)	1.2	0.9 - 1.8	CHARLESTON AREA MEDICAL CENTER	
			Comment:	ng/dL		
			Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely elevated results for the Free T4 assay.			
				Specimen		
			Blood - Blood			
				Narrative	Performed At	
				Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304	CHARLESTON AREA MEDICAL CENTER	
			Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432			

Date	Test	Performing Organization CHARLESTON AREA MEDICAL CENTER	Address 3200 MacCorkle Avenue, S.E.	City/State/Zipcode Charleston, PA 25304	Phone Number EXHIBIT NO. BSF PAGE: 20 OF 26
	THYROXINE, FREE (FREE T4)	Value: 1.2 ng/dL Ref Range: 0.9 - 1.8 ng/dL Text: THYROID, FREE (FREE T4) Comment: Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely elevated results for the Free T4 assay.	1.2	Comment: Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely elevated results for the Free T4 assay.	0.9 - 1.8 CHARLESTON AREA MEDICAL ng/dL CENTER

Narrative Text

- XR-BONE AGE HAND AND WRIST (05/11/2018)

Narrative

This result has an attachment that is not available.

Performed At

Performing Organization EXTERNAL LAB	Address	City/State/Zipcode	Phone Number
• TISSUE TRANSGlutaminase (TTG) ANTIBODY, IGA, SERUM (05/10/2018 2:42 PM EDT)	Component TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGA, SERUM	Value ≤2.4 Ref Range 0.1 - 7.0 EU/mL	Performed At CHARLESTON AREA MEDICAL CENTER

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Performed At

CHARLESTON AREA MEDICAL CENTER

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Performing Organization CHARLESTON AREA MEDICAL CENTER	Address	City/State/Zipcode Charleston, PA 25304	Phone Number
• INSULIN-LIKE GROWTH FACTOR-1 (IGF-1) ESOTERIX (05/15/2018 4:35 PM EDT)	Component IGF-1, LC/MS, S	Value 49 Ref Range ng/mL	Performed At CHARLESTON AREA MEDICAL CENTER

Comment:

-----REFERENCE VALUE-----

28-256

Tanner stages Females:

I—86-323

II—118-451

III—258-529

IV—224-586

V—188-512

Z-SCORE

-0.67

-2.0 - 2.0

CHARLESTON

Component	Value	Ref Range	Performed At	Pathologist Signature
Comment:			AREA MEDICAL CENTER	EXHIBIT NO. B8F PAGE: 21 OF 26

ADDITIONAL INFORMATION

This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration.

Test Performed by:

Mayo Clinic Laboratories – Rochester
Superior Drive
3050 Superior Drive NW, Rochester,
MN 55901

Specimen

Blood—Blood

Performing Organization

CHARLESTON AREA MEDICAL 3200 MacCorkle Avenue, S.E.
CENTER

Address

City/State/Zipcode
Charleston, PA 25304

Phone Number

- ANTI-MULLERIAN HORMONE (05/15/2018 4:35 PM EDT)

Component**Value**

Ref Range
<8.8 ng/mL

Performed At
CHARLESTON
AREA MEDICAL
CENTER

Pathologist Signature

Comment:

ADDITIONAL INFORMATION

The testing method is a manual immunoenzymatic assay manufactured by Ansh Labs. Values obtained with different assay methods or kits may be different and cannot be used interchangeably. If this test is being ordered as a tumor marker, results cannot be interpreted as absolute evidence for the presence or absence of malignant disease.

This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration.

Test Performed by:

Mayo Clinic Laboratories – Rochester
Superior Drive
3050 Superior Drive NW, Rochester,
MN 55901

Specimen

Blood—Blood

Performing Organization

CHARLESTON AREA MEDICAL 3200 MacCorkle Avenue, S.E.
CENTER

Address

City/State/Zipcode
Charleston, PA 25304

Phone Number

- THYROGLOBULIN ANTIBODY, SERUM (05/09/2018 5:32 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
ANTI-THYROGLOBULIN	<15.0	unit/mL	CHARLESTON AREA MEDICAL CENTER	EXHIBIT NO. B8F PAGE: 22 OF 26
Comment:	Thyroglobulin Antibody Negative ≤60.0 U/mL Thyroglobulin Antibody Positive >60.0 U/mL			

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
• THYROPEROXIDASE (TPO) ANTIBODIES, SERUM (05/09/2018 5:32 PM EDT)			
Component	Value	Ref Range	Performed At
THYROID PEROXIDASE AB	<28.0	unit/mL	CHARLESTON AREA MEDICAL CENTER
Comment:	Thyroid Peroxidase AB Negative ≤60.0 U/mL Thyroid Peroxidase AB Positive >60.0 U/mL		

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
• THYROID STIMULATING HORMONE (SENSITIVE TSH) (05/09/2018 6:41 PM EDT)			
Component	Value	Ref Range	Performed At
TSH	1.790	0.400–6.000 mIU/mL	CHARLESTON AREA MEDICAL CENTER
Comment:	Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely lowered results for the TSH assay.		

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Performing Organization	Address	City/State/Zipcode	Phone Number	
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304		
• Free T4 (05/09/2018 5:32 PM EDT)			EXHIBIT NO. B8F	
Component	Value	Ref Range	Performed At	Pathologist Signature
THYROXINE, FREE-(FREE T4)	1.2	0.9 – 1.8 ng/dL	CHARLESTON AREA MEDICAL CENTER	
Comment:				
Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely elevated results for the Free T4 assay.				
-				

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Performing Organization	Address	City/State/Zipcode	Phone Number	
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304		
• HGA1C (HEMOGLOBIN A1C WITH EST AVG GLUCOSE) (05/09/2018 5:49 PM EDT)				
Component	Value	Ref Range	Performed At	Pathologist Signature
HEMOGLOBIN A1C	4.7	%	CHARLESTON AREA MEDICAL CENTER	
Comment:				
Normal: <5.7% PreDiabetes: 5.7% – 6.4% Diabetes: 6.5% or higher Diabetic Goal: <7%				
ESTIMATED AVERAGE GLUCOSE	88	77 – 114 mg/dL	CHARLESTON AREA MEDICAL CENTER	
Comment:				
Formula 28.7 X A1C – 46.7 = Estimated Avg. Glucose(eAG). Reference: ^a b Nathan DM, Kuenen J, Borg R, Zheng H, Schoenfeld D, Heine RJ (2008). "Translating the A1C assay into estimated average glucose values". Diabetes Care 31(8):1473-8. doi:10.2337/dc08-0545.PMC 2742903 PMID 18540046. http://care.diabetesjournals.org/content/31/8/1473.full . Estimation of average glucose levels over approximately the preceding 120 days, as measured by HbA1c, should not be used in patients with abnormal RBC turnover. This reference range is obtained from the calculated glucose using a reference range of 4.3 – 5.6% HbA1C.				

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

EXHIBIT NO. B8F
 Performed At
PAGE: 24 OF 26
 CHARLESTON AREA
 MEDICAL CENTER
Performing OrganizationCHARLESTON AREA MEDICAL 3200 MacCorkle Avenue, S.E.
CENTER**Address****City/State/Zipcode**

Charleston, PA 25304

Phone Number

- IMMUNOGLOBULIN A (05/14/2018 5:57 PM EDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
IMMUNOGLOBULIN A	58.5	20.0 - 100.0 mg/dL	CHARLESTON AREA MEDICAL CENTER	

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Performed At
 CHARLESTON AREA
 MEDICAL CENTER

Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
CENTER			

City/State/Zipcode**Phone Number**

from 07/20/2014 to 12/20/2018

VITALS

Vital Signs

<u>Type</u>	<u>Date</u>	<u>Interpretation</u>	<u>Value</u>	<u>Ref Range</u>
BP dias	10/04/2018		78 mm[Hg]	
BP sys	10/04/2018		135 mm[Hg]	
Bdy height	10/04/2018		88.3 cm	
Heart rate	10/04/2018		133 /min	
Weight	10/04/2018		14.515 kg	

Narrative Text

Vital Sign	Reading	Time Taken
Blood Pressure	135 / 78	10/04/2018 11:29 AM EDT
Pulse	133	10/04/2018 11:29 AM EDT
Temperature	-	-
Respiratory Rate	-	-
Oxygen Saturation	-	-
Inhaled Oxygen Concentration	-	-
Weight	14.5 kg (32 lb)	10/04/2018 11:29 AM EDT
Height	88.3 cm (2' 10.76")	10/04/2018 11:29 AM EDT
Body Mass Index	18.62	10/04/2018 11:29 AM EDT

EXHIBIT NO. B8F
PAGE: 25 OF 26

MEDS

Medication Information

Narrative Text

No known medications

CARE PLAN

Plan of Care

Narrative Text

Upcoming Encounters

Date	Type	Specialty	Care Team	Description
01/02/2019	Office Visit		Lawson, April, CPNP	
<hr/>				
			830 PENNSYLVANIA AVE	
			ROOM 401	
			CHARLESTON, WV 25302	
			304-388-1552	
			304-388-1540 (Fax)	
Health Maintenance		Due Date	Last Done	Comments
Hepatitis B Vaccine (1 of 3 - 3-dose primary series)		07/21/2015		
DTaP-Tdap-Td Series (1 - DTaP)		09/21/2015		
IPV Vaccines (1 of 4 - All-IPV series)		09/21/2015		
Hepatitis A Vaccine (1 of 2 - 2-dose series)		07/21/2016		
MMR Vaccines (1 of 2 - Standard series)		07/21/2016		
Varicella Vaccine (1 of 2 - 2-dose childhood series)		07/21/2016		
HIB Vaccines (1 of 1 - Start at 15 months series)		10/21/2016		
Pneumococcal 0-5 Years (1 of 1 - Start at 24 months series)		07/21/2017		
Influenza Vaccine (1 of 2)		09/01/2018		
Meningococcal Vaccine (1 - 2-dose series)		07/21/2026		
Rotavirus vaccine	Aged Out	12/17/2015		No longer eligible based on patient's age to complete this topic

PROV LIST

EXHIBIT NO. B8F
PAGE 26 OF 26

Healthcare Providers

West Virginia University Medicine (05/09/2018 - No Date Available)

<u>Provider Name</u>	<u>Address</u>	<u>Telecom</u>	<u>MRN</u>
Rahmet Muzaffer, MD			

Health Information Technology (HIT) Medical Report

NOTE: The following displays data transmitted to the SSA from the health IT partner using standards-based computer transactions and is reformatted to assist with navigating through the clinical details of the record. Known duplicative information will be struck-through (e.g. sample).

**Summarization of Episode Note
Continuity of Care Document**
Received From: Carilion Clinic

MEGAHIT sent a request for electronic medical records from the following claimant-provided source(s):

Source Type: Doctor/Therapist
 Source Name: CARILION CLINICCLINICAL GENETICS
 Address: 102 HIGHLAND AVE SE STE 104
 ROANOKE, VA 24013
 Voice Phone: 540-985-8454

Creation Date:	Date Range Requested:	Type of Request:
12/20/2018	07/21/2014 - 12/20/2018	MEGAHIT Triggered

Nevaeh Hope Adams		
SSN: 794-01-8055	DOB: 07/21/2015	Sex: Female

Partner Medical Record Demographics:		
Name: Nevaeh Hope Adams	DOB: 07/21/2015	Sex: Female

Table of Contents

- Problems List [PROB LIST]
- Encounters [ENC]
- Procedures [PROCED]
- Laboratory Results [LABS]
- Vital Signs [VITALS]
- Medication Information [MEDS]
- Plan of Care [CARE PLAN]
- Healthcare Providers [PROV LIST]

PROB LIST

Problems List

<u>Problem [Code]</u>	<u>Occurrences</u>	<u>First Date</u>	<u>Last Date</u>	<u>Associated Types</u>	<u>Last Prognosis Value</u>	<u>Last Prognosis Date</u>
Bicuspid aortic valve [72352009] Congenital insufficiency of aortic valve [Q23.1] Cong aorta valv insuffic [746.4] Bicuspid aortic valve [5970]	1	07/22/2015	-	Disease		
Birth [3950001] Single liveborn infant, delivered vaginally [Z38.00] Single lb in-hosp w/o cs [V30.00] Single liveborn infant delivered vaginally [1824057]	1	07/21/2015	-	Disease		
Term birth of newborn female [9343003] Single live birth [Z37.0] Deliver-single liveborn [V27.0] Term birth of female newborn [710700]	1	07/24/2015	-	Disease		
Turner syndrome [38804009] Turner's syndrome, unspecified [Q96.9] Gonadal dysgenesis [758.6] Turner syndrome [56422]	1	07/22/2015	-	Disease		

Narrative Text

<u>Problem</u>	<u>Narrative Text</u>	<u>Noted Date</u>
Term birth of female newborn		07/24/2015
Bicuspid aortic valve		07/22/2015
Turner syndrome		07/22/2015
Single liveborn infant delivered vaginally		07/21/2015

**EXHIBIT NO. B9F
PAGE: 3 OF 90**

ENC

Encounters

Date	Type	Specialty	Care Team	Description
12/10/2018	Ancillary Orders		Herold, Steven E, MD	NEW RIVER VALLEY MEDICAL CENTER 12/10/2018 Turner syndrome; Bicuspid aortic valve
11/27/2018	Abstract		Herold, Steven E, MD	
		ROANOKE PEDIATRIC CARDIOLOGY 11/27/2018		
		Progress Notes - Evans, Lisa G - 11/27/2018 4:50 PM EST		
		PRINTING THE LAST OFFICE NOTE FOR DR. HEROLD TO TAKE TO THE NEXT CLINIC/LGE		
11/14/2018	Telephone		Kassebaum, Barbara S, LPN	Other (requested US <u>results</u>)
		ROANOKE CLINICAL GENETICS 11/14/2018		
		Telephone Encounter - Kassebaum, Barbara S, LPN - 11/14/2018 2:16 PM EST		
		Provider in WV called requesting renal US <u>results</u> . Mother does not know where it was performed. Nothing in Carilion chart to indicate. They will call <u>PCP</u> office. Phone note of 8/3/15 mother claims <u>PCP</u> office ordered it.		
08/17/2017	Telephone		Maxey, Amy L, RN	Parent Requesting Letter
		ROANOKE PEDIATRIC CARDIOLOGY 08/17/2017		
		Telephone Encounter - Maxey, Amy L, RN - 08/17/2017 3:54 PM EDT		
		Spoke with Mother. Nevaeh needs to have sedated dental work. The dentist needs to know if it is ok to do this in their office (they do not have a local children's hospital) or if she needs to go to Morgantown to the Children's Hospital for this dental work.		
		The dental office would like a letter with what we advise. It can be faxed to 304-252-1890. The telephone number for the dentist is 304-252-0472.		
		Chart to Dr. Herold. Amy L Maxey 8/17/2017 3:57 PM		
		Telephone Encounter - Maxey, Amy L, RN - 08/18/2017 5:03 PM EDT		
		Faxed to dental office. Amy L Maxey 8/18/2017 5:03 PM		
05/08/2017	Telephone		Kassebaum, Barbara S, LPN	Other (request records)
		ROANOKE CLINICAL GENETICS 05/08/2017		
		Telephone Encounter - Kassebaum, Barbara S, LPN - 05/08/2017 2:51 PM EDT		

Date	Type	Specialty	Care Team	Description
		Nevaeh is seeing a pediatric endocrinologist next week. Requests records be faxed. The doctor is in W. Va. and is not sure of his name.		EXHIBIT NO. B9F PAGE: 4 OF 90
	<u>PCP</u>	referred, as requested by Dr. Doherty. Navaeh has had surgery on her hips, and it has been an ordeal to keep up with appts.		
		Office phone for doctor: 304-388-1552 Fax: 304-388-1565		
		I told mother that I would call and ask for a request on letter head for the records to be sent. She wants Dr. Doherty's notes and lab sent.		
		She is also calling peds cardio for their records.		
		I called 304-388-1552. She is seeing Kevin Louis. Dr. Doherty's records have not been received. April at the office will make the request.		
		Telephone Encounter - Kassebaum, Barbara S, LPN - 05/09/2017 2:40 PM EDT		
		Sent requested information to the provider, utilizing the releases module in EPIC. Fax cover sheet with request received. Sent records per mother's request for continuity of care.		
12/20/2016	Telephone	Kassebaum, Barbara S, LPN	Advice Only (records request)	
ROANOKE CLINICAL GENETICS 12/20/2016				
		Telephone Encounter - Kassebaum, Barbara S, LPN - 12/20/2016 11:40 AM EST		
		See contacts for address of JanDils Attorneys at Law request. Release dated 12/15/16 sent to CASB for CIOX records release by interoffice mail.		
11/18/2016	CV Procedure			
ROANOKE PEDIATRIC CARDIOLOGY 11/18/2016				
11/18/2016	Office Visit	Miller, Joelle D, MD	Bicuspid aortic valve Bicuspid aortic valve (Primary Dx); Turner syndrome	
ROANOKE PEDIATRIC CARDIOLOGY 11/18/2016				
	<u>Progress Notes</u>	- Miller, Joelle D, MD - 11/18/2016 2:15 PM EST		
		Formatting of this note may be different from the original.		
		CARILION CLINIC ROANOKE PEDIATRIC CARDIOLOGY 102 HIGHLAND AVENUE, SUITE 101 ROANOKE, VA 24013		
		Nevaeh Hope Adams is a 15 m.o. female brought by hermother for follow up Turner's Syndrome and a bicuspid Aortic valve She is here for her routine follow up as well as for surgical clearance.		
		Nevaeh will have hip surgery. .		
		Last echo 2015 demonstrated: Summary: 1. Bicuspid aortic valve without stenosis or insufficiency. 2. The aortic arch is well seen and appears free of obstruction. 3. Normal PFO with tiny L>R shunt.		

Date	Type	Specialty	Care Team	Description
		4. Normal biventricular size, thickness, and function. 5. No evidence of aortic coarctation. Normal flow in the descending aorta (1.24 m/sec).		EXHIBIT NO. B9F PAGE: 5 OF 90

Since last she has been doing well.
She has had no symptoms of dyspnea, tachypnea, poor exercise tolerance

Active and thriving. No interval problems.
Medications:
No current outpatient prescriptions on file.

No current facility-administered medications for this visit.

PMH:
Patient Active Problem List

Diagnosis

- Single liveborn infant delivered vaginally
- Bicuspid aortic valve
- Turner syndrome
- Term birth of female newborn

Social History : lives with both parents and 3 sisters

Tobacco exposure: None

Family History: no CHD

Review of Systems

General: Denies fatigue.

Eyes: Denies vision loss.

Ears/Nose/Throat: suspected decreased hearing. (frequent ear infections)

Cardiovascular: Complains of see HPI.

Respiratory: Denies dyspnea.

Gastrointestinal: frequent stools (6/day, will see GI)

Genitourinary: voiding well

Musculoskeletal: congenital hip abnormalities bilaterally will have surgery in January in West Virginia

Skin: diaper rash

Neurologic: Denies seizures.

Developmental: mild speech and gross motor delays

Heme/Lymphatic: Denies history of anemia.

Allergic/Immunologic: allergic to amoxicillin

OBJECTIVE:

Visit Vitals

- Pulse 120
- Ht 2' 4" (0.711 m)
- Wt 10.3 kg (22 lb 12 oz)
- BMI 20.4 kg/m²

Alert, well nourished, well appearing.

Head: Normocephalic, web neck noted (c/w Turner's Syndrome

Eyes: PERRL

Lungs clear bilaterally, normal work of breathing, no tachypnea

Abd: soft, normal BS, no masses or organomegaly

Neuro: grossly normal

Skin: no lesions

CV: Precordium quiet to palpation, pulses equal and easily palpable in the upper and lower extremities. Normal S1, normal S2 with normal splitting.

Normal rate, regular rhythm, no ectopic beats heard

Ejection click heard at the apex

No murmur is heard

ECHOCARDIOGRAM:

Normal biventricular size, thickness, and function

Bicuspid aortic valve without aortic stenosis or Aortic insufficiency

Date	Type	Specialty	Care Team	Description
		Normal Aortic arch without obstruction No shunts are seen at any level.		EXHIBIT NO. B9F PAGE: 6 OF 90

ASSESSMENT:Encounter **Diagnoses**

Name Primary?

- Bicuspid aortic valve Yes
- Turner syndrome

Turner's Syndrome with bicuspid Aortic valve

No evidence of Aortic arch obstruction

No aortic stenosis , no Aortic insufficiency, no dilation of the aortic root

PLAN:

OK for Surgery

Bacterial Endocarditis Prophylaxis: SBE prophylaxis is not indicated.

Exercise limitations: as tolerated

Follow up in 2 years .

Medication list reviewed with patient and updated as indicated. Patient given a printed copy of current medication list. Patient verbalized understanding of instructions given.

Discussed with patient and family. Questions answered.

Faxed to referring physician

11/18/2016 Ancillary Orders Miller, Joelle D, MD

**NEW RIVER
VALLEY MEDICAL
CENTER**
11/18/2016

Bicuspid aortic valve
Referral (needs more info for referral)

09/12/2016 Telephone Kassebaum, Barbara S, LPN

ROANOKE CLINICAL GENETICS**09/12/2016**

Telephone Encounter - Kassebaum, Barbara S, LPN - 09/12/2016 12:01 PM EDT

Spoke to Carrie in Dr. Khokar's office.

Needs me to refax the office note. Their toner was low, and note not legible.

Also wanted suggestions for the referrals for gastro or endo.

Re faxed the office note, with a referral request form for the peds dept..

She will call Karen to see who has the least wait time.

09/12/2016 Ancillary Orders Miller, Joelle D, MD

**NEW RIVER
VALLEY MEDICAL
CENTER**
09/12/2016

Bicuspid aortic valve
Turner syndrome karyotype 45, x
(Primary Dx)

08/29/2016 Office Visit Doherty, Emily S, MD

ROANOKE CLINICAL GENETICS**08/29/2016**Progress Notes - Kassebaum, Barbara S, LPN - 08/29/2016 11:44 AM EDT

Patient identified by name and date of birth. Medication list has been reviewed and updated with mother. At the conclusion of today's visit, the patient will receive a copy of an after visit summary which includes any orders entered, current medications, and any future appointments. If the patient leaves without receiving the after visit summary, a copy of the above information

Date	Type	Specialty	Care Team	Description
	will be mailed to them.			EXHIBIT NO. B9F PAGE: 7 OF 90

Progress Notes - Doherty, Emily S, MD - 08/29/2016 12:02 PM EDT

Formatting of this note may be different from the original.

This is a follow-up visit for Nevaeh who has Turner syndrome affecting the heart; the problem is congenital in onset. She is here today with mother. She has associated musculoskeletal anomalies with neck webbing and broad chest. No treatments or modifying factors.

ROS: HEENT: She has had "about 10 ear infections, often the left ear" will be referred to Bluefield ENT for tubes. Mother reports now she has to talk a little loudly for Nevaeh to hear her. R eye is "lazy". Chipping tooth enamel mother will take her to dentist.

Neuro: Talks well. Not walking. Has leg weakness. OT and PT mostly related to legs.

GI: she has always had frequent stooling. Mother considering a trial of lactose-free milk.

Psych: no social concerns "she is very observant" "loves to look at Mom". Mom delighted with Nevaeh and her wonderful little personality.

Musc: Leg length discrepancy R leg is longer. Going to see Kentucky Shriner's.

PMHx: Turner syndrome karyotype 45,X and congenital bicuspid aortic valve.

SocHx: healthy little sister born earlier this year; **PCP** Dr. Ghazala Khokar. Lives in WV.

Records reviewed: karyotype and growth chart. She has fallen off the regular curve for length.

PEx:

Visit Vitals

- Ht 2' 3.17" (0.69 m)
- Wt 9.526 kg (21 lb)
- HC 18.47" (46.9 cm)
- BMI 20.01 kg/m²

Short statured older infant, uncooperative with exam. HEENT: NCAT Broad face mild R esotropia. Neck: webbing is present. Chest: Broad w/widely spaced nipples. Abd: soft NT ND no HSM or masses. Extr: mild R leg longer than L. Buttock contour is narrow.

ICD-10-CM ICD-9-CM

1. Turner syndrome karyotype 45, X Q96.0 758.6

She has developed short stature, this is the natural history of TS with growth hormone deficiency presenting clinically in the first 1-2 years. **PCP** should refer to Endocrinology to discuss growth hormone treatment. Consider celiac disease as cause of frequent stooling and failure to grow; as there is increased incidence of celiac in TS. Mom will try 1 month of lactose-free diet in case the frequent stooling was due to lactose intolerance; if this is not effective then I recommend **PCP**, Endocrine consultant, or GI consultant to test for celiac disease.

See again for genetics one year. Medication list reviewed with patient/guardian and updated as indicated. Patient/guardian given a printed copy of current medication list. Patient/guardian verbalized understanding of instructions given.

08/26/2016	Telephone	Kassebaum, Barbara S, LPN	Other (auth form for paying high mileage)
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ROANOKE CLINICAL GENETICS
08/26/2016

Telephone Encounter - Kassebaum, Barbara S, LPN - 08/26/2016 2:51 PM EDT

Form received for prior auth to pay high mileage for re-imbursement.

Dr. Doherty completed, and we faxed to dept.

04/29/2016	Abstract	Miller, Joelle D, MD
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ROANOKE PEDIATRIC CARDIOLOGY
04/29/2016

Progress Notes - Orr, Chalet W - 04/29/2016 1:54 PM EDT

Date	Type	Specialty	Care Team	Description
02/04/2016	Received MR request from WV SSI. Forwarded to CIOX. Telephone		Kassebaum, Barbara S, LPN	EXHIBIT NO. B9F Other (discuss timing of appts) PAGE: 8 OF 90

ROANOKE CLINICAL GENETICS

02/04/2016

Telephone Encounter - Kassebaum, Barbara S, LPN - 02/04/2016 11:36 AM EST

Patient was a "No show" yesterday. Family lives 4 hours away, and this may be a hardship.

Per Dr. Doherty- I left a message to call me. Need to discuss whether they may want to transfer care to Morgantown, or possibly change appts to coincide with Dr. Millers, when they see her once yearly in the Radford office.

We can obtain info from the PCP to monitor growth.

Telephone Encounter - Kassebaum, Barbara S, LPN - 02/10/2016 3:25 PM EST

Called Kelli Adams again, and requested return call to discuss future plan of care.

Telephone Encounter - Kassebaum, Barbara S, LPN - 02/12/2016 1:49 PM EST

I have left mother 3 messages, and have not had a response.

Routed phone calls documentation to Dr. Doherty for further instructions.

Telephone Encounter - Kassebaum, Barbara S, LPN - 02/17/2016 3:32 PM EST

Unable to reach by phone. Letter sent.

10/06/2015	Office Visit	Miller, Joelle D, MD	Bicuspid aortic valve; Turner syndrome
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PEDS CARDIOLOGY RADFORD

10/06/2015

Progress Notes - Maxey, Amy L, RN - 10/06/2015 1:19 PM EDT

Patient identified by name and date of birth. The following literature has been provided to the patient/ caregiver and they have been given an opportunity to ask questions:

New Patient Packet Documents:

- Notice of Privacy Practices
- Carilion Patient Billing Information
- Patient Care Partnership: Understanding Your Rights and Responsibilities

The medication list has been reviewed and updated with the patient/ caregiver. At the conclusion of today's visit, the patient will receive a copy of an after visit summary which includes any orders entered, current medications and any future appointments. If the patient leaves without receiving the after visit summary, a copy of the above information will be mailed to them.

Progress Notes - Miller, Joelle D, MD - 10/06/2015 1:21 PM EDT

Formatting of this note may be different from the original.

CARILION CLINIC
ROANOKE PEDIATRIC CARDIOLOGY
102 HIGHLAND AVENUE, SUITE 101
ROANOKE, VA 24013

Nevaeh Hope Adams is a 2 m.o. female brought by her mother for follow up of Aortic valve disease.

Last echo 7/24/2015 demonstrated:

.Summary:

1. Suspected Turner Syndrome.
2. Bicuspid aortic valve without stenosis or insufficiency.

Date	Type	Specialty	Care Team	Description
		<p>3. The left ventricle is normal in size, thickness, and function.</p> <p>4. No obstruction of the aortic arch. Vp= 1.8 m/sec in the descending aorta.</p> <p>there is mild straightening and hypoplasia of the transverse arch. The isthmus is well seen and appears free of obstruction</p> <p>The distal transverse arch measures 0.4 cm, the isthmus measures 0.36 cm</p> <p>The Vp in the descending aorta is 1.8m/sec (range = 1.4-1.8)</p> <p>The PDA has closed completely.</p> <p>5. Mild, functional peripheral pulmonary stenosis.</p>		EXHIBIT NO. B9F PAGE: 9 OF 90

Since last seen there have been concerns about a recent URI, Nevaeh has been growing and thriving. Her development has been excellent, Her chromosomes did show Turner's Syndrome
She has had no symptoms of cyanosis , tachypnea or poor weight gain

Doing well since last seen.

Medications:

No current outpatient prescriptions on file.

No current facility-administered medications for this visit.

PMH:

Patient Active Problem List

Diagnosis

- Single liveborn infant delivered vaginally
- Bicuspid aortic valve
- Turner syndrome
- Term birth of female newborn

Social History lives with both parents

Tobacco exposure: none *

Family History: no CHD

Review of Systems

General: normal weight gain, short for age

Eyes: esotropia, will be followed by ophthalmology

Cardiovascular: Complains of see HPI.

Respiratory: Denies dyspnea.

Gastrointestinal: Denies vomiting, diarrhea.

Genitourinary: voiding well

Musculoskeletal: Denies joint swelling.

Skin: Denies rash.

Neurologic: Denies seizures.

Developmental: normal

OBJECTIVE:

Pulse 139 | Ht 1' 9.5" (0.546 m) | Wt 4.734 kg (10 lb 7 oz) | BMI 15.88 kg/m² | SpO₂ 100%

BP right arm 90/pal

BP right foot 90/palp

Alert, well nourished, well appearing.

Head: Normocephalic, no bruits heard

Eyes: PERRL

Lungs clear bilaterally, normal work of breathing, no tachypnea

Abd: soft, normal BS, no masses or organomegally

Neuro: grossly normal

Skin: no lesions

CV: Precordium quiet to palpation, pulses equal and easily palpable in the upper and lower extremities. Normal S1, normal S2 with normal splitting.

Normal rate, regular rhythm, no ectopic beats heard

Ejection click heard over the apex

No murmur is heard.

ECHOCARDIOGRAM:

Summary:

Date	Type	Specialty	Care Team	Description
		1. Bicuspid aortic valve without stenosis or insufficiency. 2. The aortic arch is well seen and appears free of obstruction. 3. Normal PFO with tiny L>R shunt. 4. Normal biventricular size, thickness, and function. 5. No evidence of aortic coarctation. Normal flow in the descending aorta (1.24 m/sec).		EXHIBIT NO. B9F PAGE: 10 OF 90

ASSESSMENT:**Encounter Diagnoses**

Name Primary?

- Bicuspid aortic valve
- Turner syndrome

No Aortic insufficiency or aortic stenosis

Normal pulses, normal blood pressure, Aortic arch appears normal.

Doing well

PLAN:

Bacterial Endocarditis Prophylaxis: SBE prophylaxis is not indicated.

Exercise limitations: as tolerated

Medication list reviewed with patient and updated as indicated. Patient given a printed copy of current medication list. Patient verbalized understanding of instructions given.

Discussed with patient and family. Questions answered.

Follow up in 1 year(s)

Faxed to referring physician

10/06/2015

Hospital Encounter

Miller, Joelle D, MD

CARDIO PEDS

NEW RIVER VALLEY MEDICAL CENTER**10/06/2015**

Procedures - Fitzwater, Sonia M, SONO - 10/06/2015 1:57 PM EDT

Pediatric f/u Cardiac echo completed. Tolerated procedure well. Report to follow.

10/06/2015

Ancillary Orders

Miller, Joelle D, MD

**NEW RIVER
VALLEY MEDICAL
CENTER
10/06/2015**

Bicuspid aortic valve (Primary Dx)

10/06/2015

Ancillary Orders

Miller, Joelle D, MD

**NEW RIVER
VALLEY MEDICAL
CENTER
10/06/2015**

Bicuspid aortic valve (Primary Dx)

09/18/2015

Telephone

Bulkeley, Julia A, MD

Other

ORTHO SPINE PEDS CCR3**09/18/2015**

Telephone Encounter - Lucas, Jennifer A, RN - 09/18/2015 11:30 AM EDT

Situation:

Received live call from patient's mother. Contact number 304-938-9065.

Assessment:

States patient had an ultrasound order a few weeks ago, states the hospital it was ordered at no longer does ultrasounds so the patient needs to have ultrasound ordered at Princeton Community Hospital- phone number- 304-487-7000. Also, the

Date	Type	Specialty	Care Team	Description
		patient will start to see Dr Gary McCarthy in WV which is closer to the patient, caller needs the patient's records sent to this office, 304-324-2778.		EXHIBIT NO. B9F PAGE: 11 OF 90
		Recommendation: Routed to provider's nurse and secretary.		
		JENNIFER A LUCAS, RN 9/18/2015 11:33 AM		
		Telephone Encounter - Reynolds, Megann R, LPN - 09/21/2015 8:16 AM EDT		
		New order has been faxed to Princeton Community Hospital at 304-487-7891. MEGANN R REYNOLDS, LPN 9/21/2015 8:23 AM		
09/11/2015	Telephone		Simmons, Jennifer A, RN	Other (No show for appts)

ROANOKE ORTHO BONEJT CCR3**09/11/2015**

Telephone Encounter - Simmons, Jennifer A, RN - 09/11/2015 10:05 AM EDT

Follow up call placed regarding patients appt for ultrasound of her bilateral hips and making an appt in Princeton for an orthopedic physician to follow up her hip dysplasia. Per father the mother is working now and he is unsure what physicians she has seen and if the patient had the sonogram done for her hips. Writer asked if patient was still wearing the harness and Dad states he took it off of her due to her crying and not sleeping well. Dad states the patient saw a doctor yesterday who states she did not feel the hip clicks anymore. Requested for patients mother to contact Dr. Bulkeley's clinic regarding the status of the patient seeing another orthopedic MD closer to home as the mother had requested. JENNIFER A SIMMONS, RN 9/11/2015 10:09 AM

Writer called and spoke with Donna at Bluefield Regional Medical Center regarding patients hip ultrasound report. Per Donna the patient was a no show for the appt scheduled on 9/2/15. Writer notified Dr. Bulkeley of patient no showing for ultrasound appt. JENNIFER A SIMMONS, RN 9/11/2015 10:18 AM

Telephone Encounter - Simmons, Jennifer A, RN - 09/11/2015 10:49 AM EDT

Writer called and spoke with Tara at Dr. Ghazala Khokar's office per Dr. Bulkeley's request to notify patients **PCP** the child has been a no show for her last 2 appts with Dr. Bulkeley for hip dysplasia and the hip ultrasound appts made also. Also notified Dr. Khokars office regarding the patient being a no show for an ultrasound appt scheduled at Bluefield Medical Center on 9/2/15. Tara states she will notify Dr. Khokar of Dr. Bulkeley's concerns. JENNIFER A SIMMONS, RN 9/11/2015 10:52 AM

09/01/2015	Telephone	Bulkeley, Julia A, MD	Follow-up
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ORTHO SPINE PEDS CCR3**09/01/2015**

Telephone Encounter - Blakely, Jayne A, RN - 09/01/2015 2:51 PM EDT

Situation:

Received live call from Mother, Kelly Contact number 304-938-9065

Background:

Last OV: 8/4/15

POC: A/P Hip dysplasia. Placed into pavlik harness. Get US in 3 weeks. If hip stabilize continue harness if not will need rhino brace

Assessment:

States she is calling as she needs to reschedule her child's appt. She states her child was to be seen today for US of hip as child is in a harness, and was to see Dr. Bulkeley at 1pm after the US. Mom needs to reschedule everything unless there is an orthopaedic provider closer to their home. Mom states that they are having problems with the travel due to funds. She states if she could get an ortho provider there, it would be much easier for them.

Recommendation:

Routed to Jenny for review.

JAYNE A BLAKELY, RN 9/1/2015 2:56 PM

Telephone Encounter - Simmons, Jennifer A, RN - 09/01/2015 5:33 PM EDT

Date	Type	Specialty	Care Team	Description
09/01/2015	Orders Only	Called and spoke with mother regarding setting up appointment for ultrasound at a local hospital due to mother not being able to bring child to appts in Roanoke. Appt made for ultrasound at Bluefield Regional Medical Center for 9/2/15 at 1000 am. Order faxed to 304-327-1825. Fax confirmation received. Notified mother of date, time and location of ultrasound appt. Mother states she is trying to find a MD in Princeton West Va who can follow the child for her hip dysplasia since she is having financial troubles and cannot get the child to her appts here in Roanoke. Mother to call back after speaking with orthopedic office in Princeton. Dr. Bulkeley notified of situation. JENNIFER A SIMMONS, RN 9/1/2015 5:20 PM	Miller, Joelle D, MD	EXHIBIT NO. 9F PAGE: 12 OF 90 PEDS CARDIOLOGY RADFORD 09/01/2015 PDA (patent ductus arteriosus) (Primary Dx); Bicuspid aortic valve; Turner syndrome Other
08/25/2015	Telephone		Bulkeley, Julia A, MD	

ORTHO SPINE PEDS CCR3 08/25/2015

Telephone Encounter - Blakely, Jayne A, RN - 08/25/2015 12:56 PM EDT

Situation:

Received live call from Mother, Kelly Contact number 304-938-9065

Background:

Last OV: 8/4/15

POC: A/P Hip dysplasia. Placed into pavlik harness. Get US in 3 weeks. If hip stablize continue harness if not will need rhino brace

Assessment:

States she is calling as the provider's nurse set up an US appt for today @ 11:00am and she was to come back in to Dr. Bulkeley at 3pm. They need to reschedule both appts as she is not able to make either appt today (already missed US).

Recommendation:

Routed to provider's nurse for scheduling of test and follow up.

JAYNE A BLAKELY, RN 8/25/2015 12:59 PM

Telephone Encounter - Simmons, Jennifer A, RN - 08/25/2015 2:42 PM EDT

Made appt for Ultrasound of hips on 9/1/15 at 1100 am at RMH and follow up appt with Dr. Bulkeley 9/1/15 at 100 pm. Mother aware of date, time and location of appts. R3 for appt with Dr. Bulkeley. JENNIFER A SIMMONS, RN 8/25/2015 2:43 PM

08/13/2015 Telephone Simmons, Jennifer A, RN Other (pavlik harness question)

ROANOKE ORTHO BONEJT CCR3 08/13/2015

Telephone Encounter - Simmons, Jennifer A, RN - 08/13/2015 2:07 PM EDT

----- Message from Anna E Newcomb sent at 8/13/2015 1:01 PM EDT -----

Regarding: Ort-Bulkeley-Patient concern

Contact: 304-938-9065

Patients mother calling regarding the patients harness. Please advise thanks!

Telephone Encounter - Simmons, Jennifer A, RN - 08/13/2015 2:08 PM EDT

Called and spoke with patients mother. Per mother the pediatrician is not sure how to adjust the pavlik harness and wanted the mother to take the harness off in order to weigh the baby for her check up. Mother states she was instructed to keep the harness on at all times by Dr. Bulkeley. Mother also reports the PCP did not feel that the child was in a 90 position. Mother states the child is in the same position as she was after Dr. Bulkeley placed the pavlik harness on her and that she has not taken the child out of the lower part of the harness. Per Dr. Bulkeley the child needs to always remain in the pavlik harness and as long as the child is able to move her legs then she does not need an adjustment at this time. Instructed mother to keep upcoming appt and that if the child seems to have a rapid growth spurt before her scheduled appt then call the office to

Date	Type	Specialty	Care Team	Description
08/05/2015	Telephone	request the appt to be moved up. Mom verbalized understanding.	JENNIFER A SIMMONS, RN Bulkeley, Julia A, MD	8/13/2015 2:13 PM EXHIBIT NO. B9F Patient Information PAGE: 13 OF 90

ORTHO SPINE PEDS CCR3**08/05/2015**

Telephone Encounter - Blakely, Jayne A, RN - 08/05/2015 11:36 AM EDT

Situation:

Received live call from Mom, Kelli Contact number 304-938-9065

Background:

Last OV: 8/4/15- turners syndrome

POC: Fitted with Pavlick harness by Dr. Bulkeley, mother Instructed in brace use and application

Next OV: 8/25/15

Assessment:

States child seen yesterday and given harness to wear. She states the harness is set up to go over her clothes. She states that with the back piece to the harness, she is unable to get child's clothes changed. She is wondering how to change her child's clothes.

States also someone called yesterday about her insurance after she left for the visit.

Recommendation:

Transferred to patient services for insurance question.

Routed to nurse for assist with pt's harnass.

JAYNE A BLAKELY, RN 8/5/2015 11:43 AM

Telephone Encounter - Simmons, Jennifer A, RN - 08/05/2015 2:54 PM EDT

Called and spoke with patients mother regarding changing her clothes. Per Dr. Bulkeley she does not want the patient to be out of the Pavlik harness except for 1 leg at a time. Patient is to only have sponge baths at this time. Instructed mom she could loosen the waist strap in order to get the patients onesie on. Also reminded mother of patients ultrasound appt on 8/25/15 at 1100 am at RMH and Dr. Bulkeley at 300 pm on the same day. Patient is also supposed to have an appt on the same day with Dr. Doherty for genetics. Referral already placed in Epic. Instructed mother to contact Dr. Doherty's office if she has not been contacted by them in the next several days to make an appt on the same day with she is having the ultrasound and appt with Dr. Bulkeley. Mother verbalized understanding of instructions. JENNIFER A SIMMONS, RN 8/5/2015 2:58 PM

08/04/2015 Consultation Bulkeley, Julia A, MD Turner syndrome (Primary Dx)**ORTHO SPINE PEDS CCR3****08/04/2015**Progress Notes - Harris, Celia C, MOA - 08/04/2015 1:24 PM EDT

This patient has been identified by NAME and DOB. The medication list has been reviewed and updated with the patient/caregiver. At the conclusion of today's visit, the patient will receive a copy of an after visit summary. The AVS includes any orders entered, current medications, and any future appointments. The patient has been instructed to check out at the completion of today's visit.

Patient is aware to ask any of the following questions before the end of their visit:

- Do you have any questions about your prescriptions today?
- Do you have any questions about your treatment today or in the future?
- Are you going to have surgery? If so, do you have any questions regarding the surgery or process for scheduling?
- Do you know when you are to come back to the office for your follow up appointment?
- Do you need a note for work or school today?

Patient was notified that JENNIFER " JENNY" SIMMONS, RN is the nurse working with DR. JULIA A. BULKELEY today.

Progress Notes - Ford, Kim R, Tech - 08/04/2015 1:54 PM EDT

Pt identified by name and date of birth. Fitted with Pavlick harness by Dr. Bulkeley, mother Instructed in brace use and application, paperwork explained and completed. Instructed to call or return to clinic with any questions or concerns. Kim Ford Orthopedic Tech II CTL

Date	Type	Specialty	Care Team	Description
	<u>Progress Notes</u>	- Bulkeley, Julia A, MD - 08/04/2015 2:12 PM EDT		EXHIBIT NO. B9F PAGE: 14 OF 90
2 wk.o. female presents today for evaluation of there hips. They are the third child . There is not a family history of hip problems. They were not breech presentation. Diagnosed with turners syndrome				
No past medical history on file. No past surgical history on file.				
Weight 3.402 kg (7 lb 8 oz).				
ROS : Constitutional: Denies fatigue, fever, weakness HEENT: Denies visual changes/disturbances, vertigo, epistaxis, Resp: Denies asthma, breathing problems GI: Denies N/V, rapid weight gain or loss Skin: Denies lesions, moles, rash, pruritis				
Physical exam				
Patient is a healthy appearing baby in no apparent distress. Moving bilateral arms spontaneously Skin is warm and dry without significant birth marks Back: No scoliosis No hairy patch, Nosacral dimple Feet. Flexible feet without adductus				
Gallezzi negative Ortlanti positive Barlow negative Thigh folds equal and symmetric.				
A/P Hip dysplasia. Placed into pavlik harness. Get US in 3 weeks. If hip stablize continue harness if not will need rhino brace				
08/04/2015	Telephone		Bulkeley, Julia A, MD	Other
ORTHO SPINE PEDS CCR3 08/04/2015				
Telephone Encounter - Arnold, Kimberly J, RN - 08/04/2015 11:20 AM EDT				
Situation: Received live call from pt mother . Contact number - 304-938-9065				
Background: <u>Consult</u>				
<u>Assessment:</u> Has a 1330 Appointment for her turners syndrome , running late for appointment will be 1330 before she gets to clinic . Driving 4 hrs to get to clinic .				
Recommendation: Spoke to Clarissa , will see pt as is running late . Note added to appointment . KIMBERLY J ARNOLD, RN 8/4/2015 11:32 AM				
08/03/2015	Telephone		Doherty, Emily S, MD	Results (positive for Turner syndrome); Referral (Cardiology follow-up ordered)
ROANOKE CLINICAL GENETICS 08/03/2015				
Telephone Encounter - Doherty, Emily S, MD - 08/03/2015 2:07 PM EDT				

**EXHIBIT NO. B9F
PAGE: 15 OF 90**

Date	Type	Specialty	Care Team	Description
		Spoke with mother to relay <u>results</u> of chromosome analysis . Classic 45,X TS and I am optimistic about N's developmental outcome. Mother indicates she would like a follow-up appointment with my office and I would be happy to see Nevaeh again especially it would be easy to see again when they are here for Bulkeley another time. Mother indicates has not been contacted regarding Cardiology f/up had planned to see in Radford. I suspect there was a communication error and will order. Will fax copy chromosome <u>result</u> to PCP office. Mother indicates normal renal u/s study was obtained through the PCP office.		
07/28/2015	Telephone		Doherty, Emily S, MD	Other (emotional support about Turner syndrome <u>diagnosis</u>)

ROANOKE CLINICAL GENETICS 07/28/2015

Telephone Encounter - Doherty, Emily S, MD - 07/28/2015 4:48 PM EDT

Formatting of this note may be different from the original.

I did speak with Ms. Adams. We had a nice conversation about Turners syndrome. She is planning on giving me a call after her appointment with you next week so that we can meet in person. I agave her the phone number of a mother a 2 year old recommended by the Turners Syndrome Association. I enjoyed talking with mom.

07/27/2015	Telephone	Doherty, Emily S, MD	Labs Only (cytogenetics <u>results</u> expected on 7/28/15)
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ROANOKE CLINICAL GENETICS 07/27/2015

Telephone Encounter - Doherty, Emily S, MD - 07/27/2015 4:20 PM EDT

Per customer services with Quest.

Telephone Encounter - Doherty, Emily S, MD - 08/03/2015 8:24 AM EDT

In reading today, probably result tomorrow per Pathology.

07/21/2015 - Hospital Encounter	Sherman, James M Jr., MD	Single liveborn infant delivered vaginally
07/24/2015		

ROANOKE MEMORIAL HOSPITAL 07/21/2015

Consults - McClendon, Ashleigh K, DO - 07/21/2015 7:04 PM EDT

Formatting of this note may be different from the original.

Carilion Newborn **Consult**

Date: 7/21/2015 Time: 7:04 PM

Referring Physician McCuin

Reason for **Consult** Consulted because of known fetal anomaly

Maternal Race Caucasian

Sex of Newborn #1 Female

Sex of Newborn #2 NA

Obstetric History

G3 P2 SABO TABO

EDC: 7/28/15

Gestation Weeks: 39

Past Medical History - Maternal

No past medical history on file.

Past Surgical History - Maternal

Date	Type	Specialty	Care Team	Description
	No past surgical history on file.			EXHIBIT NO. B9F PAGE: 16 OF 90
	Pregnancy			
	Complications: The pregnancy was complicated by + NIPT for Turner's syndrome (2 vessel cord, mild bowel loop dilation, normal echo)			
	Prior to Admission Medications: No prescriptions prior to admission			
	Labor and Delivery			
	Complications: no L&D complications			
	Current Medications: No current facility-administered medications for this encounter.			
	Analgesia: Epidural anesthesia was used during delivery.			
	Rupture of Membranes			
	ROM Date: 7/21/15 Time of ROM: 1529 ROM was artificial and the amniotic fluid was clear			
	Delivery Date: 7/21/15 Time of Delivery: 1841			
	Presentation: Vertex			
	Type of Delivery: Normal delivery: term.			
	Resuscitation of Newborn			
	Resuscitation Data: Routine delivery room care - warm, dry, and bulb suction.			
	Resuscitation Medications: None			
	Resuscitation Narrative: Infant vigorous. Brought to warmer for exam then transitioned back to mother for kangaroo care. Apgar 8, 9			
	Physical Exam of Newborn			
	Birth Weight 7 lbs 6.8 oz			
	Examination term and no abnormalities noted except for physical exam findings consistent with turner's syndrome (edema of hands and feet, webbed neck, wide spaced nipples, 2 vessel cord). Normal cardiac exam.			
	Plan			
	Details transition to nursery after bonding			
	talked with mother and/or family			
	ASHLEIGH K MCCLENDON, DO			
	H&P - McClendon, Ashleigh K, DO - 07/21/2015 7:09 PM EDT			
	Formatting of this note may be different from the original.			
	Carilion Newborn Admission Note			
	Date: 7/21/2015 Time: 7:09 PM			
	Name: Baby Girl(Kelli) A Adams 932097			
	Newborn Data			
	Birth Date and Time: 7/21/2015 6:41 PM			
	Birth History			
	Vitals			
	• Birth			
	Weight: 3.369 kg (7 lb 6.8 oz)			
	• Apgar			
	One: 8			
	Five: 9			
	• Delivery Method: Vaginal, Spontaneous Delivery			
	• Gestation Age: 39 wks			
	Maternal Data:			
	G 3 T 2 Pt 1 A 0 L 3			
	Age: 24 years			
	Maternal Blood Type/Rh: O+			

Date	Type	Specialty	Care Team	Description
	Screens: RPR/Syphilis non-reactive Hepatitis B negative Hepatitis C negative GBS negative <u>HIV</u> negative			EXHIBIT NO. B9F PAGE: 17 OF 90

Maternal history: Noncontributory

Pregnancy and Intrapartum Problems: Positive NIPT for turner's syndrome. Normal fetal echo. Other abnormalities: 2 vessel cord, edema of feet, dilated loop of bowel with polyhydramnios late

Delivery History: Delivered via induced vaginal delivery. Apgar 8, 9.

Vitals flow sheet reviewed.
 General Infant is well appearing and in no acute distress.
 Head Anterior fontanel is soft and flat. Molding.
 Eyes Red reflex DEFERRED in delivery room
 ENT No deformities noted. Palate is intact.
 Neck Clavicles intact. Webbed neck.
 Cardiovascular RRR, no murmur, 2/4 femoral pulses, brisk capillary refill.
 Respiratory Lungs are clear bilaterally. No distress noted. Wide spaced nipples
 Abdomen Soft. No organomegaly and no masses present. Normal bowel sounds. Two vessel cord. Anus is patent.
 Genitalia Normal female genitalia present.
 Hips No evidence of instability.
 Spine Straight and intact without significant dimples or hair tufts.
 Neurologic Normal tone and activity. Suck, grasp, and symmetric moro reflexes are present.
 Skin Pink. Intact with no lesions or vesicles. Edema of hands and feet. Right foot markedly edematous.

Assessment:

Term, AGA newborn
 Infant Feeding Plan: Breastfeeding-(initial feeding plan and review of benefits of exclusive breast feeding has been discussed with mother)
 Suspected Turner's syndrome

Plan:

Will allow infant to stay in newborn nursery for now.
 If has difficulties with feeds/abdominal distension/vomiting, will pursue imaging.
 Infant will need pediatric cardiology evaluation/echo prior to discharge.
 Consider renal US.
 Will also need to consult genetics. Infant will need confirmatory genetic testing.

ASHLEIGH K MCCLENDON, DO

Progress Notes - Craighead, Michelle L, RN - 07/21/2015 9:00 PM EDT

Infant with new ID bands placed as time was written wrong on originals. New ID band number 13251

Lactation Note - Quinones, Mercedes E, RN - 07/22/2015 8:51 AM EDT

This note was copied from the chart of Kelli Marie Adams.
 Mother states newborn attempted to breastfeed but did not latch. Mother states she supplemented with formula. Newborn in WBN at time of visit. KC encouraged to help with newborn latch. Mother to continue to attempt to breastfeed prior to any formula supplementation every 2-3 hours. Basic breastfeeding education provided. Newborn lactation education packet given. Inpatient and outpatient lactation services explained. Mother to call for LC at next feeding attempt to assist newborn with latch.

Progress Notes - Sherman, James M Jr., MD - 07/22/2015 11:07 AM EDT

Formatting of this note may be different from the original.

Carilion Newborn Nursery Progress Note
 Date: 7/22/2015 Time: 11:07 AM

Name: Baby Girl(Kelli) A Adams

Date	Type	Specialty	Care Team	Description
		Infant is both breast and bottle feeding fair. Mother reports infant not interested in nursing, but will take bottle, 20 ml. Infant spitting. Infant is voiding normally and stooling normally.. Weight is less than one% decreased from birth weight.		EXHIBIT NO. B9F PAGE: 18 OF 90

Vitals, I & O, and nursing flow sheet have been reviewed.

TCB at 5 hrs is 2.9

Labs:

Results for orders placed or performed during the hospital encounter of 07/21/15
CORD BLOOD EVALUATION, REFLEX (CBER)

Result Value Ref Range

ABO/Rh O POS

DAT, Anti-IgG Coombs Serum

NEG

Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Belleview at Jefferson Street, Roanoke, VA 24014

HEARING TEST, NEWBORN

Result Value Ref Range

Hearing Screening Pass R&L Ears

Physical Exam:

BP 50/30 mmHg | Pulse 146 | Temp(Src) 97.7 °F (36.5 °C) | Resp 36 | Wt 3.353 kg (7 lb 6.3 oz) | SpO2 100%

General: Webbed neck, wide spaced nipples, edematous feet, vigorous infant. Strong cry.

Head: sutures mobile, fontanelles normal size

Eyes: sclerae white, pupils equal and reactive, red reflex normal bilaterally

Ears: well-positioned, well-formed pinnae. pearly TM

Nose: clear, normal mucosa

Mouth: Normal tongue, palate intact,

Neck: normal structure

Chest: lungs clear to auscultation, unlabored breathing

Heart: RRR, S1 S2, no murmurs

Abd: Soft, non-tender, no masses. Umbilical stump clean and dry

Pulses: strong equal femoral pulses, brisk capillary refill

Hips: Negative Barlow, PositiveOrtolani, gluteal creases equal

GU: Normal genitalia

Extremities: well-perfused, warm and dry

Neuro: easily aroused

Good symmetric tone and strength

Positive root and suck.

Symmetric normal reflexes

Physical exam is normal except stigmata on Turner syndrome, and bilateral hip clunks on Ortolani Exam.

Medications:

Current Facility-Administered Medications

Medication Dose Route Frequency

- sucrose 24% 24% oral liquid *Override Medication*

- Hepatitis B Virus Vaccine (PF) (RECOMBIVAX) 5 mcg/0.5 mL Susp 5 mcg 5 mcg Intramuscular ONCE PRN

Assessment/Plan:

Active Problems:

Single liveborn infant delivered vaginally

Preliminary ECHO **result** is suggestive of small aortic arch, still widely patent ductus. I discussed this with mother and Dr Miller, Ped Cardiology, who will review ECHO and see infant.

JAMES M SHERMAN JR, MD

Lactation Note - Quinones, Mercedes E, RN - 07/22/2015 12:23 PM EDT

This note was copied from the chart of Kelli Marie Adams.

Mother calling for LC assistance. Assisted mother with newborn positioning and latch in football hold on right breast.

Newborn latches well with few intermittent audible swallows noted. Mother encouraged to continue to attempt to breastfeed every 2-3 hours and to call for LC if further assistance is needed.

H&P - Geissinger, Jared, PA Student - 07/22/2015 1:06 PM EDT

Date	Type	Specialty	Care Team	Description
				EXHIBIT NO. B9F PAGE: 19 OF 90
		Formatting of this note may be different from the original.		
		Carilion Newborn Admission Note Date: 7/22/2015 Time: 1:06 PM		
		Name: Baby Girl(Kelli) A Adams		
		Newborn Data Birth Date and Time: 7/21/2015 6:41 PM Birth History Vitals • Birth Length: 0.521 m (1' 8.5") Weight: 3.369 kg (7 lb 6.8 oz) HC 15" (38.1 cm) • Apgar One: 8 Five: 9 • Delivery Method: Vaginal, Spontaneous Delivery • Gestation Age: 39 wks • Feeding: Breast Fed • Hospital Name: CRMH • Hospital Location: Roanoke, VA		
		Gestational age: Term, 39.0 weeks gestation AGA Intrapartum Problems Identified: no L&D complications ROM at 1529 on 07/21/15 with ROM was artificial and the amniotic fluid was clear Type of delivery: Vaginal APGAR score: 8 @ 1 min 9 @ 5 min		
		Maternal Data G 3 T 2 Pt 1 A 0 L 3 Age: 24 Maternal Race: Caucasian Pregnancy was complicated by known fetal anomaly (Turner syndrome) Maternal Blood Type/Rh: O positive Antibody: negative Screens: RPR/Syphilis non-reactive Urine Tox not done Hepatitis B negative GBS negative HIV negative Rubella not immune		
		Vitals and nursing flow sheet reviewed. Birth Weight 3369		
		General Infant is well appearing and in no acute distress. Head Anterior and posterior fontanelles are soft and flat. Eyes Not appreciated (infant crying, unable to open eyes) ENT No deformities noted. Palate is intact. Neck No lesions noted, webbed neck. Chest Clavicles intact. Cardiovascular Regular rhythm, no murmur, brachial and femoral pulses not appreciated. Respiratory Lungs are clear bilaterally. No distress noted. Abdomen Soft and flat. No organomegaly and no masses present. Bowel sounds not appreciated. Two (2) vessels cord noted at delivery. Anus is patent. Genitalia Normal female genitalia present. Hips Ortolani maneuver positive on right hip. Spine Straight and intact without significant dimples or hair tufts. Neurologic Normal tone and activity. Suck, grasp, and symmetric moro reflexes are present. Skin Pink and well perfused. Intact with no lesions or vesicles aside from small scratches on face, chest and abdomen.		

Date	Type	Specialty	Care Team	Description
		Bilateral foot edema, slightly more pronounced on right.		EXHIBIT NO. B9F PAGE: 20 OF 90
	Labs:			
	Results for orders placed or performed during the hospital encounter of 07/21/15	CORD BLOOD EVALUATION, REFLEX (CBER)		
	Result Value Ref Range			
	ABO/Rh O POS			
	DAT, Anti-IgG Coombs Serum			
	NEG			
	Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Belleview at Jefferson Street, Roanoke, VA 24014			
	ECHO PEDIATRIC COMPLETE			
	Result Value Ref Range			
	ECHO LVEF 65 to 70%			
	HEARING TEST, NEWBORN			
	Result Value Ref Range			
	Hearing Screening Pass R&L Ears			
	Medications:			
	Current Facility-Administered Medications			
	Medication Dose Route Frequency			
	• sucrose 24% 24% oral liquid *Override Medication*			
	• Hepatitis B Virus Vaccine (PF) (RECOMBIVAX) 5 mcg/0.5 mL Susp 5 mcg 5 mcg Intramuscular ONCE PRN			
	Problems Identified			
	Active Problems:			
	Single liveborn infant delivered vaginally			
	Newborn Risk Indicators			
	Observeable at birth:			
	Congenital malformations (Webbed neck, wide spaced nipples, bow legs)			
	2 vessel cord			
	Assessment and Plan:			
	-Length approximately 90th percentile, head circumference >90th percentile; continue to monitor			
	-Positive Ortolani maneuver, consider ortho referral			
	-Physical exam findings consistent with chromosomal abnormality suspicious for Turner syndrome (Webbed neck, wide spaced nipples, bow legs; no transverse palmar crease nor low set ears which would suggest Down syndrome ; questionable flat nasal bridge); ECHO demonstrated normal LVEF, assess for kidney malformations with renal ultrasound			
	-Mother not immune to Rubella			
	routine nursery care			
	Routine newborn care.			
	Infant Feeding Plan:Breastfeeding-(initial feeding plan and review of benefits of exclusive breast feeding has been discussed with mother)			
	JARED GEISSINGER, PA Student			
	Consults - Miller, Joelle D, MD - 07/22/2015 5:46 PM EDT			
	Cardiology consult done, dictated			
	1 day old term well appearing NB with suspected Turner Syndrome			
	Her cardiac exam reveals an ejection click at the apex but no murmur.			
	Her pulses are easily palpable and equal.			
	ECHO: bicuspid Aortic valve, no aortic stenosis or Aortic insufficiency			
	No Aortic arch obstruction at this time, but the distal transverse Aortic arch appears mildly hypoplastic and the PDA remains open and at least moderate in size.			
	Despite a reassuring exam, can not rule out a coarctation at this time			
	REC:			
	I explained these findings to her mother			
	Observe in NBN			
	Repeat echo Friday July 24 and reassess Aortic arch. (if any symptoms of dyspnea, would repeat echo sooner)			
	Consults - Doherty, Emily S, MD - 07/22/2015 6:21 PM EDT			

Date	Type	Specialty	Care Team	Description
		Formatting of this note may be different from the original.		EXHIBIT NO. B9F PAGE: 21 OF 90

Department of Pediatrics
Clinical Genetics
ROANOKE MEMORIAL HOSPITAL
WELLBORN NURSERY
1906 Belleview Avenue
Roanoke VA 24014
Dept: 540-981-7000
Loc: 540-981-7000

Genetics Consultation**Subjective**

Seen at the request of :

Dr. Sherman

Reason for Consultation: Turner syndrome**History of Present Illness:**

Baby Girl(Kelli) A Adams a 1 days female is seen for initial Genetics consult, present at the bedside is: mother. "Nevaeh" was born with moderately severe R dorsal pedal edema and mild neck webbing. No intervening or modifying factors. There was a positive NIPT for Turner syndrome prenatally. Mother did not have amniocentesis.

Review of Systems:

GI: Nevaeh was having difficulty with latch yesterday but breastfed well today. She has had some vomiting. Mother comments she is concerned that Nevaeh might have lactose intolerance as the older two sibs went on Similac Sensitive. Nevaeh is passing stool.

GU: Nevaeh has had good wet diapers by parent report

HEENT: Nevaeh passed her newborn hearing screen by parent report

PMHx:

Birth History

Vitals

• Birth

Length: 0.521 m (1' 8.5")

Weight: 3.369 kg (7 lb 6.8 oz)

HC 15" (38.1 cm)

• Apgar

One: 8

Five: 9

• Delivery Method: Vaginal, Spontaneous Delivery

• Gestation Age: 39 wks

• Feeding: Breast Fed

• Hospital Name: CRMH

• Hospital Location: Roanoke, VA

Prior Medical records reviewed: Prenatally there was a loop of abnormal bowel noted on ultrasound. Postnatally Nevaeh's echo shows bicuspid aortic valve and mild aortic narrowing.

SocHx: PCP will be Dr. Khokar. Family from WVA.

FamHx: No prior hx Turner syndrome

Objective**Physical Examination**

BP 50/30 mmHg | Pulse 146 | Temp(Src) 97.7 °F (36.5 °C) | Resp 36 | Wt 3.353 kg (7 lb 6.3 oz) | SpO2 100%

44%ile (Z=-0.14) based on CDC 0-36 Months weight-for-age data using vitals from 7/22/2015.

General Appearance: Alert newborn baby. Had some retching during the exam then later vomited some breastmilk mixed

Date	Type	Specialty	Care Team	Description
	with formula. Head: Normocephalic. AFOF. Eyes: No pupil defect Ears: Posteriorly rotated esp on R Nose: Normal, no congestion. Mouth and Throat: Mouth mucosa without lesion. Palate: intact and deep. No teeth. Neck: + webbing, no mass. Chest: Broad chest with widely spaced nipples. Abdomen: Soft, nondistended, nontender. No organomegaly or masses appreciated. Extremities: Twenty digits. Moderate R dorsal pedal edema. Mild L dorsal pedal edema. Hands slightly puffy. Normal palmar creases. Small toenails. GU: NEFG Skin: Normal turgor, with rash on chest. Spine: straight no tufts or dimples. Neurological: Normal for gestational age.			EXHIBIT NO. B9F PAGE: 22 OF 90

Assessment/ Diagnosis

Clinically, has Turner syndrome with lymphedema and webbed neck.

Plan

Recommend **chromosome analysis** to confirm clinical **diagnosis** Turner syndrome. Mother consents to testing. Pediatrician should order renal ultrasound outpatient and ophthalmology **consult** to see at about 3 months of age due to risk of strabismus/higher likelihood of refractive error. Will need lifetime cardiac follow-up for bicuspid aortic valve. Girls with TS often have growth failure presenting between 1 and 2 years of age at which point establishing care with peds endocrine would be appropriate. Mother has brochure for UNC Turner syndrome study. Gave Turner Syndrome support website info.

Consult findings transmitted to referring provider: via EPIC.
Genetics follow-up: we will put on clinic follow-up list for Jan 2016.

EMILY S DOHERTY, MD

Consults - Miller, Joelle D, MD - 07/22/2015 10:03 PM EDT

Formatting of this note may be different from the original.

CARILION CLINIC
Carilion Roanoke Memorial Hospital
P.O. Box 13367
Roanoke VA 24033

Date of **Consult**: 7/22/2015

HISTORY OF PRESENT ILLNESS: Baby Girl Adams is a 1-day-old newborn with a history of an abnormal **echocardiogram** and a presumptive **diagnosis** of Turner's syndrome.

During pregnancy, a 2-vessel cord was identified, as well as edematous fetal feet with polyhydramnios. No amniocentesis was done; however, because of the **findings**, there was a concern for Turner's syndrome. A fetal **echocardiogram** was done which was normal. The baby was born at 39 weeks. Apgars were 8 and 9. She was born via spontaneous vaginal delivery. Her weight is 7 pounds 7 ounces. She has done very nicely in the newborn nursery, but dysmorphic features were noted and there continues to be a strong concern for Turner's syndrome. An **echocardiogram** was done and a **consult** was requested.

FAMILY HISTORY: No other known chromosomal abnormalities or congenital heart disease.

SOCIAL HISTORY: Mother has 2 other children. The parents are married and very involved in her care.

Date	Type	Specialty	Care Team	Description
	REVIEW OF SYSTEMS:	HEENT: Hearing screen not yet performed. LUNGS: No history of respiratory distress. CARDIOVASCULAR: See HPI. GASTROINTESTINAL: No vomiting. Has passed 2 stools. GENITOURINARY: Good urine output. SKIN: No rashes or abnormalities.		EXHIBIT NO. B9F PAGE: 23 OF 90

PHYSICAL EXAMINATION: The baby appears pink, well perfused. She is examined in her mother's room. She has no distress. Her heart rate is 139 to 146. Her respiratory rate has been normal, 36 to 42. Her blood pressures have been equal in the upper and lower extremities. Her weight is 3.3 kilos. HEENT: She has posteriorly rotated low-set ears, and a webbed neck is also noted. Her facial features appear normal to my exam. Her anterior fontanelle is soft. No bruits are heard. LUNGS: Normal work of breathing with clear breath sounds bilaterally. CARDIOVASCULAR: Her pulses are easily palpable and equal in the upper and lower extremities. There is an ejection click which is best heard at the apex. S2 is normally split. I could not hear a murmur. No murmur is heard at the back as well. ABDOMEN: Soft, nondistended, with no masses or organomegaly.

Her echocardiogram is carefully reviewed. This demonstrated a bicuspid valve without stenosis or insufficiency. The aortic arch appears unusual. The distal transverse arch appears mildly hypoplastic. The isthmus of the aorta is widely patent, and no aortic arch obstruction is seen at the time of today's study. She does have a moderate-sized PDA with a predominant left-to-right shunt, but transient right-to-left shunting is seen on frame by frame analysis of the color mapping. She has a normal patent foramen ovale.

ASSESSMENT AND PLAN: Baby Girl Adams is a well-appearing term newborn with a tentative diagnosis of Turner's syndrome. She has a bicuspid aortic valve with normal function. Her aortic arch does appear unusual, and it is impossible to rule out a significant coarctation at this time because the patent ductus arteriosus is open. She does not have any evidence of aortic arch obstruction either on clinical exam or by echocardiogram today.

I explained to her mother very carefully that a coarctation may not be readily available when the ductus arteriosus is open. For that reason I would feel most comfortable observing the baby closely in the newborn nursery and repeating the echocardiogram the day after tomorrow. Hopefully we will see complete closure of the ductus without significant aortic arch obstruction. However, she could be continuously assessed, intermittently assessed for any evidence of tachypnea or poor pulses in her legs.

I also did chat with her mother about what symptoms she may present with if she does have clinical evidence of aortic arch obstruction. We will follow her along while she is in the hospital, and advise on outpatient management once she is able to go home.

JOELLE D. MILLER, MD
Job: 431156
DD: 07/22/2015 17:46:38
DT: 07/22/2015 22:03:56

Patient: ADAMS, BABY GIRL(KELLI) A Acct#: 139776854 MR#: 932097
Date of Birth: 07/21/2015 Admit Date: 07/21/2015 Room#: 1269
Attending: JAMES M SHERMAN Discharge Date: Service: PED

Consultation

Progress Notes - Geissinger, Jared, PA Student - 07/23/2015 8:43 AM EDT

Formatting of this note may be different from the original.

Carilion Newborn Nursery Progress Note
Date: 7/23/2015 Time: 8:43 AM

Name: Baby Girl(Kelli) A Adams

Infant is both breast and bottle feeding well (mom prefers to breast feed, baby also receiving bottle b/c mom will be discharged today, baby to receive repeat ECHO tomorrow). Infant is voiding normally and stooling normally.. Weight is 3.98% decreased from birth weight.

Vitals, I & O, and nursing flow sheet have been reviewed.

TCB at 30 hrs is 8.2, in the intermediate risk zone

Labs:

Results for orders placed or performed during the hospital encounter of 07/21/15

CORD BLOOD EVALUATION, REFLEX (CBER)

Result Value Ref Range

Date	Type	Specialty	Care Team	Description
	ABO/Rh O POS DAT, Anti-IgG Coombs Serum NEG			EXHIBIT NO. B9F PAGE: 24 OF 90
	Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Bellevue at Jefferson Street, Roanoke, VA 24014			

CHROMOSOME ANALYSIS, BLOOD (Q2631)**Result** Value Ref Range

Clinical Indication

clinical features of Turner syndrome

Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Bellevue at Jefferson Street, Roanoke, VA 24014

ECHO PEDIATRIC COMPLETE

Result Value Ref Range

ECHO LVEF 65 to 70%

HEARING TEST, NEWBORN

Result Value Ref Range

Hearing Screening Pass R&L Ears

Physical Exam:

BP 50/30 mmHg | Pulse 136 | Temp(Src) 98.5 °F (36.9 °C) | Resp 44 | Wt 3.24 kg (7 lb 2.3 oz) | SpO2 100%

General: healthy-appearing, vigorous infant. Strong cry.

Head: sutures mobile, fontanelles normal size

Eyes: eye exam not performed, examiner unable to open infant eyes for adequate exam

Ears: well-positioned, well-formed pinnae.

Nose: clear, normal mucosa

Mouth: Normal tongue, palate intact,

Neck: normal structure

Chest: lungs clear to auscultation, unlabored breathing

Heart: RRR, S1 S2, no murmurs

Abd: Soft, non-tender, no masses. Umbilical stump clean and dry

Pulses: femoral pulses not appreciated, brachial pulses strong

Hips: gluteal creases equal

GU: Normal genitalia

Extremities: well-perfused, warm and dry

Neuro: easily aroused

Good symmetric tone and strength

Positive root and suck.

Symmetric normal reflexes

Physical exam is normal, positive Ortolani yesterday, did not repeat today.

Medications:

Current Facility-Administered Medications

Medication Dose Route Frequency

- sucrose 24% 24% oral liquid *Override Medication*

Assessment/Plan:

Active Problems:

Single liveborn infant delivered vaginally

PDA (patent ductus arteriosus)

Bicuspid aortic valve

Turner syndrome

-ECHO demonstrates bicuspid aortic valve; repeat ECHO Friday per cardiology note, attention to aortic arch

-Genetics **consult** placed, follow their notes

-Mom to be discharged today, plans to visit baby whom is staying until tomorrow for repeat ECHO

Routine newborn care.

JARED GEISSINGER, PA Student

Progress Notes - Craver, Sally B, SW - 07/23/2015 10:28 AM EDT

Date	Type	Specialty	Care Team	Description
	Mom is going to board today while her baby is still in the nursery.	Sally Craver, MSW Clinical Social Worker Carilion Children's Clinic (540) 588-8821		EXHIBIT NO. B9F PAGE: 25 OF 90

Progress Notes - Miller, Joelle D, MD - 07/23/2015 10:39 AM EDT

BP 50/30 mmHg | Pulse 136 | Temp(Src) 98.5 °F (36.9 °C) | Resp 44 | Wt 3.24 kg (7 lb 2.3 oz) | SpO2 100%

Breast feeding well.
Voiding and stooling well.
No problems overnight

Pink, well appearing newborn
Lungs: clear, normal work of breathing
CV:
Pulses easily palpable upper and lower, equal
Click noted over apex
No murmur heard

ASSESSMENT:

Probable Turner's Syndrome
Bicuspid Aortic valve without aortic stenosis or Aortic insufficiency
Moderate PDA with possible hypoplasia of the Aortic arch but without obstruction on yesterday's echo.
No evidence of hemodynamic compromise
No change in cardiac exam
Plan echo 7/24/2015 and reassess Aortic arch
Discussed with neonatal staff and with patient's mother.

Progress Notes - Sherman, James M Jr., MD - 07/23/2015 10:42 AM EDT

Formatting of this note may be different from the original.

Carilion Newborn Nursery Progress Note
Date: 7/23/2015 Time: 10:42 AM

Name: Baby Girl(Kelli) A Adams

Infant is breast feeding well. Infant is voiding normally and stooling normally.. Weight is 3.8% decreased from birth weight.

Vitals, I & O, and nursing flow sheet have been reviewed.

TCB at 24 hrs is 8.2, in the intermediate risk zone

Labs:

Results for orders placed or performed during the hospital encounter of 07/21/15
CORD BLOOD EVALUATION, REFLEX (CBER)

Result Value Ref Range

ABO/Rh O POS

DAT, Anti-IgG Coombs Serum

NEG

Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Bellevue at Jefferson Street, Roanoke, VA 24014

CHROMOSOME ANALYSIS, BLOOD (Q2631)

Result Value Ref Range

Clinical Indication

clinical features of Turner syndrome

Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Bellevue at Jefferson Street, Roanoke, VA 24014

ECHO PEDIATRIC COMPLETE

Result Value Ref Range

Date	Type	Specialty	Care Team	Description
	ECHO LVEF 65 to 70%			EXHIBIT NO. B9F
	HEARING TEST, NEWBORN			PAGE: 26 OF 90
	Result Value Ref Range			
	Hearing Screening Pass R&L Ears			
	Physical Exam:			
	BP 50/30 mmHg Pulse 136 Temp(Src) 98.5 °F (36.9 °C) Resp 44 Wt 3.24 kg (7 lb 2.3 oz) SpO2 100%			
	General: healthy-appearing, vigorous infant. Strong cry.			
	Head: sutures mobile, fontanelles normal size			
	Eyes: sclerae white, pupils equal and reactive, red reflex normal bilaterally			
	Ears: well-positioned, well-formed pinnae. pearly TM			
	Nose: clear, normal mucosa			
	Mouth: Normal tongue, palate intact,			
	Neck: normal structure			
	Chest: lungs clear to auscultation, unlabored breathing			
	Heart: RRR, S1 S2, no murmurs			
	Abd: Soft, non-tender, no masses. Umbilical stump clean and dry			
	Pulses: strong equal femoral pulses, brisk capillary refill			
	Hips: Negative Barlow, Bilateral hip clunks			
	GU: Normal genitalia			
	Extremities: well-perfused, warm and dry, feet still edematous			
	Neuro: easily aroused			
	Good symmetric tone and strength			
	Positive root and suck.			
	Symmetric normal reflexes			
	Physical exam shows stigmata of Turner. PULses palpable, good perfusion of feet. No murmur			
	Medications:			
	Current Facility-Administered Medications			
	Medication Dose Route Frequency			
	• sucrose 24% 24% oral liquid *Override Medication*			
	Assessment/Plan:			
	Active Problems:			
	Single liveborn infant delivered vaginally			
	PDA (patent ductus arteriosus)			
	Bicuspid aortic valve			
	Turner syndrome			
	Repeat ECHO tomorrow, mother will board			
	JAMES M SHERMAN JR, MD			
	Discharge Summaries - Geissinger, Jared, PA Student - 07/23/2015 1:44 PM EDT			
	Formatting of this note may be different from the original.			
	Basic Data			
	Name: Baby Girl(Kelli) A Adams			
	Birth History			
	Vitals			
	• Birth			
	Length: 0.521 m (1' 8.5")			
	Weight: 3.369 kg (7 lb 6.8 oz)			
	HC 15" (38.1 cm)			
	• Apgar			
	One: 8			
	Five: 9			
	• Delivery Method: Vaginal, Spontaneous Delivery			
	• Gestation Age: 39 wks			
	• Feeding: Breast Fed			
	• Hospital Name: CRMH			

Date	Type	Specialty	Care Team	Description
	• Hospital Location: Roanoke, VA			EXHIBIT NO. B9F PAGE: 27 OF 90
	Procedures Done: ECHO			
	Hearing screen: Algo (A-ABR): Passed right and left ear			
	Oximetry screen for severe congenital heart disease: preductal saturation 100%, postductal saturation 100%, difference 0%, negative screen			
	Medications given: Eye prophylaxis (erythromycin), Vitamin K and Hepatitis B			
	Complications: Congenital Anomalies (Probably Turner syndrome, bicuspid aortic valve)			
	Lab Tests			
	Last transcutaneous bilirubin at 54 hrs of age was 15.1, in the high intermediate risk zone; TSB at 54 hrs was 10.8 which borders the low intermediate and high intermediate risk zone, phototherapy not indicated			
	Lab Tests Sent: Blood Type/Rh, Coombs Direct, Bilirubin, Serology			
	Lab Results :			
	Results for orders placed or performed during the hospital encounter of 07/21/15			
	CORD BLOOD EVALUATION, REFLEX (CBER)			
	Result Value Ref Range			
	ABO/Rh O POS			
	DAT, Anti-IgG Coombs Serum			
	NEG			
	Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Bellevue at Jefferson Street, Roanoke, VA 24014			
	CHROMOSOME ANALYSIS, BLOOD (Q2631)			
	Result Value Ref Range			
	Clinical Indication			
	clinical features of Turner syndrome			
	Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Bellevue at Jefferson Street, Roanoke, VA 24014			
	ECHO PEDIATRIC COMPLETE			
	Result Value Ref Range			
	ECHO LVEF 65 to 70%			
	HEARING TEST, NEWBORN			
	Result Value Ref Range			
	Hearing Screening Pass R&L Ears			
	Newborn Risk Indicators within 24 hours postpartum:			
	No risk factors noted aside from two vessel cord and physical exam findings consistent with Turner syndrome (Webbed neck, wide spaced nipples, bilateral pedal edema; Ortolani maneuver bilaterally positive)			
	Discharge Data			
	Weight Analysis			
	Birth: 3005 Discharge: 3167 change: -6.0%			
	Feeding: breast feeding			
	Feeding Problems Identified: None			
	Physical Examination Date: 07/24/2015 Time: 8:15AM Age 3 days			
	Vitals and nursing flow sheet reviewed.			
	General Infant is well appearing and in no acute distress.			
	Head Anterior and posterior fontanelles are soft and flat.			
	Eyes Pupils are reactive to light with red reflex present bilaterally.			
	ENT No deformities noted. Palate is intact.			
	Neck No lesions noted, webbed neck			
	Chest Clavicles intact, wide spaced nipples, protruding xiphoid process			
	Cardiovascular Regular rhythm, no murmur, +2 brachials, femoral pulses not appreciated.			
	Respiratory Lungs are clear bilaterally. No distress noted.			
	Abdomen Soft and flat. No organomegaly and no masses present. Normal bowel sounds. Two (2) vessels cord noted at			

Date	Type	Specialty	Care Team	Description
		<p>delivery. Anus is patent.</p> <p>Genitalia Normal female genitalia present.</p> <p>Hips Positive Ortolani maneuver of right and left hip.</p> <p>Spine Straight and intact without significant dimples or hair tufts.</p> <p>Neurologic Normal tone and activity. Suck, grasp, and symmetric moro reflexes are present.</p> <p>Skin Pink, and well perfused. Intact with no lesions or vesicles.</p> <p>Problems Identified</p> <p>Active Problems:</p> <ul style="list-style-type: none"> Single liveborn infant delivered vaginally PDA (patent ductus arteriosus) Bicuspid aortic valve Turner syndrome Ortolani maneuver positive bilaterally 		EXHIBIT NO. B9F PAGE: 28 OF 90

Assessment and Plan:

Admission (Birth) Date 07/21/2015

Discharge Date: 07/24/2015 Time: (I don't know what is appropriate to list, needs to be after repeat ECHO)

Discharge to home with mother.

Follow-up Care: Follow up pediatrics appointment (Martinsville) on Monday 07/27/2015; Follow up with Dr. Bulkley (pediatric orthopedist) regarding positive Ortolani maneuver suggesting hip dysplasia

Medications for discharge: None. Consider vitamin D supplementation (400 IU daily).

JARED GEISSINGER, PA Student

Progress Notes - Geissinger, Jared, PA Student - 07/24/2015 7:24 AM EDT

Formatting of this note may be different from the original.

Carilion Newborn Nursery Progress Note

Date: 7/24/2015 Time: 7:24 AM

Name: Baby Girl(Kelli) A Adams

Infant is breast and bottle feeding well. Infant is voiding normally and stooling normally.. Weight is 6.0% decreased from birth weight.

Vitals, I & O, and nursing flow sheet have been reviewed.

TCB at 54 hrs is 15.1, in the High intermediate risk zone, TSB at 54hrs is 10.8, phototherapy not indicated

Labs:

Results for orders placed or performed during the hospital encounter of 07/21/15

CORD BLOOD EVALUATION, REFLEX (CBER)

Result Value Ref Range

ABO/Rh O POS

DAT, Anti-IgG Coombs Serum

NEG

Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Belleview at Jefferson Street, Roanoke, VA 24014

CHROMOSOME ANALYSIS, BLOOD (Q2631)**Result** Value Ref Range

Clinical Indication

clinical features of Turner syndrome

Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Belleview at Jefferson Street, Roanoke, VA 24014

BILIRUBIN TOTAL (BILT)**Result** Value Ref Range

Total Bilirubin 10.8 <12.0 MG/DL

ECHO PEDIATRIC COMPLETE**Result** Value Ref Range

ECHO LVEF 65 to 70%

HEARING TEST, NEWBORN**Result** Value Ref Range

Date	Type	Specialty	Care Team	Description
	Hearing Screening	Pass R&L Ears		EXHIBIT NO. B9F PAGE: 29 OF 90
	Physical Exam:			
	BP 50/30 mmHg Pulse 144 Temp(Src) 98.3 °F (36.8 °C) Resp 52 Wt 3.167 kg (6 lb 15.7 oz) SpO2 100%			
	General: healthy-appearing, vigorous infant. Strong cry.			
	Head: sutures mobile, fontanelles normal size			
	Eyes: sclerae white, pupils equal and reactive, red reflex normal bilaterally			
	Ears: well-positioned, well-formed pinnae.			
	Nose: clear, normal mucosa			
	Mouth: Normal tongue, palate intact,			
	Neck: Webbed neck			
	Chest: lungs clear to auscultation, unlabored breathing, wide spaced nipples, slight elevation of chest mass likely xiphoid process			
	Heart: RRR, S1 S2, no murmurs			
	Abd: Soft, non-tender, no masses. Umbilical stump clean and dry, slightly erythematous (not warm, not indurated)			
	Pulses: strong equal brachial pulses, brisk capillary refill			
	Hips: Negative Barlow, Ortolani positive bilaterally, gluteal creases equal			
	GU: Normal genitalia			
	Extremities: well-perfused, warm and dry, bilateral pedal edema more prominent on right foot			
	Neuro: easily aroused			
	Good symmetric tone and strength			
	Positive root and suck.			
	Symmetric normal reflexes			

Physical exam is normal except webbed neck, wide spaced nipples,, slight protrusion of xiphoid process, 3mm area of erythema around umbilicus, bilateral pedal edema more prominent on right foot

Medications:

- Current Facility-Administered Medications
- Medication Dose Route Frequency
- sucrose 24% 24% oral liquid *Override Medication*

Assessment/Plan:

Active Problems:

Single liveborn infant delivered vaginally

PDA (patent ductus arteriosus)

Bicuspid aortic valve

Turner syndrome

-TCB at 54 hrs in high intermediate risk zone, TSB does not indicate phototherapy

-Physical exam **findings** abnormally unchanged from prior **findings** with exception of protrusion of xiphoid process, erythema around umbilicus (not warm nor indurated lowering suspicion for cellulitis), ortolani positive bilaterally (previously only noted on right hip by me, bilaterally by Dr. Sherman).

-Repeat ECHO today, attention to aortic arch per cardiology note

-Plan for discharge after ECHO

Routine newborn care.

JARED GEISSINGER, PA Student

Progress Notes - Miller, Joelle D, MD - 07/24/2015 7:49 AM EDT

SUBJECTIVE:

Nevaeh is breast feeding well, voiding well. No tachypnea

OBJECTIVE:

BP 50/30 mmHg | Pulse 144 | Temp(Src) 98.3 °F (36.8 °C) | Resp 52 | Wt 3.167 kg (6 lb 15.7 oz) | SpO2 100%

Pink, well perfused, well appearing newborn

Lungs: normal air movement, clear, normal work of breathing

CV: precordium quiet

Pulses easily palpable in the lower extremities , normal pulse in the right arm

Ejection click noted over the apex (no change)

No murmur heard.

ASSESSMENT:

Date	Type	Specialty	Care Team	Description
	Probable Turner's Syndrome Bicuspid Aortic valve Last echo demonstrated a moderate to large PDA and unusual (but not obstructive) Aortic arch No clinical evidence of hemodynamic compromise but with an open PDA it is not possible to predict the Aortic arch patency . Plan: repeat echocardiogram this am. Discussed with patient's mother on rounds this am. Will discuss echo results once available.			EXHIBIT NO. B9F PAGE: 30 OF 90

Discharge Summaries - Sherman, James M Jr., MD - 07/24/2015 10:42 AM EDT

Formatting of this note may be different from the original.

Basic Data

Name: Baby Girl(Kelli) A Adams

Birth History

Vitals

- Birth

Length: 0.521 m (1' 8.5")

Weight: 3.369 kg (7 lb 6.8 oz)

HC 15" (38.1 cm)

- Apgar

One: 8

Five: 9

- Delivery Method: Vaginal, Spontaneous Delivery

- Gestation Age: 39 wks

- Feeding: Breast Fed

- Hospital Name: CRMH

- Hospital Location: Roanoke, VA

Procedures Done: **Echocardiogram**

Hearing screen: Algo (A-ABR): passed both ears

Oximetry screen for severe congenital heart disease: passed, 100/100

Medications given: Eye prophylaxis erythromycin ointment, Vitamin K and Hepatitis B

Complications: None

Lab Tests

Last serum bilirubin at 53 hrs of age was 10.8, in the low intermediate risk zone

Lab Tests Sent: genotype, Metabolic Screen (PKU, Thyroid)

Lab **Results**:

Results for orders placed or performed during the hospital encounter of 07/21/15

CORD BLOOD EVALUATION, REFLEX (CBER)

Result Value Ref Range

ABO/Rh O POS

DAT, Anti-IgG Coombs Serum

NEG

Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Belleview at Jefferson Street, Roanoke, VA 24014

CHROMOSOME ANALYSIS, BLOOD (Q2631)

Result Value Ref Range

Clinical Indication

clinical features of Turner syndrome

Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Belleview at Jefferson Street, Roanoke, VA 24014

BILIRUBIN TOTAL (BILT)

Result Value Ref Range

Total Bilirubin 10.8 <12.0 MG/DL

ECHO PEDIATRIC COMPLETE

Result Value Ref Range

ECHO LVEF 65 to 70%

ECHO PEDIATRIC COMPLETE

Date	Type	Specialty	Care Team	Description
	Result Value Ref Range ECHO LVEF 60 to 65%			EXHIBIT NO. B9F
	HEARING TEST, NEWBORN Result Value Ref Range Hearing Screening Pass R&L Ears			PAGE: 31 OF 90

Newborn Risk Indicators within 24 hours postpartum:
Infant with prenatal dx of Turners Syndrome (XO), consistent with clinical **findings**

Discharge Data

Weight Analysis
Birth: 3369 Discharge: 3167 change: 6%

Feeding: breast feeding
Feeding Problems Identified: none

Physical Examination Date: 7/24 Time: 0900 Age 3 days

Vitals and nursing flow sheet reviewed.
General Infant is well appearing and in no acute distress.
Head Anterior and posterior fontanelles are soft and flat.
Eyes Pupils are reactive to light with red reflex present bilaterally.
ENT No deformities noted. Palate is intact.
Neck No lesions noted. Mild webbed neck
Chest Clavicles intact. Shield chest, wide spaced nipples
Cardiovascular Regular rhythm, no murmur +2 femorals = brachials.
Respiratory Lungs are clear bilaterally. No distress noted.
Abdomen Soft and flat. No organomegaly and no masses present. Normal bowel sounds. Three (3) vessels cord noted at delivery. Anus is patent.
Genitalia Normal female genitalia present.
Hips Bilateral positive Ortolani
Spine Straight and intact without significant dimples or hair tufts.
Neurologic Normal tone and activity. Suck, grasp, and symmetric moro reflexes are present.
Skin Pink with jaundice, and well perfused. Intact with no lesions or vesicles. Edema of feet

Problems Identified

Active Problems:
Single liveborn infant delivered vaginally
PDA (patent ductus arteriosus)
Bicuspid aortic valve
Turner syndrome
Term birth of female newborn
Bilateral hip clunks
ECHO on day of discharge shows no coarctation of aorta with closed ductus

Assessment and Plan:

Admission (Birth) Date 7/21
Discharge Date: 7/24 Time: 1200
Discharge to home with mother.
Follow-up Care: Khokar in three days for bili and weight check
Cardiology f/u in 4 weeks, Ped Ortho f/u in about 4 weeks, needs renal ultrasound per Genetics request. F/U with Genetics in Jan 2016. See Genetics and Cardiology consults for more details. I will route copy of this **discharge summary** to Dr Bulkeley who will arrange Ortho f/u. Mother will call cardiology to get appt on same day due to distance of travel
Medications for discharge: none

JAMES M SHERMAN JR, MD

APGAR Scores -

1min:8, 5min:9

from 07/20/2014 to 12/20/2018

PROCED

Procedures

Non-identified Provider

<u>Date</u>	<u>Procedure/Encounter Type [Code]</u>
11/18/2016	ECHO HEART XTHORACIC,LIMITED [93308]
10/06/2015	HB ECHO 2D COMPLETE [93307]
08/03/2015	CHROMOSOME ANALYSIS, BLOOD (Q2631) [20719936]
07/24/2015	HB ECHO 2D COMPL SPEC & COLOR DOP [93306]
07/24/2015	BILIRUBIN TOTAL [82247] Bilirub SerPl-mCnc [1975-2]
07/22/2015	HB ECHO 2D COMPL SPEC & COLOR DOP [93306]
07/22/2015	HEARING TEST, NEWBORN [20743786]
07/22/2015	ABO+Rh Gp BldCo [34474-7]

<u>Narrative Text</u>				
<u>Procedure Name</u>	<u>Priority</u>	<u>Date/Time</u>	<u>Associated Diagnosis</u>	<u>Comments</u>
PEDIATRIC ECHO 2D W OR WORoutine M-MODE LIMITED	Routine	11/18/2016 2:43 PM EST	Bicuspid aortic valve	<u>Results</u> for this procedure are in the <u>results</u> section
ECHO PEDIATRIC 2D-COLOR LIMITED/FOLLOW-UP	Routine	10/06/2015 1:58 PM EDT	Bicuspid aortic valve	<u>Results</u> for this procedure are in the <u>results</u> section
ECHO PEDIATRIC COMPLETE	Routine	07/24/2015 9:49 AM EDT		<u>Results</u> for this procedure are in the <u>results</u> section
BILIRUBIN TOTAL (BILT)	Routine	07/24/2015 12:12 AM EDT		<u>Results</u> for this procedure are in the <u>results</u> section
ECHO PEDIATRIC COMPLETE	Routine	07/22/2015 12:06 PM EDT		<u>Results</u> for this procedure are in the <u>results</u> section
HEARING TEST, NEWBORN	Routine	07/22/2015 10:38 AM EDT		<u>Results</u> for this procedure are in the <u>results</u> section
CHROMOSOME ANALYSIS BLOOD (Q2631)	Routine	07/22/2015 12:15 AM EDT		<u>Results</u> for this procedure are in the <u>results</u> section

Procedure Name	Priority	Date/Time	Associated Diagnosis	Comments
CORD BLOOD EVALUATION, REFLEX (CBER)	Routine	07/21/2015 6:41 PM EDT		Results for this procedure are in the EXHIBIT NO. B9F PAGE: 33 OF 90 results section

from 07/20/2014 to 12/20/2018

LABS

Laboratory Results

Date	Test														
11/18/2016	PEDIATRIC ECHO 2D W OR WO M-MODE LIMITED <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">ECHO LVEF</td> <td> Value: 60 to 65% Text: ECHO LVEF 60 to 65% MUSE </td> </tr> <tr> <td>Associated Procedure: PEDIATRIC ECHO 2D W OR WO M-MODE LIMITED</td> <td> Text: PEDIATRIC ECHO 2D W OR WO M-MODE LIMITED (11/18/2016 2:43 PM) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 20%;">Component</th> <th style="width: 20%;">Value</th> <th style="width: 20%;">Ref Range</th> <th style="width: 20%;">Performed At</th> </tr> <tr> <td>ECHO LVEF</td> <td>60 to 65%</td> <td>MUSE</td> <td>MUSE</td> </tr> </table> Narrative Pediatric Cardiology Clinic IAC Accredited Lab PEDIATRIC ECHOCARDIOGRAM REPORT </td> </tr> <tr> <td></td> <td> Patient Name: NEVAEH HOPE ADAMS Date of 11/18/2016 Exam: MPI: 3636998 Acct #: 212783801 Site Name: Pediatric Cardiology MRN: 7444644 Clinic IAC Accredited Lab Date of Birth: 7/21/2015 Height: 11.0 in Patient Age: 15 months Weight: 22.8 lb Patient Gender: F BSA: 0.22 m² Authorizing 720037 JOELLE D MILLER BP: 50/30 Provider: Referring Provider: Miller. Sonographer: Kimberly Coleman RDGS Indication: Bicuspid av. </td> </tr> </table>	ECHO LVEF	Value: 60 to 65% Text: ECHO LVEF 60 to 65% MUSE	Associated Procedure: PEDIATRIC ECHO 2D W OR WO M-MODE LIMITED	Text: PEDIATRIC ECHO 2D W OR WO M-MODE LIMITED (11/18/2016 2:43 PM) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 20%;">Component</th> <th style="width: 20%;">Value</th> <th style="width: 20%;">Ref Range</th> <th style="width: 20%;">Performed At</th> </tr> <tr> <td>ECHO LVEF</td> <td>60 to 65%</td> <td>MUSE</td> <td>MUSE</td> </tr> </table> Narrative Pediatric Cardiology Clinic IAC Accredited Lab PEDIATRIC ECHOCARDIOGRAM REPORT	Component	Value	Ref Range	Performed At	ECHO LVEF	60 to 65%	MUSE	MUSE		Patient Name: NEVAEH HOPE ADAMS Date of 11/18/2016 Exam: MPI: 3636998 Acct #: 212783801 Site Name: Pediatric Cardiology MRN: 7444644 Clinic IAC Accredited Lab Date of Birth: 7/21/2015 Height: 11.0 in Patient Age: 15 months Weight: 22.8 lb Patient Gender: F BSA: 0.22 m ² Authorizing 720037 JOELLE D MILLER BP: 50/30 Provider: Referring Provider: Miller. Sonographer: Kimberly Coleman RDGS Indication: Bicuspid av.
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<u>Date</u>	<u>Test</u>
	<p>Summary:</p> <p style="text-align: right;">EXHIBIT NO. B9F PAGE: 34 OF 90</p> <ol style="list-style-type: none"> 1. Overall left ventricular ejection fraction is estimated at 60 to 65%. 2. Normal biventricular size, thickness, and function. 3. Bicuspid aortic valve with normal function. 4. Normal aortic root. no coarctation or abnormal dilation noted. 5. No shunts are seen at any level. 6. Commisures in the 3:00 and 9:00 positions. <p>No associated dilation of the aortic root. No stenosis or insufficiency.</p> <ol style="list-style-type: none"> 7. The aortic arch is free of obstruction. The Vp in the descending aorta is 1.3 m/sec. 8. Peak systolic descending aorta gradient = 7 mmHg. <p>Segmental Cardiotype, Cardiac Position, and Situs:</p> <p>\(S,D,S\). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.</p> <p>Systemic Veins:</p> <p>The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.</p> <p>Pulmonary Veins:</p> <p>Four pulmonary veins drain to the left atrium.</p> <p>Atria:</p> <p>No atrial septal defect is detected. There is no evidence of patent foramen ovale. The right atrium is normal in size. The left atrium is normal in size.</p> <p>Mitral Valve:</p> <p>The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.</p> <p>Tricuspid Valve:</p> <p>The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.</p> <p>AV Canal/Complex Inlet/Single Ventricle:</p> <p>The crux of the heart is normal.</p> <p>Left Ventricle:</p> <p>Overall left ventricular ejection fraction is estimated at 60 to 65%. The left ventricle is normal in size. Left ventricular systolic function is normal.</p> <p>Right Ventricle:</p> <p>The right ventricle is normal in size. Right ventricular systolic function is normal.</p> <p>Left Ventricular Outflow Tract and Aortic Valve:</p> <p>There is no evidence of left ventricular outflow obstruction. Based on Doppler</p>

Date	Test
	<p>velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency. Commisures in the 3:00 and 9:00 positions.</p> <p>No associated dilation of the aortic root. No stenosis or insufficiency.</p> <p>Right Ventricular Outflow Tract and Pulmonary Valve:</p> <p>There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.</p> <p>Aorta:</p> <p>The peak systolic gradient recorded in the descending aorta is 7 mmHg. The aortic arch is free of obstruction. The Vp in the descending aorta is 1.3 m/sec.</p> <p>Pulmonary Arteries:</p> <p>The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal.</p> <p>Ductus Arteriosus:</p> <p>There is no evidence of ductus arteriosus patency.</p> <p>Coronary Arteries:</p> <p>The coronary arteries were not evaluated.</p> <p>Aortic Valve Doppler:</p> <p>Peak velocity: 1.50 m/sec</p> <p>Ao ascending Vmax 1.48 m/sec</p> <p>Ao descending Vmax 1.30 m/sec</p> <p>Peak gradient 9.00 mmHg</p> <p>Electronically signed by Joelle Miller, MD</p> <p>Signature Date/Time: 11/18/2016 5:57:05 PM</p> <p>*** Final ***</p> <p style="text-align: center;">Procedure Note</p> <p>Edicardi - 11/18/2016 5:57 PM EST</p> <p>Pediatric Cardiology Clinic</p> <p>IAC Accredited Lab</p> <p>PEDIATRIC ECHOCARDIOGRAM REPORT</p> <hr/> <p>-----</p> <p>-----</p> <p>Patient Name: NEVAEH HOPE ADAMS Date of 11/18/2016</p> <p>Exam:</p> <p>MPI: 3636998 Accn #: 212783801</p>

**EXHIBIT NO. B9F
PAGE: 35 OF 90**

<u>Date</u>	<u>Test</u>
	<p>Site Name: Pediatric Cardiology MRN: 7444644 Clinic IAC Accredited Lab Date of Birth: 7/21/2015 Height: 11.0 in Patient Age: 15 months Weight: 22.8 lb Patient Gender: F BSA: 0.22 m² Authorizing 720037 JOELLE D MILLER BP: 50/30 Provider: Referring Provider: Miller. Sonographer: Kimberly Coleman RDCS Indication: Bicuspid av.</p> <p>Summary:</p> <ol style="list-style-type: none"> 1. Overall left ventricular ejection fraction is estimated at 60 to 65%. 2. Normal biventricular size, thickness, and function. 3. Bicuspid aortic valve with normal function. 4. NOrmal aortic root. no coarctation or abnormal dilation noted. 5. No shunts are seen at any level. 6. Commisures in the 3:00 and 9:00 positions. <p>No associated dilation of the aortic root. No stenosis or insufficiency.</p> <ol style="list-style-type: none"> 7. The aortic arch is free of obstruction. The Vp in the descending aorta is 1.3 m/sec. 8. Peak systolic descending aorta gradient = 7 mmHg. <p>Segmental Cardiotype, Cardiac Position, and Situs:</p> <p>\(S,D,S\). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.</p> <p>Systemic Veins:</p> <p>The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.</p> <p>Pulmonary Veins:</p>

<u>Date</u>	<u>Test</u>	
		<p>Four pulmonary veins drain to the left atrium.</p> <p>EXHIBIT NO. B9F PAGE: 37 OF 90</p> <p>Atria:</p> <p>No atrial septal defect is detected. There is no evidence of patent foramen ovale. The right atrium is normal in size. The left atrium is normal in size.</p> <p>Mitral Valve:</p> <p>The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.</p> <p>Tricuspid Valve:</p> <p>The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.</p> <p>AV Canal/Complex Inlet/Single Ventricle:</p> <p>The crux of the heart is normal.</p> <p>Left Ventricle:</p> <p>Overall left ventricular ejection fraction is estimated at 60 to 65%. The left ventricle is normal in size. Left ventricular systolic function is normal.</p> <p>Right Ventricle:</p> <p>The right ventricle is normal in size. Right ventricular systolic function is normal.</p> <p>Left Ventricular Outflow Tract and Aortic Valve:</p> <p>There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency. Commisures in the 3:00 and 9:00 positions.</p> <p>No associated dilation of the aortic root. No stenosis or insufficiency.</p> <p>Right Ventricular Outflow Tract and Pulmonary Valve:</p> <p>There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.</p> <p>Aorta:</p> <p>The peak systolic gradient recorded in the descending aorta is 7 mmHg. The aortic arch is free of obstruction. The Vp in the descending aorta is 1.3 m/sec.</p>

<u>Date</u>	<u>Test</u>	EXHIBIT NO. B9F PAGE: 38 OF 90 Pulmonary Arteries: The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal. Ductus Arteriosus: There is no evidence of ductus arteriosus patency. Coronary Arteries: The coronary arteries were not evaluated. Aortic Valve Doppler: Peak velocity: 1.50 m/sec Ao ascending Vmax 1.48 m/sec Ao descending Vmax 1.30 m/sec Peak gradient 9.00 mmHg Electronically signed by Joelle Miller, MD Signature Date/Time: 11/18/2016/5:57:05 PM *** Final ***									
10/06/2015	ECHO PEDIATRIC 2D-COLOR LIMITED/FOLLOW-UP	Performing Organization MUSE	Address City/State/Zipcode Phone Number								
10/06/2015	ECHO LVEF	Value: 50 to 55% Text: ECHO LVEF 50 to 55%	MUSE								
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Component	Value	Ref Range	Performed At								
ECHO LVEF	50 to 55%	Narrative	MUSE								
		Patient Name: NEVAEH HOPE ADAMS Date of Exam: 10/6/2015 MPI: 3636998 Accn #: 312091912 Site Name: Carilion New River Valley MRN: 355228									

<u>Date</u>	<u>Test</u>		EXHIBIT NO. B9F PAGE: 39 OF 90
		<p>Medical Center IAC Accredited Lab</p> <p>Date of Birth: 7/21/2015 Height:</p> <p>Patient Age: 2 months Weight:</p> <p>Patient Gender: F BSA:</p> <p>Authorizing Provider: 720037 JOELLE D MILLER BP: 90/</p> <p>Referring Provider: Sono grapher: Sonia Fitzwater</p> <p>Indication:</p> <p>Summary:</p> <ol style="list-style-type: none"> 1. Bicuspid aortic valve without stenosis or insufficiency. 2. The aortic arch is well seen and appears free of obstruction. 3. Normal PFO with tiny L>R shunt. 4. Normal biventricular size, thickness, and function. 5. No evidence of aortic coarctation. Normal flow in the descending aorta (1.24 m/sec). <p>Segmental Cardiotype, Cardiac Position, and Situs:</p> <p>(S,D,S). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.</p> <p>Pulmonary Veins:</p> <p>Four pulmonary veins drain to the left atrium.</p> <p>Atria:</p> <p>No atrial septal defect is detected. There is there is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.</p> <p>Mitral Valve:</p> <p>The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.</p> <p>Tricuspid Valve:</p> <p>The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.</p> <p>AV Canal/Complex Inlet/Single Ventricle:</p> <p>The crux of the heart is normal.</p> <p>Left Ventricle:</p> <p>Overall left ventricular ejection fraction is estimated at 50 to 55%.</p> <p>Right Ventricle:</p> <p>The right ventricle is normal in size. Right ventricular systolic function is normal.</p>	

<u>Date</u>	<u>Test</u>
	<p>Left Ventricular Outflow Tract and Aortic Valve:</p> <p>There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency.</p> <p>Right Ventricular Outflow Tract and Pulmonary Valve:</p> <p>There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.</p> <p>Aorta:</p> <p>No evidence of aortic coarctation. Normal flow in the descending aorta (1.24 m/sec).</p> <p>Pulmonary Arteries:</p> <p>The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal.</p> <p>Ductus Arteriosus:</p> <p>There is no evidence of ductus arteriosus patency.</p> <p>2-Dimensional:</p> <p>AoV annulus, s: 1.00 cm</p> <p>Ao sinus, s: 1.40 cm</p> <p>Ao asc, s: 0.50 cm</p> <p>Ao arch, proximal transv s: 0.60 cm</p> <p>Ao arch, distal transv s: 0.50 cm</p> <p>Aortic Valve Doppler:</p> <p>Peak velocity: 1.00 m/sec</p> <p>Peak gradient 4.00 mmHg</p> <p>Electronically signed by Joelle Miller, MD</p> <p>Signature Date/Time: 10/6/2015/3:03:34 PM</p> <p>*** Final ***</p> <p style="text-align: center;">Procedure Note</p> <p>Edicardi - 10/06/2015 3:03 PM EDT</p> <p>Carilion New River Valley Medical Center</p> <p>IAC Accredited Lab</p> <p>PEDIATRIC ECHOCARDIOGRAM REPORT</p> <hr/> <p>-----</p> <p>-----</p> <p>Patient Name: NEVAEH HOPE ADAMS Date of Exam:</p>

<u>Date</u>	<u>Test</u>
	<p>10/6/2015</p> <p>MPI: 3636998 Accn #: 312091912</p> <p>Site Name: Carilion New River Valley MRN: 355228</p> <p>Medical Center</p> <p>IAC Accredited Lab</p> <p>Date of Birth: 7/21/2015 Height:</p> <p>Patient Age: 2 months Weight:</p> <p>Patient Gender: F BSA:</p> <p>Authorizing Provider: 720037 JOELLE D MILLER BP: 90/</p> <p>Referring Provider: Sonographer: Sonia Fitzwater</p> <p>Indication:</p> <p>Summary:</p> <ul style="list-style-type: none"> 1. Bicuspid aortic valve without stenosis or insufficiency. 2. The aortic arch is well seen and appears free of obstruction. 3. Normal PFO with tiny L>R shunt. 4. Normal biventricular size, thickness, and function. 5. No evidence of aortic coarctation. Normal flow in the descending aorta (1.24 m/sec). <p>Segmental Cardiotype, Cardiac Position, and Situs:</p> <p>\(S,D,S\). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.</p> <p>Pulmonary Veins:</p> <p>Four pulmonary veins drain to the left atrium.</p> <p>Atria:</p> <p>No atrial septal defect is detected. There is there is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.</p> <p>Mitral Valve:</p> <p>The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of</p>

<u>Date</u>	<u>Test</u>
	<p>mitral valve insufficiency.</p> <p>EXHIBIT NO. B9F PAGE: 42 OF 90</p> <p>Tricuspid Valve:</p> <p>The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.</p> <p>AV Canal/Complex Inlet/Single Ventricle:</p> <p>The crux of the heart is normal.</p> <p>Left Ventricle:</p> <p>Overall left ventricular ejection fraction is estimated at 50 to 55%.</p> <p>Right Ventricle:</p> <p>The right ventricle is normal in size. Right ventricular systolic function is normal.</p> <p>Left Ventricular Outflow Tract and Aortic Valve:</p> <p>There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency.</p> <p>Right Ventricular Outflow Tract and Pulmonary Valve:</p> <p>There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.</p> <p>Aorta:</p> <p>No evidence of aortic coarctation. Normal flow in the descending aorta (1.24 m/sec).</p> <p>Pulmonary Arteries:</p> <p>The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal.</p> <p>Ductus Arteriosus:</p> <p>There is no evidence of ductus arteriosus patency.</p> <p>2-Dimensional:</p> <p>AoV annulus, s: 1.00 cm</p> <p>Ao sinus, s: 1.40 cm</p> <p>Ao asc, s: 0.50 cm</p> <p>Ao arch, proximal transv s: 0.60 cm</p>

<u>Date</u>	<u>Test</u>		EXHIBIT NO. B9F PAGE: 43 OF 90								
		<p>Ao arch, distal transv s: 0.50 cm</p> <p>Aortic Valve Doppler:</p> <p>Peak velocity: 1.00 m/sec</p> <p>Peak gradient 4.00 mmHg</p> <p>Electronically signed by Joelle Miller, MD</p> <p>Signature Date/Time: 10/6/2015/3:03:34 PM</p> <p>*** Final ***</p> <table> <thead> <tr> <th>Performing Organization</th> <th>Address</th> <th>City/State/Zipcode</th> <th>Phone Number</th> </tr> </thead> <tbody> <tr> <td>MUSE</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Performing Organization	Address	City/State/Zipcode	Phone Number	MUSE				
Performing Organization	Address	City/State/Zipcode	Phone Number								
MUSE											
08/03/2015	CHROMOSOME ANALYSIS, BLOOD (Q2631)	<p>Associated Procedure: CHROMOSOME ANALYSIS, BLOOD (Q2631)</p> <p>Text: CHROMOSOME ANALYSIS, BLOOD (Q2631) (07/22/2015 12:15 AM)</p> <table> <thead> <tr> <th>Component</th> <th>Value</th> <th>Ref Range</th> <th>Performed At</th> </tr> </thead> <tbody> <tr> <td>Chromosome Analysis, Blood (Note)</td> <td>REPORT</td> <td></td> <td>CARILION LABS</td> </tr> </tbody> </table> <p>CYTOGENETIC RESULTS</p> <p>Cytogenetic Reference #: CB-15-013012 Test Setup Date: 07/24/2015 Test Completion Date: 08/03/2015 Specimen Source: Peripheral Blood Clinical History: Rule out Turner syndrome Culture Type: PHA stimulated whole blood Metaphases Counted: 20 Analyzed: 5 Karyotyped: 2 Banding Level (G-bands): >= 550 KARYOTYPE: 45,X INTERPRETATION and COMMENTS: Abnormal female karyotype, consistent with the clinical diagnosis of Turner syndrome. An abnormal female chromosome complement with a single X chromosome (monosomy X) was observed in all metaphases. An additional 10 cells were scored for sex chromosome complement only. All cells had a single X chromosome. This study rules out the presence of a 10% mosaicism for a second cell line (normal or abnormal) with a differing sex chromosome complement at a 95% confidence limit. Genetic counseling is recommended. Electronic Signature on File</p>	Component	Value	Ref Range	Performed At	Chromosome Analysis, Blood (Note)	REPORT		CARILION LABS	Jie Xu, Ph.D., FCCMG, DABMG
Component	Value	Ref Range	Performed At								
Chromosome Analysis, Blood (Note)	REPORT		CARILION LABS								

Date	Test		
	Results Received	Technical Director, Cytogenetics, 703-802-7156 08/03/15 (Note) Reference lab accession: CB15013012EC For more information on this test, go to http://education.questdiagnostics.com/faq/chromsblood Test Performed by Quest, Chantilly, Quest Diagnostics Nichols Institute, 14225 Newbrook Drive, Chantilly, VA 20151 Patrick W Mason, M.D., Ph.D., Director of Laboratories (703) 802-6900, CLIA 49D0221801	EXHIBIT NO. B9F <small>CARILION LABS</small> PAGE: 44 OF 90
	Clinical Indication	clinical features of Turner syndrome Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Bellevue at Jefferson Street, Roanoke, VA 24014	CARILION LABS
Specimen			
	Blood, Venous	Performing Organization CARILION LABS CARILION LABS	Address City/State/Zipcode Phone Number Roanoke, VA
Chromosome Analysis, Blood	<p>Text: Chromosome Analysis, Blood</p> <p>REPORT (Note)</p> <p>CYTOGENETIC RESULTS Cytogenetic Reference #: CB-15-013012 Test Setup Date: 07/24/2015 Test Completion Date: 08/03/2015 Specimen Source: Peripheral Blood Clinical History: Rule out Turner syndrome Culture Type: PHA stimulated whole blood Metaphases Counted: 20 Analyzed: 5 Karyotyped: 2 Banding Level (G-bands): >=550 KARYOTYPE: 45,X INTERPRETATION and COMMENTS: Abnormal female karyotype, consistent with the clinical diagnosis of Turner syndrome. An abnormal female chromosome complement with a single X chromosome (monosomy X) was observed in all metaphases. An additional 10 cells were scored for sex chromosome complement only. All cells had a single X chromosome. This study rules out the presence of a 10% mosaicism for a second cell line (normal or abnormal) with a differing sex chromosome complement at a 95% confidence limit. Genetic counseling is recommended. Electronic Signature on File</p> <hr/> <p>Jie Xu, Ph.D., FCCMG, DABMG Technical Director, Cytogenetics, 703-802-7156</p>	CARILION LABS	
Clinical Indication	<p>Text: Clinical Indication</p> <p>clinical features of Turner syndrome Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Bellevue at Jefferson Street, Roanoke, VA 24014</p>	CARILION LABS	

Date	Test	EXHIBIT NO. B9F CARILION LABS PAGE: 45 OF 90			
	Results Received	Text: Results Received 08/03/15 (Note) Reference lab accession: CB15013012EC For more information on this test, go to http://education.questdiagnostics.com/faq/chr_omsblood Test Performed by Quest, Chantilly, Quest Diagnostics Nichols Institute, 14225 Newbrook Drive, Chantilly, VA 20151 Patrick W Mason, M.D., Ph.D., Director of Laboratories (703) 802-6900, CLIA 49D0221801			
07/24/2015	ECHO PEDIATRIC COMPLETE				
	ECHO LVEF	Value: 60 to 65%	Text: ECHO LVEF	60 to 65%	MUSE
	Associated Procedure: ECHO PEDIATRIC COMPLETE	Text: ECHO PEDIATRIC COMPLETE (07/24/2015 9:49 AM)	Component	Value	Ref Range
		ECHO LVEF	60 to 65%		MUSE
		Narrative			
		Carilion Roanoke Memorial Hospital			
		IAC Accredited Lab			
		PEDIATRIC ECHOCARDIOGRAM REPORT			
		<hr/>			
		Patient Name: BABY GIRL(KELLI) A Date of Exam: 7/24/2015			
		ADAMS			
		MPI: 3636998 Accn #: 111969955			
		Site Name: Carilion Roanoke MRN: 932097			
		Memorial Hospital			
		IAC Accredited Lab			
		Date of Birth: 7/21/2015 Height: 20.5 in			
		Patient Age: 3 days Weight: 7.0 lb			
		Patient Gender: F BSA: 0.21 m ²			
		Authorizing Provider: 701466 JAMES M SHERMAN BP: 50/30			
		JR			
		Referring Provider: Sonographer: Marguerite Underwood			
		Indication: Turner's syndrome, evaluate for coarctation.			
		Summary: 1. Suspected Turner Syndrome. 2. Bicuspid aortic valve without stenosis or insufficiency. 3. The left ventricle is normal in size, thickness, and function.			

Date	Test
	<p>4. No obstruction of the aortic arch. Vp= 1.8 m/sec in the descending aorta. There is mild straightening and hypoplasia of the transverse arch. The isthmus is well seen and appears free of obstruction</p> <p>The distal transverse arch measures 0.4 cm, the isthmus measures 0.36 cm</p> <p>The Vp in the descending aorta is 1.8m/sec (range = 1.4-1.8)</p> <p>The PDA has closed completely.</p> <p>5. Mild, functional peripheral pulmonary stenosis.</p> <p>Segmental Cardiotype, Cardiac Position, and Situs:</p> <p>(S,D,S). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.</p> <p>Systemic Veins:</p> <p>The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.</p> <p>Pulmonary Veins:</p> <p>Four pulmonary veins drain to the left atrium.</p> <p>Atria:</p> <p>No atrial septal defect is detected. There is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.</p> <p>Mitral Valve:</p> <p>The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.</p> <p>Tricuspid Valve:</p> <p>The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.</p> <p>AV Canal/Complex Inlet/Single Ventricle:</p> <p>The crux of the heart is normal.</p> <p>Left Ventricle:</p> <p>Overall left ventricular ejection fraction is estimated at 60 to 65%.</p> <p>Right Ventricle:</p> <p>The right ventricle is borderline hypertrophied.</p> <p>Conotruncal Anatomy:</p> <p>The outflow tracts cross in the usual manner.</p> <p>Left Ventricular Outflow Tract and Aortic Valve:</p> <p>There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency.</p> <p>Right Ventricular Outflow Tract and Pulmonary Valve:</p>

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Date	Test
	<p>There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.</p> <p>EXHIBIT NO. B9F PAGE 47 OF 90</p> <p>Aorta:</p> <p>No obstruction of the aortic arch. Vp= 1.8 m/sec in the descending aorta.</p> <p>there is mild straightening and hypoplasia of the transverse arch. The isthmus is well seen and appears free of obstruction</p> <p>The distal transverse arch measures 0.4 cm, the isthmus measures 0.36 cm</p> <p>The Vp in the descending aorta is 1.8m/sec (range = 1.4-1.8)</p> <p>The PDA has closed completely.</p> <p>Pulmonary Arteries:</p> <p>The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal. Mild, functional peripheral pulmonary stenosis.</p> <p>Ductus Arteriosus:</p> <p>There is no evidence of ductus arteriosus patency. Completely closed.</p> <p>Coronary Arteries:</p> <p>The proximal coronary arteries appear to be normal.</p> <p>M-mode:</p> <p>RVIDd: 0.98 cm</p> <p>IVSd: 0.35 cm</p> <p>LVIDd: 1.21 cm</p> <p>LVIDs: 0.99 cm</p> <p>LVPWd: 0.38 cm</p> <p>LV mass (ASE corr.): 5 g</p> <p>LV mass index: 33.24 g/ht^2.7</p> <p>LA diam Systole 1.40 cm</p> <p>AoV Cusp Sep Syst 0.60 cm</p> <p>Z-score</p> <p>IVSd: -0.19</p> <p>LVIDd: -4.19</p> <p>LVIDs: -1.13</p> <p>LVPWd: 1.43</p> <p>Systolic Function:</p> <p>LV SF (M-mode): 18 %</p> <p>LV EF (M-mode): 42 %</p> <p>*Calculated EF may differ from visual estimation*</p>

<u>Date</u>	<u>Test</u>
	<p>LVOT Doppler:</p> <p>Peak velocity: 0.49 m/s</p> <p>Peak gradient: 1 mmHg</p> <p>Aortic Valve Doppler:</p> <p>Peak velocity: 0.84 m/sec</p> <p>Ao descending Vmax 1.88 m/sec</p> <p>Peak gradient 2.85 mmHg</p> <p>Pulmonary Valve Doppler:</p> <p>Peak velocity: 0.70 m/sec</p> <p>Peak gradient: 1.97 mmHg</p> <p>Pulmonary Arteries Doppler:</p> <p>LPA peak velocity: 1.49 m/s</p> <p>LPA peak gradient: 8.88 mmHg</p> <p>RPA peak velocity: 1.53 m/s</p> <p>RPA peak gradient: 9.36 mmHg</p> <p>Electronically signed by Joelle Miller, MD</p> <p>Signature Date/Time: 7/24/2015/10:04:34 AM</p> <p>*** Final ***</p> <p style="text-align: center;">Procedure Note</p> <p>Edicardi - 07/24/2015 10:04 AM EDT</p> <p>Carilion Roanoke Memorial Hospital</p> <p>IAC Accredited Lab</p> <p>PEDIATRIC ECHOCARDIOGRAM REPORT</p> <hr/> <p>-----</p> <p>Patient Name: BABY GIRL(KELLI) A Date of Exam: 7/24/2015</p> <p>ADAMS</p> <p>MPI: 3636998 Accn #: 111969955</p> <p>Site Name: Carilion Roanoke MRN: 932097</p> <p>Memorial Hospital</p> <p>IAC Accredited Lab</p> <p>Date of Birth: 7/21/2015 Height: 20.5 in</p>

<u>Date</u>	<u>Test</u>
	<p>Patient Age: 3 days Weight: 7.0 lb Patient Gender: F BSA: 0.21 m² Authorizing Provider: 701466 JAMES M SHERMAN BP: 50/30 JR Referring Provider: Sonographer: Marguerite Underwood Indication: Turner's syndrome, evaluate for coarctation.</p> <p>Summary:</p> <ol style="list-style-type: none"> 1. Suspected Turner Syndrome. 2. Bicuspid aortic valve without stenosis or insufficiency. 3. The left ventricle is normal in size, thickness, and function. 4. No obstruction of the aortic arch. Vp= 1.8 m/sec in the descending aorta. there is mild straightening and hypoplasia of the transverse arch. The isthmus is well seen and appears free of obstruction The distal transverse arch measures 0.4 cm, the isthmus measures 0.36 cm The Vp in the descending aorta is 1.8m/sec (range = 1.4-1.8) The PDA has closed completely. 5. Mild, functional peripheral pulmonary stenosis. <p>Segmental Cardiotype, Cardiac Position, and Situs: \{S,D,S\}. The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.</p> <p>Systemic Veins: The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.</p> <p>Pulmonary Veins: Four pulmonary veins drain to the left atrium.</p> <p>Atria:</p>

Date	Test
	<p>No atrial septal defect is detected. There is there is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.</p> <p>Mitral Valve:</p> <p>The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.</p> <p>Tricuspid Valve:</p> <p>The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.</p> <p>AV Canal/Complex Inlet/Single Ventricle:</p> <p>The crux of the heart is normal.</p> <p>Left Ventricle:</p> <p>Overall left ventricular ejection fraction is estimated at 60 to 65%.</p> <p>Right Ventricle:</p> <p>The right ventricle is borderline hypertrophied.</p> <p>Conotruncal Anatomy:</p> <p>The outflow tracts cross in the usual manner.</p> <p>Left Ventricular Outflow Tract and Aortic Valve:</p> <p>There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency.</p> <p>Right Ventricular Outflow Tract and Pulmonary Valve:</p> <p>There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.</p> <p>Aorta:</p> <p>No obstruction of the aortic arch. Vp= 1.8 m/sec in the descending aorta.</p> <p>there is mild straightening and hypoplasia of the transverse arch. The isthmus is well seen and appears free of obstruction</p> <p>The distal transverse arch measures 0.4 cm, the isthmus measures 0.36 cm</p> <p>The Vp in the descending aorta is 1.8m/sec (range = 1.4-1.8)</p>

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<u>Date</u>	<u>Test</u>	
		<p>The PDA has closed completely.</p> <p>EXHIBIT NO. B9F PAGE: 51 OF 90</p> <p>Pulmonary Arteries:</p> <p>The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal. Mild, functional peripheral pulmonary stenosis.</p> <p>Ductus Arteriosus:</p> <p>There is no evidence of ductus arteriosus patency. Completely closed.</p> <p>Coronary Arteries:</p> <p>The proximal coronary arteries appear to be normal.</p> <p>M-mode:</p> <p>RVIDd: 0.98 cm</p> <p>IVSd: 0.35 cm</p> <p>LVIDd: 1.21 cm</p> <p>LVIDs: 0.99 cm</p> <p>LVPWd: 0.38 cm</p> <p>LV mass (ASE corr.): 5 g</p> <p>LV mass index: 33.24 g/ht^2.7</p> <p>LA diam Systole 1.40 cm</p> <p>AoV Cusp Sep Syst 0.60 cm</p> <p>Z-score</p> <p>IVSd: -0.19</p> <p>LVIDd: -4.19</p> <p>LVIDs: -1.13</p> <p>LVPWd: 1.43</p> <p>Systolic Function:</p> <p>LV SF (M-mode): 18 %</p> <p>LV EF (M-mode): 42 %</p> <p>*Calculated EF may differ from visual estimation*</p> <p>LVOT Doppler:</p> <p>Peak velocity: 0.49 m/s</p>

<u>Date</u>	<u>Test</u>	Peak gradient: 1 mmHg Aortic Valve Doppler: Peak velocity: 0.84 m/sec Ao descending Vmax 1.88 m/sec Peak gradient 2.85 mmHg Pulmonary Valve Doppler: Peak velocity: 0.70 m/sec Peak gradient: 1.97 mmHg Pulmonary Arteries Doppler: LPA peak velocity: 1.49 m/s LPA peak gradient: 8.88 mmHg RPA peak velocity: 1.53 m/s RPA peak gradient: 9.36 mmHg Electronically signed by Joelle Miller, MD Signature Date/Time: 7/24/2015/10:04:34 AM	EXHIBIT NO. B9F PAGE: 52 OF 90																												
07/24/2015	Bilirub SerPl-mCnc	*** Final *** <table> <thead> <tr> <th>Performing Organization</th> <th>Address</th> <th>City/State/Zipcode</th> <th>Phone Number</th> </tr> </thead> <tbody> <tr> <td>MUSE</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Performing Organization	Address	City/State/Zipcode	Phone Number	MUSE																								
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MUSE																															
	Associated Procedure: Bilirub SerPl-mCnc	<p>Text: BILIRUBIN TOTAL (BILT) (07/24/2015 12:12 AM)</p> <table> <thead> <tr> <th>Component</th> <th>Value</th> <th>Ref Range</th> <th>Performed At</th> </tr> </thead> <tbody> <tr> <td>Total Bilirubin</td> <td>10.8</td> <td><12.0 MG/DL</td> <td>CARILION LABS</td> </tr> </tbody> </table> <p>Comment: Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Bellevue at Jefferson Street, Roanoke, VA 24014</p> <table> <thead> <tr> <th>Specimen</th> <th></th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>Blood, Venous</td> <td></td> <td></td> <td></td> </tr> <tr> <th>Performing Organization</th> <th>Address</th> <th>City/State/Zipcode</th> <th>Phone Number</th> </tr> <tr> <td>CARILION LABS</td> <td></td> <td></td> <td></td> </tr> <tr> <td>CARILION LABS</td> <td></td> <td>Roanoke, VA</td> <td></td> </tr> </tbody> </table>	Component	Value	Ref Range	Performed At	Total Bilirubin	10.8	<12.0 MG/DL	CARILION LABS	Specimen				Blood, Venous				Performing Organization	Address	City/State/Zipcode	Phone Number	CARILION LABS				CARILION LABS		Roanoke, VA		
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Date	Test	Total Bilirubin 10.8 Comment: Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Belleview at Jefferson Street, Roanoke, VA 24014	EXHIBIT NO. B9F 120 CARILION MC/PL LABS PAGE: 53 OF 90								
07/22/2015	ECHO PEDIATRIC COMPLETE										
	ECHO LVEF	Value: 65 to 70% Text: ECHO LVEF 65 to 70% MUSE									
	Associated Procedure: ECHO PEDIATRIC COMPLETE	Text: ECHO PEDIATRIC COMPLETE (07/22/2015 12:06 PM) <table> <thead> <tr> <th>Component</th> <th>Value</th> <th>Ref Range</th> <th>Performed At</th> </tr> </thead> <tbody> <tr> <td>ECHO LVEF</td> <td>65 to 70%</td> <td>MUSE</td> <td>MUSE</td> </tr> </tbody> </table> <p>Narrative Carilion Roanoke Memorial Hospital IAC Accredited Lab PEDIATRIC ECHOCARDIOGRAM REPORT</p> <hr/> <p>Patient Name: BABY GIRL(KELLI) A ADAMS Date of Exam: 7/22/2015</p> <p>MPI: 3636998 Accn #: 111966142</p> <p>Site Name: Carilion Roanoke Memorial Hospital MRN: 932097</p> <p>IAC Accredited Lab</p> <p>Date of Birth: 7/21/2015 Height: 21.0 in</p> <p>Patient Age: 1 day Weight: 7.4 lb</p> <p>Patient Gender: F BSA: 0.21 m²</p> <p>Authorizing Provider: 701466 JAMES M SHERMAN JR BP: 50/30</p> <p>Referring Provider: Sherman MD. Sonographer: DF</p> <p>Indication: Turner Syndrome.</p> <p>Summary:</p> <ol style="list-style-type: none"> 1. Mild RV hypertrophy with normal systolic function. 2. The left ventricular size, thickness, and function is normal. 3. Moderate PDA with predominant L>R shunt. there is transient R>L shunting is noted. on doppler mapping. 4. Bicuspid aortic valve with normal function. No stenosis or insufficiency. The commissures are at the 3:00 and 9:00 positions. 5. The aortic arch is closely inspected. <p>No obstruction is noted at the time of this study. The distal transverse arch measures 3.3 mm and appears mildly hypoplastic.</p>	Component	Value	Ref Range	Performed At	ECHO LVEF	65 to 70%	MUSE	MUSE	
Component	Value	Ref Range	Performed At								
ECHO LVEF	65 to 70%	MUSE	MUSE								

Date	Test
	<p>There is mild flow acceleration at the level fo the isthmus. The $V_{p,1}$ is 2.1 m/sec.</p> <p>EXHIBIT NO. B9F PAGE: 54 OF 90</p> <p>The ductus arteriosus is patent and appears moderate in size. No obstruction is seen at the level of the isthmus. (measures 5.3 mm).</p> <p>6. Aortic sino-tubular junction dimension (systole) = 0.70 cm (z = -0.64).</p> <p>7. Aortic sinuses of Valsalva dimension (systole) = 0.84 cm (z = -1.32).</p> <p>8. Ascending aorta dimension (systole) = 0.4 cm.</p> <p>9. Descending thoracic aorta systolic dimension (distal to the isthmus) = 0.50 cm (z = -1.06).</p> <p>10. Distal transverse aortic arch dimension (systole) = 0.33 cm.</p> <p>Segmental Cardiotype, Cardiac Position, and Situs:</p> <p>\(S,D,S\). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.</p> <p>Systemic Veins:</p> <p>The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.</p> <p>Pulmonary Veins:</p> <p>Four pulmonary veins drain to the left atrium.</p> <p>Atria:</p> <p>No atrial septal defect is detected. There is there is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.</p> <p>Mitral Valve:</p> <p>The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.</p> <p>Tricuspid Valve:</p> <p>The tricuspid valve is normal. There is normal laminar forward flow. There is mild tricuspid valve regurgitation.</p> <p>AV Canal/Complex Inlet/Single Ventricle:</p> <p>The crux of the heart is normal.</p> <p>Left Ventricle:</p> <p>Overall left ventricular ejection fraction is estimated at 65 to 70%.</p> <p>Right Ventricle:</p> <p>The right ventricle is borderline dilated. Right ventricular systolic function is normal.</p> <p>Left Ventricular Outflow Tract and Aortic Valve:</p> <p>There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency. Bicuspid aortic valve with normal function. No</p>

Date	Test
	<p>stenosis or insufficiency. The commissures are at the 3:00 and 9:00 positions.</p> <p>EXHIBIT NO. B9F PAGE: 55 OF 90</p> <p>Right Ventricular Outflow Tract and Pulmonary Valve:</p> <p>There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.</p> <p>Aorta:</p> <p>The aortic sinuses of Valsalva systolic dimension is 0.84 cm ($z = -1.32$). The aortic sino-tubular junction dimension (systole) is 0.70 cm ($z = -0.64$). The ascending aorta dimension (systole) is 0.4 cm. The distal transverse aortic arch dimension (systole) is 0.33 cm. The descending thoracic aorta systolic dimension (distal to the isthmus) is 0.50 cm ($z = -1.06$). The aortic arch is closely inspected.</p> <p>No obstruction is noted at the time of this study. The distal transverse arch measures 3.3 mm and appears mildly hypoplastic.</p> <p>There is mild flow acceleration at the level fo the isthmus. The V_p is 2.1 m/sec.</p> <p>The ductus arteriosus is patent and appears moderate in size. No obstruction is seen at the level of the isthmus. (measures 5.3 mm).</p> <p>Ductus Arteriosus:</p> <p>A patent ductus arteriosus is present The shunt is predominantly left to right, moderate-size. Moderate PDA with predominant L>R shunt. there is transient R>L shunting is noted. on doppler mapping.</p> <p>Coronary Arteries:</p> <p>The proximal coronary arteries appear to be normal.</p> <p>M-mode:</p> <p>RVIDd: 0.92 cm</p> <p>IVSd: 0.38 cm</p> <p>LVIDd: 1.50 cm</p> <p>LVIDs: 0.78 cm</p> <p>LVPWd: 0.35 cm</p> <p>LV mass (ASE corr.): 7 g</p> <p>LV mass index: 43.95 g/$ht^{2.7}$</p> <p>LA diam Systole 1.60 cm</p> <p>AoV Cusp Sep Syst 0.60 cm</p> <p>Z-score</p> <p>IVSd: 0.17</p> <p>LVIDd: -2.21</p> <p>LVIDs: -3.14</p> <p>LVPWd: 1.01</p> <p>2-Dimensional: z-score</p> <p>Ao sinus, s: 0.84 cm -1.32</p>

<u>Date</u>	<u>Test</u>	
		<p>Ao ST junct, s: 0.70 cm -0.64</p> <p>Ao asc, s: 0.44 cm</p> <p>Ao arch, distal transv s: 0.33 cm</p> <p>Ao isthmus, s: 0.53 cm</p> <p>Ao desc, thoracic s: 0.50 cm -1.06</p> <p>Systolic Function:</p> <p>LV SF (M-mode): 48 %</p> <p>LV EF (M-mode): 83 %</p> <p>*Calculated EF may differ from visual estimation*</p> <p>LVOT Doppler:</p> <p>Peak velocity: 0.66 m/s</p> <p>Peak gradient: 2 mmHg</p> <p>Aortic Valve Doppler:</p> <p>Peak velocity: 0.85 m/sec</p> <p>Ao descending Vmax 2.10 m/sec</p> <p>Peak gradient 2.91 mmHg</p> <p>PDA Vmax 1.12 m/sec</p> <p>PDA diam 3.0 mm</p> <p>Pulmonary Valve Doppler:</p> <p>Peak velocity: 0.60 m/sec</p> <p>Peak gradient: 1.46 mmHg</p> <p>Pulmonary Arteries Doppler:</p> <p>MPA peak velocity: 0.74 m/s</p> <p>MPA peak gradient: 2.17 mmHg</p> <p>LPA peak velocity: 0.63 m/s</p> <p>LPA peak gradient: 1.57 mmHg</p> <p>RPA peak velocity: 0.90 m/s</p> <p>RPA peak gradient: 3.28 mmHg</p> <p>Electronically signed by Joelle Miller, MD</p> <p>Signature Date/Time: 7/22/2015/12:17:35 PM</p> <p>*** Final ***</p> <p style="text-align: right;">Procedure Note</p> <p>Edicardi - 07/22/2015 12:17 PM EDT</p> <p>Carilion Roanoke Memorial Hospital</p>

<u>Date</u>	<u>Test</u>	
	<p>IAC Accredited Lab</p> <p>PEDIATRIC ECHOCARDIOGRAM REPORT</p> <hr/> <p>-----</p> <p>Patient Name: BABY GIRL(KELLI) A ADAMS Date of Exam: 7/22/2015</p> <p>MPI: 3636998 Accn #: 111966142</p> <p>Site Name: Carilion Roanoke Memorial Hospital MRN: 932097</p> <p>IAC Accredited Lab</p> <p>Date of Birth: 7/21/2015 Height: 21.0 in</p> <p>Patient Age: 1 day Weight: 7.4 lb</p> <p>Patient Gender: F BSA: 0.21 m²</p> <p>Authorizing Provider: 701466 JAMES M SHERMAN JR BP: 50/30</p> <p>Referring Provider: Sherman MD. Sonographer: DF</p> <p>Indication: Turner Syndrome.</p> <p>Summary:</p> <ol style="list-style-type: none"> 1. Mild RV hypertrophy with normal systolic function. 2. The left ventricular size, thickness, and function is normal. 3. Moderate PDA with predominant L>R shunt. there is transient R>L shunting is noted. on doppler mapping. 4. Bicuspid aortic valve with normal function. No stenosis or insufficiency. The commissures are at the 3:00 and 9:00 positions. 5. The aortic arch is closely inspected. <p>No obstruction is noted at the time of this study. The distal transverse arch measures 3.3 mm and appears mildly hypoplastic.</p> <p>There is mild flow acceleration at the level fo the isthmus. The Vp is 2.1 m/sec.</p> <p>The ductus arteriosus is patent and appears moderate in size. No</p>	EXHIBIT NO. B9F PAGE: 57 OF 90

Date	Test
	<p>obstruction is seen at the level of the isthmus. (measures 5.3 mm).</p> <p>6. Aortic sino-tubular junction dimension (systole) = 0.70 cm (z = -0.64).</p> <p>7. Aortic sinuses of Valsalva dimension (systole) = 0.84 cm (z = -1.32).</p> <p>8. Ascending aorta dimension (systole) = 0.4 cm.</p> <p>9. Descending thoracic aorta systolic dimension (distal to the isthmus) = 0.50 cm (z = -1.06).</p> <p>10. Distal transverse aortic arch dimension (systole) = 0.33 cm.</p> <p>Segmental Cardiotype, Cardiac Position, and Situs: \(S,D,S\). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.</p> <p>Systemic Veins: The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.</p> <p>Pulmonary Veins: Four pulmonary veins drain to the left atrium.</p> <p>Atria: No atrial septal defect is detected. There is there is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.</p> <p>Mitral Valve: The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.</p> <p>Tricuspid Valve: The tricuspid valve is normal. There is normal laminar forward flow. There is mild tricuspid valve regurgitation.</p> <p>AV Canal/Complex Inlet/Single Ventricle: The crux of the heart is normal.</p> <p>Left Ventricle: Overall left ventricular ejection fraction is estimated at 65 to 70%.</p>

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PAGE: 58 OF 90**

<u>Date</u>	<u>Test</u>	
		<p style="text-align: right;">EXHIBIT NO. B9F PAGE: 59 OF 90</p> <p>Right Ventricle:</p> <p>The right ventricle is borderline dilated. Right ventricular systolic function is normal.</p> <p>Left Ventricular Outflow Tract and Aortic Valve:</p> <p>There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency. Bicuspid aortic valve with normal function. No stenosis or insufficiency. The commissures are at the 3:00 and 9:00 positions.</p> <p>Right Ventricular Outflow Tract and Pulmonary Valve:</p> <p>There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.</p> <p>Aorta:</p> <p>The aortic sinuses of Valsalva systolic dimension is 0.84 cm (z = -1.32). The aortic sino-tubular junction dimension (systole) is 0.70 cm (z = -0.64). The ascending aorta dimension (systole) is 0.4 cm. The distal transverse aortic arch dimension (systole) is 0.33 cm. The descending thoracic aorta systolic dimension (distal to the isthmus) is 0.50 cm (z = -1.06). The aortic arch is closely inspected.</p> <p>No obstruction is noted at the time of this study. The distal transverse arch measures 3.3 mm and appears mildly hypoplastic.</p> <p>There is mild flow acceleration at the level fo the isthmus. The Vp is 2.1 m/sec.</p> <p>The ductus arteriosus is patent and appears moderate in size. No obstruction is seen at the level of the isthmus. (measures 5.3 mm).</p> <p>Ductus Arteriosus:</p> <p>A patent ductus arteriosus is present. The shunt is predominantly left to right, moderate-size. Moderate PDA with predominant L>R shunt. there is transient R>L shunting is noted. on doppler mapping.</p> <p>Coronary Arteries:</p> <p>The proximal coronary arteries appear to be normal.</p> <p>M-mode:</p> <p>RVIDd: 0.92 cm</p> <p>IVSd: 0.38 cm</p> <p>LVIDd: 1.50 cm</p>

<u>Date</u>	<u>Test</u>	
	<p>LVIDs: 0.78 cm LVPWd: 0.35 cm LV mass (ASE corr.): 7 g LV mass index: 43.95 g/ht^2.7 LA diam Systole 1.60 cm AoV Cusp Sep Syst 0.60 cm Z-score IVSd: 0.17 LVIDd: -2.21 LVIDs: -3.14 LVPWd: 1.01 2-Dimensional: z-score Ao sinus, s: 0.84 cm -1.32 Ao ST junct, s: 0.70 cm -0.64 Ao asc, s: 0.44 cm Ao arch, distal transv s: 0.33 cm Ao isthmus, s: 0.53 cm Ao desc, thoracic s: 0.50 cm -1.06 Systolic Function: LV SF (M-mode): 48 % LV EF (M-mode): 83 % *Calculated EF may differ from visual estimation* LVOT Doppler: Peak velocity: 0.66 m/s Peak gradient: 2 mmHg Aortic Valve Doppler: Peak velocity: 0.85 m/sec Ao descending Vmax 2.10 m/sec Peak gradient 2.91 mmHg PDA Vmax 1.12 m/sec </p>	EXHIBIT NO. B9F PAGE: 60 OF 90

Date	Test	Performing Organization CARILION LABS CARILION LABS	Address Roanoke, VA	City/State/Zipcode Phone Number	EXHIBIT NO. B9F PAGE: 62 OF 90
	ABO/Rh	Value: O POS Text: ABO/Rh	O POS	CARILION LABS	
	DAT, Anti-IgG Coombs Serum	Text: DAT, Anti-IgG Coombs Serum	NEG Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Belleview at Jefferson Street, Roanoke, VA 24014	CARILION LABS	

Narrative Text

- PEDIATRIC ECHO-2D W OR WO M-MODE LIMITED (11/18/2016 2:43 PM)

Component	Value	Ref Range	Performed At
ECHO LVEF	60 to 65%		MUSE
			Performed At
Pediatric Cardiology Clinic			MUSE

IAC Accredited Lab

PEDIATRIC ECHOCARDIOGRAM REPORT

Patient Name: NEVAEH HOPE ADAMS Date of 11/18/2016

Exam:

MPI: 3636998 Acct #: 212783801

Site Name: Pediatric Cardiology MRN: 7444644

Clinic

IAC Accredited Lab

Date of Birth: 7/21/2015 Height: 11.0 in

Patient Age: 15 months Weight: 22.8 lb

Patient Gender: F BSA: 0.22 m²

Authorizing 720037 JOELLE D MILLER BP: 50/30

Provider:

Referring Provider: Miller Sonographer: Kimberly Coleman

RDCS

Indication: Bicuspid av.

Summary:

- Overall left ventricular ejection fraction is estimated at 60 to 65%.
- Normal biventricular size, thickness, and function.
- Bicuspid aortic valve with normal function.
- Normal aortic root, no coarctation or abnormal dilation noted.
- No shunts are seen at any level.

Narrative**Performed At****EXHIBIT NO. B9F
PAGE: 63 OF 90**

6. Commisures in the 3:00 and 9:00 positions.
 —No associated dilation of the aortic root. No stenosis or insufficiency.
7. The aortic arch is free of obstruction. The Vp in the descending aorta is 1.3 m/sec.
8. Peak systolic descending aorta gradient = 7 mmHg.

Segmental Cardiotype, Cardiac Position, and Situs:

(S,D,S). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.

Systemic Veins:

The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.

Pulmonary Veins:

Four pulmonary veins drain to the left atrium.

Atria:

No atrial septal defect is detected. There is no evidence of patent foramen ovale. The right atrium is normal in size. The left atrium is normal in size.

Mitral Valve:

The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.

Tricuspid Valve:

The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.

AV Canal/Complex Inlet/Single Ventricle:

The crux of the heart is normal.

Left Ventricle:

Overall left ventricular ejection fraction is estimated at 60 to 65%. The left ventricle is normal in size. Left ventricular systolic function is normal.

Right Ventricle:

The right ventricle is normal in size. Right ventricular systolic function is normal.

Left Ventricular Outflow Tract and Aortic Valve:

There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency. Commisures in the 3:00 and 9:00 positions.

No associated dilation of the aortic root. No stenosis or insufficiency.

Right Ventricular Outflow Tract and Pulmonary Valve:

There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.

Aorta:

The peak systolic gradient recorded in the descending aorta is 7 mmHg. The aortic arch is free of obstruction. The Vp in the descending aorta is 1.3 m/sec.

Narrative**Performed At****EXHIBIT NO. B9F
PAGE: 64 OF 90**

Pulmonary Arteries:

The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal.

Ductus Arteriosus:

There is no evidence of ductus arteriosus patency.

Coronary Arteries:

The coronary arteries were not evaluated.

Aortic Valve Doppler:

Peak velocity: 1.50 m/sec

Ao ascending Vmax 1.48 m/sec

Ao descending Vmax 1.30 m/sec

Peak gradient 9.00 mmHg

Electronically signed by Joelle Miller, MD

Signature Date/Time: 11/18/2016/5:57:05 PM

*** Final ***

Procedure Note

Edicardi 11/18/2016 5:57 PM EST

Pediatric Cardiology Clinic

IAC Accredited Lab

PEDIATRIC ECHOCARDIOGRAM REPORT

Patient Name: NEVAEH HOPE ADAMS Date of 11/18/2016

Exam:

MPI: 3636998 Acct #: 212783801

Site Name: Pediatric Cardiology MRN: 7444644

Clinic

IAC Accredited Lab

Date of Birth: 7/21/2015 Height: 11.0 in

Patient Age: 15 months Weight: 22.8 lb

Patient Gender: F BSA: 0.22 m²

Authorizing 720037 JOELLE D MILLER BP: 50/30

Procedure Note

Provider:

**EXHIBIT NO. B9F
PAGE: 65 OF 90**Referring Provider: Miller. Sonographer: Kimberly
Coleman

RDCS

Indication: Bicuspid av.

Summary:

1. Overall left ventricular ejection fraction is estimated at 60 to 65%.
2. Normal biventricular size, thickness, and function.
3. Bicuspid aortic valve with normal function.
4. Normal aortic root. No coarctation or abnormal dilation noted.
5. No shunts are seen at any level.
6. Commisures in the 3:00 and 9:00 positions.

No associated dilation of the aortic root. No stenosis or insufficiency.

7. The aortic arch is free of obstruction. The Vp in the descending aorta is 1.3 m/sec.
8. Peak systolic descending aorta gradient = 7 mmHg.

Segmental Cardiotype, Cardiac Position, and Situs:

\(S,D,S\). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.

Systemic Veins:

The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.

Pulmonary Veins:

Four pulmonary veins drain to the left atrium.

Atria:

No atrial septal defect is detected. There is no evidence of patent foramen ovale. The right atrium is normal in size. The left atrium is normal in size.

Mitral Valve:

The mitral valve is normal. There is normal laminar forward flow. The

Procedure Note

papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.

EXHIBIT NO. B9F
PAGE: 66 OF 90

Tricuspid Valve:

The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.

AV Canal/Complex Inlet/Single Ventricle:

The crux of the heart is normal.

Left Ventricle:

Overall left ventricular ejection fraction is estimated at 60 to 65%. The left ventricle is normal in size. Left ventricular systolic function is normal.

Right Ventricle:

The right ventricle is normal in size. Right ventricular systolic function is normal.

Left Ventricular Outflow Tract and Aortic Valve:

There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency. Commisures in the 3:00 and 9:00 positions.

No associated dilation of the aortic root. No stenosis or insufficiency.

Right Ventricular Outflow Tract and Pulmonary Valve:

There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.

Aorta:

The peak systolic gradient recorded in the descending aorta is 7 mmHg. The aortic arch is free of obstruction. The Vp in the descending aorta is 1.3 m/sec.

Pulmonary Arteries:

The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal.

Ductus Arteriosus:

There is no evidence of ductus arteriosus patency.

Coronary Arteries:

Procedure Note

The coronary arteries were not evaluated.

EXHIBIT NO. B9F
PAGE: 67 OF 90

Aortic Valve Doppler:

Peak velocity: 1.50 m/sec

Ao-ascending Vmax 1.48 m/sec

Ao-descending Vmax 1.30 m/sec

Peak gradient 9.00 mmHg

Electronically signed by Joelle Miller, MD

Signature Date/Time: 11/18/2016/5:57:05 PM

*** Final ***

Performing Organization	Address	City/State/Zipcode	Phone Number
MUSE			
• ECHO PEDIATRIC 2D-COLOR LIMITED/FOLLOW-UP (10/06/2015 1:58 PM)			
Component	Value	Ref Range	Performed At
ECHO LVEF	50 to 55%		MUSE
Carilion New River Valley Medical Center	Narrative		Performed At MUSE

IAC Accredited Lab

PEDIATRIC ECHOCARDIOGRAM REPORT

Patient Name: NEVAEH HOPE ADAMS Date of Exam: 10/6/2015

MPI: 3636998 Acn #: 312091912

Site Name: Carilion New River Valley MRN: 355228

Medical Center

IAC Accredited Lab

Date of Birth: 7/21/2015 Height:

Patient Age: 2 months Weight:

Patient Gender: F BSA:

Authorizing Provider: 720037 JOELLE D MILLER BP: 90/

Referring Provider: Sono-grapher: Sonia Fitzwater

Indication:

Summary:

1. Bicuspid aortic valve without stenosis or insufficiency.
2. The aortic arch is well seen and appears free of obstruction.

Narrative**Performed At****EXHIBIT NO. B9F
PAGE: 68 OF 90**

3. Normal PFO with tiny L>R shunt.
4. Normal biventricular size, thickness, and function.
5. No evidence of aortic coarctation. Normal flow in the descending aorta (1.24 m/sec).

Segmental Cardiotype, Cardiac Position, and Situs:

\(S,D,S\). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.

Pulmonary Veins:

Four pulmonary veins drain to the left atrium.

Atria:

No atrial septal defect is detected. There is there is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.

Mitral Valve:

The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.

Tricuspid Valve:

The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.

AV Canal/Complex Inlet/Single Ventricle:

The crux of the heart is normal.

Left Ventricle:

Overall left ventricular ejection fraction is estimated at 50 to 55%.

Right Ventricle:

The right ventricle is normal in size. Right ventricular systolic function is normal.

Left Ventricular Outflow Tract and Aortic Valve:

There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency.

Right Ventricular Outflow Tract and Pulmonary Valve:

There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.

Aorta:

No evidence of aortic coarctation. Normal flow in the descending aorta (1.24 m/sec).

Pulmonary Arteries:

The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal.

Ductus Arteriosus:

There is no evidence of ductus arteriosus patency.

2-Dimensional:

Narrative**Performed At****EXHIBIT NO. B9F
PAGE: 69 OF 90**

AoV annulus, s: 1.00 cm

Ao sinus, s: 1.40 cm

Ao asc, s: 0.50 cm

Ao arch, proximal transv s: 0.60 cm

Ao arch, distal transv s: 0.50 cm

Aortic Valve Doppler:

Peak velocity: 1.00 m/sec

Peak gradient 4.00 mmHg

Electronically signed by Joelle Miller, MD

Signature Date/Time: 10/6/2015/3:03:34 PM

*** Final *****Procedure Note**

Edicardi 10/06/2015 3:03 PM EDT

Carilion New River Valley Medical Center

IAC Accredited Lab

PEDIATRIC ECHOCARDIOGRAM REPORT

Patient Name: NEVAEH HOPE ADAMS Date of Exam:
10/6/2015MPI: 3636998 Accn #:
312091912

Site Name: Carilion New River Valley MRN: 355228

Medical Center

IAC Accredited Lab

Date of Birth: 7/21/2015 Height:

Patient Age: 2 months Weight:

Patient Gender: F BSA:

Authorizing Provider: 720037 JOELLE D MILLER BP: 90/

Referring Provider: Sonographer: Sonia
Fitzwater

Indication:

Procedure Note

Summary:

1. Bicuspid aortic valve without stenosis or insufficiency.
2. The aortic arch is well seen and appears free of obstruction.
3. Normal PFO with tiny L>R shunt.
4. Normal biventricular size, thickness, and function.
5. No evidence of aortic coarctation. Normal flow in the descending aorta (1.24 m/sec).

**EXHIBIT NO. B9F
PAGE: 70 OF 90**

Segmental Cardiotype, Cardiac Position, and Situs:

\(S,D,S\). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.

Pulmonary Veins:

Four pulmonary veins drain to the left atrium.

Atria:

No atrial septal defect is detected. There is there is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.

Mitral Valve:

The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.

Tricuspid Valve:

The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.

AV Canal/Complex Inlet/Single Ventricle:

The crux of the heart is normal.

Left Ventricle:

Overall left ventricular ejection fraction is estimated at 50 to 55%.

Right Ventricle:

The right ventricle is normal in size. Right ventricular systolic function is normal.

Left Ventricular Outflow Tract and Aortic Valve:

Procedure Note

There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency.

EXHIBIT NO. B9F
PAGE: 71 OF 90

Right Ventricular Outflow Tract and Pulmonary Valve:

There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.

Aorta:

No evidence of aortic coarctation. Normal flow in the descending aorta (1.24 m/sec).

Pulmonary Arteries:

The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal.

Ductus Arteriosus:

There is no evidence of ductus arteriosus patency.

2-Dimensional:

AoV-annulus, s: 1.00 cm

Ao-sinus, s: 1.40 cm

Ao-ase, s: 0.50 cm

Ao-arch, proximal transv s: 0.60 cm

Ao-arch, distal transv s: 0.50 cm

Aortic Valve Doppler:

Peak velocity: 1.00 m/sec

Peak gradient 4.00 mmHg

Electronically signed by Joelle Miller, MD

Signature Date/Time: 10/6/2015 3:03:34 PM

*** Final ***

Performing Organization	Address	City/State/Zipcode	Phone Number
MUSE			
• ECHO PEDIATRIC COMPLETE (07/24/2015 9:49 AM)			

Component	Value	Ref Range	Performed At
ECHO-LVEF	60 to 65%		MUSE Performed At MOSE
Carilion Roanoke Memorial Hospital	Narrative		
IAC Accredited Lab			
PEDIATRIC ECHOCARDIOGRAM REPORT			

Patient Name: BABY GIRL(KELLI) A Date of Exam: 7/24/2015

ADAMS

MPI: 3636998 Accn #: 111969955

Site Name: Carilion Roanoke MRN: 932097

Memorial Hospital

IAC Accredited Lab

Date of Birth: 7/21/2015 Height: 20.5 in

Patient Age: 3 days Weight: 7.0 lb

Patient Gender: F BSA: 0.21 m²

Authorizing Provider: 701466 JAMES M SHERMAN BP: 50/30

JR

Referring Provider: Sonographer: Marguerite Underwood

Indication: Turner's syndrome,

evaluate for

coarctation.

Summary:

1. Suspected Turner Syndrome.
2. Bicuspid aortic valve without stenosis or insufficiency.
3. The left ventricle is normal in size, thickness, and function.
4. No obstruction of the aortic arch. Vp= 1.8 m/sec in the descending aorta.

— there is mild straightening and hypoplasia of the transverse arch. The isthmus is well seen and appears free of obstruction

— The distal transverse arch measures 0.4 cm, the isthmus measures 0.36 cm

— The Vp in the descending aorta is 1.8m/sec (range = 1.4-1.8)

— The PDA has closed completely.

5. Mild, functional peripheral pulmonary stenosis.

Segmental Cardiotype, Cardiac Position, and Situs:

\(S,D,S\). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.

Systemic Veins:

EXHIBIT NO. B9F
Performed At
PAGE: 72 OF 90

Narrative**Performed At**

The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.

EXHIBIT NO. B9F
PAGE: 73 OF 90

Pulmonary Veins:

Four pulmonary veins drain to the left atrium.

Atria:

No atrial septal defect is detected. There is there is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.

Mitral Valve:

The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.

Tricuspid Valve:

The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.

AV Canal/Complex Inlet/Single Ventricle:

The crux of the heart is normal.

Left Ventricle:

Overall left ventricular ejection fraction is estimated at 60 to 65%.

Right Ventricle:

The right ventricle is borderline hypertrophied.

Conotruncal Anatomy:

The outflow tracts cross in the usual manner.

Left Ventricular Outflow Tract and Aortic Valve:

There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency.

Right Ventricular Outflow Tract and Pulmonary Valve:

There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.

Aorta:

No obstruction of the aortic arch. $V_p = 1.8 \text{ m/sec}$ in the descending aorta.

there is mild straightening and hypoplasia of the transverse arch. The isthmus is well seen and appears free of obstruction

The distal transverse arch measures 0.4 cm, the isthmus measures 0.36 cm

The V_p in the descending aorta is 1.8m/sec (range = 1.4-1.8)

The PDA has closed completely.

Pulmonary Arteries:

The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal. Mild, functional peripheral pulmonary stenosis.

Ductus Arteriosus:

Narrative**Performed At****EXHIBIT NO. B9F
PAGE: 74 OF 90**

There is no evidence of ductus arteriosus patency. Completely closed.

Coronary Arteries:

The proximal coronary arteries appear to be normal.

M-mode:

RVIDd: 0.98 cm

IVSd: 0.35 cm

LVIDd: 1.21 cm

LVIDs: 0.99 cm

LVPWd: 0.38 cm

LV mass (ASE corr.): 5 g

LV mass index: 33.24 g/m²

LA diam Systole: 1.40 cm

AoV Cusp Sep Syst: 0.60 cm

Z-score

IVSd: -0.19

LVIDd: -4.19

LVIDs: -1.13

LVPWd: -1.43

Systolic Function:

LV SF (M-mode): 18 %

LV EF (M-mode): 42 %

Calculated EF may differ from visual estimation

LVOT Doppler:

Peak velocity: 0.49 m/s

Peak gradient: 1 mmHg

Aortic Valve Doppler:

Peak velocity: 0.84 m/sec

Ao-descending Vmax: 1.88 m/sec

Peak gradient: 2.85 mmHg

Pulmonary Valve Doppler:

Peak velocity: 0.70 m/sec

Peak gradient: 1.97 mmHg

Pulmonary Arteries Doppler:

LPA peak velocity: 1.49 m/s

LPA peak gradient: 8.88 mmHg

Narrative

Performed At

**EXHIBIT NO. B9F
PAGE: 75 OF 90**

RPA peak velocity: 1.53 m/s

RPA peak gradient: 9.36 mmHg

Electronically signed by Joelle Miller, MD

Signature Date/Time: 7/24/2015/10:04:34 AM

*** Final ***

Procedure Note

Edicardi - 07/24/2015 10:04 AM EDT

Carilion Roanoke Memorial Hospital

IAC Accredited Lab

PEDIATRIC ECHOCARDIOGRAM REPORT

Patient Name: BABY GIRL(KELLI) A Date of Exam: 7/24/2015

ADAMS

MPI: 3636998-Accn #: 111969955

Site Name: Carilion Roanoke MRN: 932097

Memorial Hospital

IAC Accredited Lab

Date of Birth: 7/21/2015 Height: 20.5 in

Patient Age: 3 days Weight: 7.0 lb

Patient Gender: F BSA: 0.21 m²

Authorizing Provider: 701466-JAMES M SHERMAN BP: 50/30

JR

Referring Provider: Sonographer: Marguerite Underwood

Indication: Turner's syndrome,

evaluate for

coarctation.

Summary:

1. Suspected Turner Syndrome.

Procedure Note

2. Bicuspid aortic valve without stenosis or insufficiency.
3. The left ventricle is normal in size, thickness, and function.
4. No obstruction of the aortic arch. Vp= 1.8 m/sec in the descending aorta.

there is mild straightening and hypoplasia of the transverse arch. The isthmus is well seen and appears free of obstruction

The distal transverse arch measures 0.4 cm, the isthmus measures 0.36 cm

The Vp in the descending aorta is 1.8m/sec (range = 1.4-1.8)

The PDA has closed completely.

5. Mild, functional peripheral pulmonary stenosis.

~~Segmental Cardiotype, Cardiac Position, and Situs:~~

~~(S,D,S)~~. The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.

Systemic Veins:

The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.

Pulmonary Veins:

Four pulmonary veins drain to the left atrium.

Atria:

No atrial septal defect is detected. There is there is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.

Mitral Valve:

The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.

Tricuspid Valve:

The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.

AV Canal/Complex Inlet/Single Ventricle:

The crux of the heart is normal.

**EXHIBIT NO. B9F
PAGE: 76 OF 90**

Procedure Note

Left Ventricle:

Overall left ventricular ejection fraction is estimated at 60 to 65%.

**EXHIBIT NO. B9F
PAGE: 77 OF 90**

Right Ventricle:

The right ventricle is borderline hypertrophied.

Conotruncal Anatomy:

The outflow tracts cross in the usual manner.

Left Ventricular Outflow Tract and Aortic Valve:

There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency.

Right Ventricular Outflow Tract and Pulmonary Valve:

There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.

Aorta:

No obstruction of the aortic arch. $V_p = 1.8 \text{ m/sec}$ in the descending aorta.

there is mild straightening and hypoplasia of the transverse arch. The isthmus is well seen and appears free of obstruction

The distal transverse arch measures 0.4 cm, the isthmus measures 0.36 cm

The V_p in the descending aorta is 1.8m/sec (range = 1.4-1.8)

The PDA has closed completely.

Pulmonary Arteries:

The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal. Mild, functional peripheral pulmonary stenosis.

Ductus Arteriosus:

There is no evidence of ductus arteriosus patency. Completely closed.

Coronary Arteries:

The proximal coronary arteries appear to be normal.

M-mode:

RVIDd: 0.98 cm

Procedure Note

IVSd: 0.35 cm

LVIDd: 1.21 cm

LVIDs: 0.99 cm

LVPWd: 0.38 cm

LV mass (ASE corr.): 5 g

LV mass index: 33.24 g/m²

LA-diam Systole 1.40 cm

AeV Cusp Sep Syst 0.60 cm

Z-score

IVSd: -0.19

LVIDd: -4.19

LVIDs: -1.13

LVPWd: 1.43

Systolic Function:

LV SF (M-mode): 18 %

LV EF (M-mode): 42 %

Calculated EF may differ from visual estimation

LVOT Doppler:

Peak velocity: 0.49 m/s

Peak gradient: 1 mmHg

Aortic Valve Doppler:

Peak velocity: 0.84 m/sec

Ao descending Vmax 1.88 m/sec

Peak gradient 2.85 mmHg

Pulmonary Valve Doppler:

Peak velocity: 0.70 m/sec

Peak gradient: 1.97 mmHg

Pulmonary Arteries Doppler:

LPA peak velocity: 1.49 m/s

LPA peak gradient: 8.88 mmHg

EXHIBIT NO. B9F**PAGE: 78 OF 90**

Procedure Note

RPA peak velocity: 1.53 m/s

RPA peak gradient: 9.36 mmHg

**EXHIBIT NO. B9F
PAGE: 79 OF 90**

Electronically signed by Joelle Miller, MD

Signature Date/Time: 7/24/2015/10:04:34 AM

***** Final *****

Performing Organization	Address	City/State/Zipcode	Phone Number
MUSE			
• BILIRUBIN TOTAL (BILT) (07/24/2015 12:12 AM)			
Component	Value	Ref Range	Performed At
Total Bilirubin	10.8	<12.0 MG/DL	CARILION LABS

Comment:

Lab studies performed by: SOLSTAS
 LAB PARTNERS located at CRMH,
 Bellevue at
 Jefferson Street, Roanoke, VA 24014

Specimen

Performing Organization	Address	City/State/Zipcode	Phone Number
CARILION LABS			
CARILION LABS		Roanoke, VA	
• ECHO PEDIATRIC COMPLETE (07/22/2015 12:06 PM)			
Component	Value	Ref Range	Performed At
ECHO LVEF	65-to-70%		MUSE
Narrative			Performed At
Carilion Roanoke Memorial Hospital			MUSE

IAC Accredited Lab

PEDIATRIC ECHOCARDIOGRAM REPORT

Patient Name: BABY GIRL(KELLI) A ADAMS Date of Exam: 7/22/2015

MPI: 3636998 Acn #: 111966142

Site Name: Carilion Roanoke Memorial Hospital MRN: 932097

IAC Accredited Lab

Date of Birth: 7/21/2015 Height: 21.0 in

Patient Age: 1 day Weight: 7.4 lb

Patient Gender: F BSA: 0.21 m²

Authorizing Provider: 701466 JAMES M SHERMAN JR BP: 50/30

Referring Provider: Sherman MD Sonographer: DF

Indication: Turner Syndrome.

Narrative**Performed At****EXHIBIT NO. B9F
PAGE: 80 OF 90**

Summary:

1. Mild RV hypertrophy with normal systolic function.
2. The left ventricular size, thickness, and function is normal.
3. Moderate PDA with predominant L>R shunt. There is transient R>L shunting is noted on doppler mapping.
4. Bicuspid aortic valve with normal function. No stenosis or insufficiency. The commissures are at the 3:00 and 9:00 positions.
5. The aortic arch is closely inspected.

—No obstruction is noted at the time of this study. The distal transverse arch measures 3.3 mm and appears mildly hypoplastic.

—There is mild flow acceleration at the level of the isthmus. The Vp is 2.1 m/sec.

—The ductus arteriosus is patent and appears moderate in size. No obstruction is seen at the level of the isthmus. (measures 5.3 mm).

6. Aortic sino-tubular junction dimension (systole) = 0.70 cm (z = -0.64).
7. Aortic sinuses of Valsalva dimension (systole) = 0.84 cm (z = -1.32).
8. Ascending aorta dimension (systole) = 0.4 cm.
9. Descending thoracic aorta systolic dimension (distal to the isthmus) = 0.50 cm (z = -1.06).
10. Distal transverse aortic arch dimension (systole) = 0.33 cm.

Segmental Cardiotype, Cardiac Position, and Situs:

(S,D,S). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.

Systemic Veins:

The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.

Pulmonary Veins:

Four pulmonary veins drain to the left atrium.

Atria:

No atrial septal defect is detected. There is there is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.

Mitral Valve:

The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.

Tricuspid Valve:

The tricuspid valve is normal. There is normal laminar forward flow. There is mild tricuspid valve regurgitation.

AV Canal/Complex Inlet/Single Ventricle:

Narrative**Performed At****EXHIBIT NO. B9F
PAGE: 81 OF 90**

The crux of the heart is normal.

Left Ventricle:

Overall left ventricular ejection fraction is estimated at 65 to 70%.

Right Ventricle:

The right ventricle is borderline dilated. Right ventricular systolic function is normal.

Left Ventricular Outflow Tract and Aortic Valve:

There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency. Bicuspid aortic valve with normal function. No stenosis or insufficiency. The commissures are at the 3:00 and 9:00 positions.

Right Ventricular Outflow Tract and Pulmonary Valve:

There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.

Aorta:

The aortic sinuses of Valsalva systolic dimension is 0.84 cm ($z = -1.32$). The aortic sino-tubular junction dimension (systole) is 0.70 cm ($z = -0.64$). The ascending aorta dimension (systole) is 0.4 cm. The distal transverse aortic arch dimension (systole) is 0.33 cm. The descending thoracic aorta systolic dimension (distal to the isthmus) is 0.50 cm ($z = -1.06$). The aortic arch is closely inspected.

No obstruction is noted at the time of this study. The distal transverse arch measures 3.3 mm and appears mildly hypoplastic.

There is mild flow acceleration at the level of the isthmus. The V_p is 2.1 m/sec.

The ductus arteriosus is patent and appears moderate in size. No obstruction is seen at the level of the isthmus. (measures 5.3 mm).

Ductus Arteriosus:

A patent ductus arteriosus is present. The shunt is predominantly left to right, moderate size. Moderate PDA with predominant L>R shunt. There is transient R>L shunting is noted on doppler mapping.

Coronary Arteries:

The proximal coronary arteries appear to be normal.

M-mode:

RVIDd: 0.92 cm

IVSd: 0.38 cm

LVIDd: 1.50 cm

LVIDs: 0.78 cm

LVPWd: 0.35 cm

LV mass (ASE corr.): 7 g

LV mass index: 43.95 g/ $ht^2.7$

LA diam Systole: 1.60 cm

AoV Cusp Sep Syst: 0.60 cm

Z-score

IVSd: 0.17

Narrative**Performed At****EXHIBIT NO. B9F
PAGE: 82 OF 90**

LVIDd: 2.24

LVIDs: 3.14

LVPWd: 1.01

2-Dimensional: z-score

Ao sinus, s: 0.84 cm -1.32

Ao ST junct, s: 0.70 cm -0.64

Ao ase, s: 0.44 cm

Ao arch, distal transv s: 0.33 cm

Ao isthmus, s: 0.53 cm

Ao desc, thoracic s: 0.50 cm -1.06

Systolic Function:

LV SF (M-mode): 48 %

LV EF (M-mode): 83 %

Calculated EF may differ from visual estimation

LVOT Doppler:

Peak velocity: 0.66 m/s

Peak gradient: 2 mmHg

Aortic Valve Doppler:

Peak velocity: 0.85 m/sec

Ao descending Vmax 2.10 m/sec

Peak gradient 2.91 mmHg

PDA Vmax 1.12 m/sec

PDA diam 3.0 mm

Pulmonary Valve Doppler:

Peak velocity: 0.60 m/sec

Peak gradient: 1.46 mmHg

Pulmonary Arteries Doppler:

MPA peak velocity: 0.74 m/s

MPA peak gradient: 2.17 mmHg

LPA peak velocity: 0.63 m/s

LPA peak gradient: 1.57 mmHg

RPA peak velocity: 0.90 m/s

RPA peak gradient: 3.28 mmHg

Electronically signed by Joelle Miller, MD

Signature Date/Time: 7/22/2015/12:17:35 PM

Narrative**Performed At******* Final *******Procedure Note****EXHIBIT NO. B9F
PAGE: 83 OF 90**

Edicardi - 07/22/2015 12:17 PM EDT

Carilion Roanoke Memorial Hospital

IAC Accredited Lab

PEDIATRIC ECHOCARDIOGRAM REPORT

Patient Name: BABY GIRL(KELLI) A ADAMS Date of Exam:
7/22/2015

MPI: 3636998 Acct #:
111966142

Site Name: Carilion Roanoke Memorial Hospital MRN:
932097

IAC Accredited Lab

Date of Birth: 7/21/2015 Height:
21.0 in

Patient Age: 1 day Weight: 7.4
lb

Patient Gender: F BSA:
0.21 m²

Authorizing Provider: 701466 JAMES M SHERMAN-JR-BP:
50/30

Referring Provider: Sherman MD. Sonographer:
DF

Indication: Turner Syndrome.

Summary:

1. Mild RV hypertrophy with normal systolic function.
2. The left ventricular size, thickness, and function is normal.
3. Moderate PDA with predominant L>R shunt. There is transient R>L shunting noted on doppler mapping.
4. Bicuspid aortic valve with normal function. No stenosis or insufficiency. The commissures are at the 3:00 and 9:00 positions.
5. The aortic arch is closely inspected.

Procedure Note

No obstruction is noted at the time of this study. The distal transverse arch measures 3.3 mm and appears mildly hypoplastic.

EXHIBIT NO. B9F
PAGE: 84 OF 90

There is mild flow acceleration at the level of the isthmus. The Vp is 2.1 m/sec.

The ductus arteriosus is patent and appears moderate in size. No obstruction is seen at the level of the isthmus. (measures 5.3 mm).

6. Aortic sino-tubular junction dimension (systole) = 0.70 cm (z = -0.64)
)

7. Aortic sinuses of Valsalva dimension (systole) = 0.84 cm (z = -1.32)
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9. Descending thoracic aorta systolic dimension (distal to the isthmus) = 0.50 cm (z = -1.06).

10. Distal transverse aortic arch dimension (systole) = 0.33 cm.

Segmental Cardiotype, Cardiac Position, and Situs:

\(S,D,S\). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.

Systemic Veins:

The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.

Pulmonary Veins:

Four pulmonary veins drain to the left atrium.

Atria:

No atrial septal defect is detected. There is a normal patent foramen ovale. There is predominantly left to right flow across the interatrial septum. The right atrium is normal in size. The left atrium is normal in size.

Mitral Valve:

The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.

Tricuspid Valve:

The tricuspid valve is normal. There is normal laminar forward flow. There is mild tricuspid valve regurgitation.

Procedure Note

AV Canal/Complex Inlet/Single Ventricle:

The crux of the heart is normal.

EXHIBIT NO. B9F
PAGE: 85 OF 90

Left Ventricle:

Overall left ventricular ejection fraction is estimated at 65 to 70%.

Right Ventricle:

The right ventricle is borderline dilated. Right ventricular systolic function is normal.

Left Ventricular Outflow Tract and Aortic Valve:

There is no evidence of left ventricular outflow obstruction. Based on Doppler velocities, there is no aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency. Bicuspid aortic valve with normal function. No stenosis or insufficiency. The commissures are at the 3:00 and 9:00 positions.

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There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern.

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No obstruction is noted at the time of this study. The distal transverse arch measures 3.3 mm and appears mildly hypoplastic.

There is mild flow acceleration at the level of the isthmus. The V_p is 2.1 m/sec.

The ductus arteriosus is patent and appears moderate in size. No obstruction is seen at the level of the isthmus. (measures 5.3 mm).

Ductus Arteriosus:

A patent ductus arteriosus is present. The shunt is predominantly left to right, moderate size. Moderate PDA with predominant L>R shunt. There is transient R>L shunting noted on doppler mapping.

Coronary Arteries:

The proximal coronary arteries appear to be normal.

M-mode:

Procedure Note

RVIDd: 0.92 cm

IVSd: 0.38 cm

LVIDd: 1.50 cm

LVIDs: 0.78 cm

LVPWd: 0.35 cm

LV mass (ASE corr.): 7 g

LV mass index: 43.95 g/ht^2.7

LA diam Systole: 1.60 cm

AoV-Cusp-Sep-Syst: 0.60 cm

Z-score

IVSd: 0.17

LVIDd: 2.21

LVIDs: -3.14

LVPWd: 1.01

2-Dimensional: z-score

Ao-sinus, s: 0.84 cm -1.32

Ao-ST junct, s: 0.70 cm -0.64

Ao-asc, s: 0.44 cm

Ao-arch, distal transv s: 0.33 cm

Ao-isthmus, s: 0.53 cm

Ao-desc, thoracic s: 0.50 cm -1.06

Systolic Function:

LV SF (M-mode): 48 %

LV EF (M-mode): 83 %

Calculated EF may differ from visual estimation

LVOT-Doppler:

Peak velocity: 0.66 m/s

Peak gradient: 2 mmHg

Aortic Valve-Doppler:

Peak velocity: 0.85 m/sec

EXHIBIT NO. B9F
PAGE: 86 OF 90

Procedure Note

Ao-descending Vmax 2.10 m/sec

EXHIBIT NO. B9F
PAGE: 87 OF 90

Peak gradient 2.91 mmHg

PDA Vmax 1.12 m/sec

PDA diam 3.0 mm

Pulmonary Valve Doppler:

Peak velocity: 0.60 m/sec

Peak gradient: 1.46 mmHg

Pulmonary Arteries Doppler:

MPA peak velocity: 0.74 m/s

MPA peak gradient: 2.17 mmHg

LPA peak velocity: 0.63 m/s

LPA peak gradient: 1.57 mmHg

RPA peak velocity: 0.90 m/s

RPA peak gradient: 3.28 mmHg

Electronically signed by Joelle Miller, MD

Signature Date/Time: 7/22/2015/12:17:35 PM

*** Final ***

Performing Organization	Address	City/State/Zipcode	Phone Number
MUSE			
• HEARING TEST, NEWBORN (07/22/2015 10:38 AM)			
Component	Value	Ref Range	Performed At
Hearing Screening	Pass R&L Ears		RMH
Performing Organization	Address	City/State/Zipcode	Phone Number
RMH			
• CHROMOSOME ANALYSIS, BLOOD (Q2631) (07/22/2015 12:15 AM)			

Component	Value	Ref Range	Performed At
Chromosome Analysis, Blood (Note)	REPORT		CARILION LABS EXHIBIT NO. B9F PAGE: 88 OF 90
<hr/>			
CYTOGENETIC RESULTS			
Cytogenetic Reference #: CB-15-013012			
Test Setup Date: 07/24/2015			
Test Completion Date: 08/03/2015			
Specimen Source: Peripheral Blood			
Clinical History: Rule out Turner syndrome			
Culture Type: PHA-stimulated whole blood			
Metaphases Counted: 20 — Analyzed: 5			
Karyotyped: 2			
Banding Level (G-bands): >= 550			
KARYOTYPE:			
45,X			
INTERPRETATION and COMMENTS:			
Abnormal female karyotype, consistent with the clinical diagnosis of Turner syndrome.			
An abnormal female chromosome complement with a single X chromosome (monosomy X) was observed in all metaphases. An additional 10 cells were scored for sex chromosome complement only. All cells had a single X chromosome. This study rules out the presence of a 10% mosaicism for a second cell line (normal or abnormal) with a differing sex chromosome complement at a 95% confidence limit.			
Genetic counseling is recommended.			
Electronic Signature on File			
<hr/>			
Jie Xu, Ph.D., FCCMG, DABMG			
Technical Director, Cytogenetics, 703-802-7156			
Results Received	08/03/15 (Note)		CARILION LABS
Reference lab accession: CB15013012EC			
For more information on this test, go to http://education.questdiagnostics.com/faq/chromosomesblood			
Test Performed by Quest, Chantilly, Quest Diagnostics Nichols Institute, 14225 Newbrook Drive, Chantilly, VA 20151			
Patrick W Mason, M.D., Ph.D., Director of Laboratories			
(703) 802-6900, CLIA 49D0221801			
Clinical Indication	clinical features of Turner syndrome		CARILION LABS
Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Bellevue at Jefferson Street, Roanoke, VA 24014			
<hr/>			
Specimen			
Blood, Venous			
Performing Organization	Address	City/State/Zipcode	Phone Number
CARILION LABS			
CARILION LABS		Roanoke, VA	
• CORD BLOOD EVALUATION, REFLEX (CBER) (07/21/2015 6:41 PM)			
Component	Value	Ref Range	Performed At
ABO/Rh	O POS		CARILION LABS

Component	Value	Ref Range	Performed At
DAT, Anti-IgG Coombs Serum	NEG Lab studies performed by: SOLSTAS LAB PARTNERS located at CRMH, Bellevue at Jefferson Street, Roanoke, VA 24014		CARILION LABS EXHIBIT NO. B9F PAGE: 89 OF 90
Specimen			
Blood, Venous - CORD BLOOD			
Performing Organization	Address	City/State/Zipcode	Phone Number
CARILION LABS			
CARILION LABS		Roanoke, VA	

from 07/20/2014 to 12/20/2018

VITALS

Vital Signs

Type	Date	Interpretation	Value	Ref Range
BP dias	07/22/2015		30 mm[Hg]	
BP sys	07/22/2015		50 mm[Hg]	
Bdy height	11/18/2016		71.1 cm	
Body temperature	07/24/2015		36.67 Cel	
Head Circum OFC by Tape measure	08/29/2016		46.9 cm	
Heart rate	11/18/2016		120 /min	
Resp rate	07/24/2015		44 /min	
SaO2 % BldA PulseOx	10/06/2015		100 %	
Weight	11/18/2016		10.319 kg	

Narrative Text

Vital Sign	Reading	Time Taken
Blood Pressure	50 / 30	07/22/2015 8:06 AM EDT
Pulse	120	11/18/2016 2:55 PM EST
Temperature	36.7 °C (98 °F)	07/24/2015 8:00 AM EDT
Respiratory Rate	44	07/24/2015 8:00 AM EDT
Oxygen Saturation	100%	10/06/2015 1:18 PM EDT
Inhaled Oxygen Concentration	-	-
Weight	10.3 kg (22 lb 12 oz)	11/18/2016 2:55 PM EST
Height	71.1 cm (2' 4")	11/18/2016 2:55 PM EST
Head Circumference	46.9 cm	08/29/2016 11:28 AM EDT
Body Mass Index	20.4	11/18/2016 2:55 PM EST

MEDS

Medication Information

Narrative Text

No known medications

EXHIBIT NO. B9F
PAGE: 90 OF 90

CARE PLAN

Plan of Care

Narrative Text

Upcoming Encounters

Date	Type
01/15/2019	Office Visit

Specialty

Care Team

Description

Herold, Steven E, MD

102 Highland Ave

Ste 101

Roanoke, VA 24013

540-224-4545

540-985-5304 (Fax)

Last Done

Comments

Health Maintenance

Due Date

Fluoride Varnish	11/21/2015
AMB IMMUNIZATION	07/21/2016
VARICELLA (#1)	
MMR IMMUNIZATION (#1)	07/21/2016
pneumococcal Peds 0-5 years: all	07/21/2017
risks (1 of 1 - Start at 24 months series)	
INFLUENZA VACCINE	09/01/2018

PROV LIST

Healthcare Providers

Carilion Clinic (11/18/2016 - No Date Available)

Provider Name

Inas Hassan Al-Attar, MD

Address

Telecom

MRN

932097

**EXHIBIT NO. B10F
PAGE: 1 OF 1**

Health IT Response Document

Type of Request: MEGAHit Triggered

Nevaeh Hope Adams
250 MELVIN ST
BIG SANDY, WV 24816

SSN: 794-01-8055
DOB: 07/21/2015
Sex: Female

Date Range Requested:
07/21/2014 - 12/20/2018

MEGAHit sent a request to University of Virginia Health System on 12/20/2018 for electronic medical records from the following claimant-provided source(s):

Source Type: Doctor/Therapist
Source Name: PEDIATRIC CARDIOLOGY
Address: 102 HIGHLAND AVE SW STE 404
ROANOKE, VA 24013
Voice Phone: 540-224-4545

The request resulted in the following:

No patient match.

Consider other case development procedures.

**EXHIBIT NO. B11F
PAGE: 1 OF 8****Patient Information**

Patient Name: ADAMS, NEVAEH HOPE
 Home Address: PO BOX 46
 BIG SANDY, WV 248160046
 Home Phone: (681)729-2017
 Employer Name: NOTEMPLOYED
 Employer Phone:

Sex: Female
 DOB: 07/21/2015
 Age: 3 Years
 Religion: None/No Preference
 SSN:
 Race: White

Guarantor Information

Guarantor Name: ADAMS, KELLI MARIE
 Patient's Reltn: Child
 Billing Address: PO BOX 491
 PANTHER, WV 248720491
 Billing Phone: (304)656-7434
 Employer Name:
 Employer Phone:

Sex: Female
 DOB: 04/02/1991
 Age: 27 Years
 Religion:
 SSN:
 Marital Status:

Contact Information

Emergency Contact
 Contact Name: KELLI ADAMS
 Patient's Reltn: Child - FT
 Sex:
 Home Phone: (304)656-7434

Next of Kin
 Contact Name:
 Patient's Reltn:
 Sex:
 Home Phone:

Primary Insurance

Subscriber Name: ADAMS, RICO
 Patient's Reltn: Child
 Sex: Male
 DOB: 05/19/1990
 Age: 28 Years
 Employer Name: BLUE STONE
 Employer Phone:
 Financial Class: Commercial
 Group Name:

Insurance Name: ACS Benefit
 Claim Address:

 Insurance Phone: (800)849-5370
 Policy Number:
 Group Number: 830
 Authorization Number:
 Authorization Phone:
 Authorization Contact:

Secondary Insurance

Subscriber Name:
 Patient's Reltn:
 Sex:
 DOB:
 Age:
 Employer Name:
 Employer Phone:
 Financial Class:
 Group Name:

Insurance Name:
 Claim Address:

 Insurance Phone:
 Policy Number:
 Group Number:
 Authorization Number:
 Authorization Phone:
 Authorization Contact:

Encounter Information

Reg Dt/Tm:
 Est Dt of Arrival:
 Inpt Adm Dt/Tm:
 Disch Dt/Tm:
 Observation Dt/Tm:
 VIP Indicator:
 Admit Reason:

Patient Type:
 Medical Service:
 Location:
 Room/Bed: /
 Isolation:
 Disease Alert:

Admit Type:
 Admit Source:
 Advance Directive: Patient is a minor
 Reg Clerk:
 Admit Physician:
 Attend Physician:
 PCP:

ADAMS, NEVAEH HOPE
MRN: 0011065171



Female / 3 Years
FIN:



Printed By: McCarroll, Charlene on 01/11/2019 08:42

Registration last updated by: SYSTEM, SYSTEM Cerner on 04/12/2018 09:50

EXHIBIT NO. B11F
PAGE: 2 OF 8



Charleston Area
Medical Center

n/a
n/a

Patient: **ADAMS, NEVAEH HOPE**

MRN: n/a
 FIN: n/a
 DOB/Age/Sex: 7/21/2015 3 years Female
 Location: n/a
 Patient Phone: (681)729-2017

Enc Type: n/a
 Admit: n/a
 Disch: n/a
 Admitting: n/a
 Copy To: McCarroll,Charlene

Chemistry

Legend: c=Corrected, f=Result Comment, *=Performing Lab, S=Susceptible, I=Intermediate, R=Resistant, N/A=Not Applicable
 Laboratory Director: CLIA#

Routine Chemistry

Procedure	Collected Date	1/2/2019	Collected Time	14:02 EST	Units	Reference Range
Sodium Level		137 ^c			mmol/L	[134-142]
Potassium Level		4.5 ^c			mmol/L	[3.5-4.9]
Chloride Level		104 ^c			mmol/L	[96-111]
CO2		22 ^c			mmol/L	[18-29]
Glucose Level		84 ^c			mg/dL	[67-138]
CA		9.2 ^c			mg/dL	[8.0-10.4]
BUN		11 ^c			mg/dL	[4-18]
Creatinine Level		0.4 ^c			mg/dL	[0.1-0.7]
Total Protein		6.8 ^c			g/dL	[4.9-8.3]
Albumin Level		3.6 ^c			g/dL	[3.5-5.5]
Total Bilirubin		0.2 ^c			mg/dL	[0.2-0.9]
Alkaline Phosphatase (ALP)		181 ^c			unit/L	[59-291]
ALT		28 ^c			unit/L	[5-39]
AST		43 ^c			unit/L	[11-47]
Amylase Level		56 ^c			unit/L	[6-105]
Lipase Level		84 ^L ^c			unit/L	[145-209]

Thyroid Studies

Procedure	Collected Date	1/2/2019	Collected Time	14:02 EST	5/9/2018	Collected Time	14:28 EDT	Units	Reference Range
TSH		2.970 ¹¹ ^c			1.790 ¹¹ ^c			mclU/ml	[0.400-6.000]
Free T4 Level		1.3 ¹² ^c			1.2 ¹² ^c			ng/dL	[0.9-1.8]
Thyroid Peroxidase Antibodies		-			<28.0 ¹³ ^c			unit/mL	
Thyroglobulin Antibodies		-			<15.0 ¹⁴ ^c			unit/mL	

LEGEND: c=Corrected, @=Abnormal, C=Critical, L=Low, H=High, f=Result Comment, i=Interp Data, *=Performing Lab

Report Request ID: 103928993

Page 2 of 8

Print Date/Time: 1/11/2019 08:42 EST

**EXHIBIT NO. B11F
PAGE: 3 OF 8**

n/a

Patient Name: ADAMS, NEVAEH HOPE

MRN: n/a

Admit: n/a

FIN: n/a

Disch: n/a

DOB/Age/Sex: 7/21/2015 3 years Female

Admitting: n/a

Chemistry

Legend: c=Corrected, f=Result Comment, *=Performing Lab, S=Susceptible, I=Intermediate, R=Resistant, N/A=Not Applicable
 Laboratory Director: CLIA#

Thyroid Studies**Interpretive Data**

i1: TSH

Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely lowered results for the TSH assay.

i2: Free T4 Level

Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely elevated results for the Free T4 assay.

i3: Thyroid Peroxidase Antibodies

Thyroid Peroxidase AB Negative <=60.0 U/mL

Thyroid Peroxidase AB Positive >60.0 U/mL

i4: Thyroglobulin Antibodies

Thyroglobulin Antibody Negative <=60.0 U/mL

Thyroglobulin Antibody Positive > 60.0 U/mL

Miscellaneous Chemistry

Collected Date:	5/9/2018
Collected Time:	14:28 EDT
Procedure	
Hemoglobin A1c	4.7 ^{15.2} %
Estimated Average Glucose	88 ^{16.2} mg/dL [77-114]

Interpretive Data

i5: Hemoglobin A1c

Normal: <5.7%

PreDiabetes: 5.7% - 6.4%

Diabetes: 6.5% or higher

Diabetic Goal: <7%

i6: Estimated Average Glucose

Formula 28.7 X A1C - 46.7 = Estimated Avg. Glucose(eAG).

Reference: ^a b Nathan DM, Kuenen J, Borg R, Zheng H, Schoenfeld D, Heine RJ (2008). "Translating the A1C assay into estimated average glucose values". Diabetes Care 31(8):1473-8. doi:10.2337/dc08-0545.PMC 2742903.PMID 18540046.

<http://care.diabetesjournals.org/content/31/8/1473.full>.

Estimation of average glucose levels over approximately the preceding 120 days, as measured by HbA1c, should not be used in patients with abnormal RBC

LEGEND: c=Corrected, @=Abnormal, C=Critical, L=Low, H=High, f=Result Comment, i=Interp Data, *=Performing Lab

Report Request ID: 103928993

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Print Date/Time: 1/11/2019 08:42 EST

**EXHIBIT NO. B11F
PAGE: 4 OF 8**

n/a

Patient Name: ADAMS, NEVAEH HOPE

MRN: n/a

Admit: n/a

FIN: n/a

Disch: n/a

DOB/Age/Sex: 7/21/2015 3 years Female

Admitting: n/a

Chemistry

Legend: c=Corrected, f=Result Comment, *=Performing Lab, S=Susceptible, I=Intermediate, R=Resistant, N/A=Not Applicable
 Laboratory Director: CLIA#

Miscellaneous Chemistry**Interpretive Data**

i6: Estimated Average Glucose turnover. This reference range is obtained from the calculated glucose using a reference range of 4.3 - 5.6% HbA1C.

Specific Protein Studies

Collected Date:	1/2/2019	
Collected Time:	14:02 EST	
Procedure		
CRP	<2.9 ¹¹	mg/L [0.0-2.9]

Endocrinology

Collected Date:	5/9/2018	
Collected Time:	14:28 EDT	
Procedure		
IGF-1,LC/MS-Mayo	49 ¹¹	ng/mL
Z-score-Mayo	-0.67 ¹²	[-2.0 -+2.0]

Result Comments

f1: IGF-1, LC/MS-Mayo

-----REFERENCE VALUE-----

28-256

Tanner stages Females:

I 86-323

II 118-451

III 258-529

IV 224-586

V 188-512

f2: Z-score-Mayo

-----ADDITIONAL INFORMATION-----

This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration.

Test Performed by:

LEGEND: c=Corrected, @=Abnormal, C=Critical, L=Low, H=High, f=Result Comment, i=Interp Data, *=Performing Lab

Report Request ID: 103928993

Page 4 of 8

Print Date/Time: 1/11/2019 08:42 EST

**EXHIBIT NO. B11F
PAGE: 5 OF 8**

n/a

Patient Name: ADAMS, NEVAEH HOPE

MRN: n/a

Admit: n/a

FIN: n/a

Disch: n/a

DOB/Age/Sex: 7/21/2015 3 years Female

Admitting: n/a

Chemistry

Legend: c=Corrected, f=Result Comment, *=Performing Lab, S=Susceptible, I=Intermediate, R=Resistant, N/A=Not Applicable
 Laboratory Director: CLIA#

Endocrinology

Result Comments

f2: Z-score-Mayo

 Mayo Clinic Laboratories - Rochester Superior Drive
 3050 Superior Drive NW, Rochester, MN 55901

Performing Locations

*1: This test was performed at:

Womens and Childrens Hospital Laboratory, Lab Director: Milton Plata, MD, CLIA# 51D0661691 - 800 Pennsylvania Avenue, Charleston, WV, 25302-, US

*2: This test was performed at:

Memorial Hospital Laboratory, Lab Director: Milton Plata, MD, CLIA# 51D0234333 - 3200 MacCorkle Avenue SE, Charleston, WV, 25304-, US

Hematology

Legend: c=Corrected, f=Result Comment, *=Performing Lab, S=Susceptible, I=Intermediate, R=Resistant, N/A=Not Applicable
 Laboratory Director: CLIA#

Miscellaneous Hematology

Collected Date	1/2/2019
Collected Time	14:02 EST
Procedure	
Erythrocyte Sedimentation Rate	9* ¹

Units	Reference Range
mm/hr	[0-13]

Automated Hematology

Collected Date	1/2/2019
Collected Time	14:02 EST
Procedure	
White Cell Count	7.0* ¹
Red Cell Count	4.26* ¹
Hemoglobin	12.5* ¹
Hematocrit	36.4* ¹
Mean Cell Volume	85.5* ¹
Mean Cell Hgb	29.4* ¹
Mean Cell Hgb Concentration	34.3* ¹
Red Cell Distribution Width	13.1* ¹
Platelet Count	202* ¹
Mean Platelet Volume	7.6* ¹

Units	Reference Range
x10^3/mcL	[4.2-13.2]
x10^6/mcL	[3.96-5.36]
g/dL	[11.2-14.7]
%	[34.0-43.8]
fL	[76.0-90.0]
pg	[25.1-30.7]
g/dL	[32.3-34.8]
%	[10.7-14.0]
x10^3/mcL	[163-461]
fL	[6.4-9.2]

LEGEND: c=Corrected, @=Abnormal, C=Critical, L=Low, H=High, f=Result Comment, i=Interp Data, *=Performing Lab

Report Request ID: 103928993

Page 5 of 8

Print Date/Time: 1/11/2019 08:42 EST

**EXHIBIT NO. B11F
PAGE: 6 OF 8**

n/a

Patient Name: ADAMS, NEVAEH HOPE

MRN: n/a

Admit: n/a

FIN: n/a

Disch: n/a

DOB/Age/Sex: 7/21/2015 3 years Female

Admitting: n/a

Hematology

Legend: c=Corrected, f=Result Comment, *=Performing Lab, S=Susceptible, I=Intermediate, R=Resistant, N/A=Not Applicable
 Laboratory Director: CLIA#

Automated Hematology

Procedure	Collected Date	1/2/2019	Collected Time	14:02 EST	Units	Reference Range
Neutrophil % Auto		52.7 ^{*1}	%		[32.0-91.0]	
Lymphocyte % Auto		36.4 ^{*1}	%		[7.0-55.0]	
Monocyte % Auto		7.9 ^{*1}	%		[3.0-15.0]	
Eosinophil %		2.4 ^{*1}	%		[0.0-7.0]	
Basophil % Auto		0.6 ^{*1}	%		[0.0-4.0]	
Absolute Neutrophil		3.70 ^{*1}	x10^3/mcL		[1.34-12.01]	
Absolute Lymphocyte		2.50 ^{*1}	x10^3/mcL		[0.29-7.26]	
Absolute Monocyte		0.60 ^{*1}	x10^3/mcL		[0.13-1.98]	
Absolute Eosinophil		0.20 ^{*1}	x10^3/mcL		[0.00-0.92]	
Absolute Basophil		0.00 ^{*1}	x10^3/mcL		[0.00-0.53]	

Performing Locations

*1: This test was performed at:

Womens and Childrens Hospital Laboratory, Lab Director: Milton Plata, MD, CLIA# 51D0661691 - 800 Pennsylvania Avenue, Charleston, WV, 25302-, US

Immunology-Serology

Legend: c=Corrected, f=Result Comment, *=Performing Lab, S=Susceptible, I=Intermediate, R=Resistant, N/A=Not Applicable
 Laboratory Director: CLIA#

Autoimmune

Procedure	Collected Date	1/2/2019	Collected Time	14:02 EST	5/9/2018	14:28 EDT	Units	Reference Range
Tissue Transglutaminase Ab, IgG					<6.0 ^{*2}	-	EU/mL	[0.6-7.0]
zzTissue Transglutaminase Ab, IgA					<2.4 ^{*2}	<2.4 ^{*2}	EU/mL	[0.1-7.0]

Immunology

Procedure	Collected Date	1/2/2019	Collected Time	14:02 EST	5/9/2018	14:28 EDT	Units	Reference Range
Deamidated Gliadin Peptide Ab IgA					<2.8 ^{*2}	-	EU/mL	[0.1-7.0]
Deamidated Gliadin Peptide Ab IgG					<6.3 ^{*2}	-	EU/mL	[0.4-7.0]

LEGEND: c=Corrected, @=Abnormal, C=Critical, L=Low, H=High, f=Result Comment, i=Interp Data, *=Performing Lab

Report Request ID: 103928993

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Print Date/Time: 1/11/2019 08:42 EST

**EXHIBIT NO. B11F
PAGE: 7 OF 8**

n/a

Patient Name: ADAMS, NEVAEH HOPE

MRN: n/a

Admit: n/a

FIN: n/a

Disch: n/a

DOB/Age/Sex: 7/21/2015 3 years Female

Admitting: n/a

Immunology-Serology			
Legend: c=Corrected, f=Result Comment, *=Performing Lab, S=Susceptible, I=Intermediate, R=Resistant, N/A=Not Applicable Laboratory Director: CLIA#			

Legend: c=Corrected, f=Result Comment, *=Performing Lab, S=Susceptible, I=Intermediate, R=Resistant, N/A=Not Applicable
Laboratory Director: CLIA#

Immunology

	Collected Date	1/2/2019	Collected Time	14:02 EST	5/9/2018	14:28 EDT	Units	Reference Range
Procedure								
Endomysial Antibody IgA		Negative ^{*2}			-			[Negative]
IgA		-			58.5 ^{*2}	mg/dL	[20.0-100.0]	
IgA		77.6 ^{*2}			-	mg/dL	[27.0-195.0]	
AMH Antimüllerian Hormone-Mayo		-			<0.1 ^{*3}	ng/mL	[<8.8]	

Result Comments

f3: AMH Antimüllerian Hormone-Mayo

-----ADDITIONAL INFORMATION-----

The testing method is a manual immunoenzymatic assay manufactured by Ansh Labs. Values obtained with different assay methods or kits may be different and cannot be used interchangeably. If this test is being ordered as a tumor marker, results cannot be interpreted as absolute evidence for the presence or absence of malignant disease.

This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration.

Test Performed by:

Mayo Clinic Laboratories - Rochester Superior Drive
3050 Superior Drive NW, Rochester, MN 55901

Performing Locations

*2: This test was performed at:

Memorial Hospital Laboratory, Lab Director: Milton Plata, MD, CLIA# 51D0234333 - 3200 MacCorkle Avenue SE, Charleston, WV, 25304-, US

LEGEND: c=Corrected, @=Abnormal, C=Critical, L=Low, H=High, f=Result Comment, i=Interp Data, *=Performing Lab

Report Request ID: 103928993

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Print Date/Time: 1/11/2019 08:42 EST

**EXHIBIT NO. B11F
PAGE: 8 OF 8**

n/a

Patient Name: ADAMS, NEVAEH HOPE

MRN: n/a

Admit: n/a

FIN: n/a

Disch: n/a

DOB/Age/Sex: 7/21/2015 3 years Female

Admitting: n/a

<i>Diagnostic Radiology</i>				
Accession XR-18-0092479	Exam Date/Time 5/9/2018 15:09 EDT	Exam XR Bone Age Studies	Ordering Physician Dye,MD,Amanda Stephens	Patient Age at Exam 2 years

Accession

XR-18-0092479

Exam Date/Time

5/9/2018 15:09 EDT

Exam

XR Bone Age Studies

Ordering PhysicianDye,MD,Amanda
Stephens**Patient Age at Exam**

2 years

Reason for Exam

(XR Bone Age Studies) Other (please specify);turner syndrome karotype

ReportADDITIONAL HISTORY: Other (please specify);turner syndrome
karotype,turner syndrome

XR Bone Age Studies 5/9/2018 3:09 PM

COMPARISON: None

According to the standards of Greulich and Pyle, bone age would best fit that of a female skeletal standard 2 years of age. Patient's chronologic age is 2 years 9 months. One standard deviation for patient this age is 4.8 month. Therefore, bony is just within 2 standard deviation.

IMPRESSION: Normal bone age.

***** Final *****

Dictated by: Phillips, MD, Pamela M

Dictated DT/TM: 05/09/2018 15:24 EDT

Signed by: Phillips, MD, Pamela M

Signed (Electronic Signature): 05/09/2018 15:28 EDT

LEGEND: c=Corrected, @=Abnormal, C=Critical, L=Low, H=High, f=Result Comment, i=Interp Data, *=Performing Lab

Report Request ID: 103928993

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Print Date/Time: 1/11/2019 08:42 EST

Health Information Technology (HIT) Medical Report

NOTE: The following displays data transmitted to the SSA from the health IT partner using standards-based computer transactions and is reformatted to assist with navigating through the clinical details of the record. Known duplicative information will be struck-through (e.g. sample).

**Summarization of Episode Note
Continuity of Care Document****Received From: WVU Medicine**

Creation Date: 01/16/2019 **Date Range Requested:** 12/21/2018 - 01/16/2019 **Type of Request:** User Triggered

NEVAEH HOPE ADAMS
SSN: 794-01-8055 **DOB:** 07/21/2015 **Sex:** Female

Partner Medical Record Demographics:
Name: Nevaeh Adams **DOB:** 07/21/2015 **Sex:** Female

Table of Contents

- Problems List [PROB LIST]
- Encounters [ENC]
- Procedures [PROCED]
- Laboratory Results [LABS]
- Vital Signs [VITALS]
- Medication Information [MEDS]
- Plan of Care [CARE PLAN]
- Healthcare Providers [PROV LIST]

PROB LIST

Problems List

<u>Problem [Code]</u>	<u>Occurrences</u>	<u>First Date</u>	<u>Last Date</u>	<u>Associated Types</u>	<u>Last Prognosis Value</u>	<u>Last Prognosis Date</u>
Aortic valve regurgitation [60234000] Nonrheumatic aortic (valve) insufficiency [I35.1] Aortic valve disorder [424.1] Aortic valve insufficiency [38490]	1	05/09/2018	-	Disease		
Esotropia [16596007] Unspecified esotropia [H50.00] Esotropia NOS [378.00] Esotropia [80576]	1	05/09/2018	-	Disease		
H/O: congenital anomaly [161572004] Personal history of (corrected) congenital malformations of integument, limbs and musculoskeletal system [Z87.76] Hx-congenital malfor NEC [V13.69] Personal history of congenital hip dysplasia [734539]	1	05/09/2018	-	Disease		
Turner syndrome [38804009] Karyotype 45, X [Q96.0] Gonadal dysgenesis [758.6] Turner syndrome karyotype 45, x [41312017]	1	05/09/2018	-	Disease		

Narrative Text

Problem	Noted Date
Turner syndrome karyotype 45, x	05/09/2018
Esotropia	05/09/2018
Aortic valve insufficiency	05/09/2018
Personal history of congenital hip dysplasia	05/09/2018
Overview:	
S/p open reduction	

ENC

EXHIBIT NO. B12F
PAGE: 3 OF 27

Encounters

Date	Type	Specialty	Care Team	Description
01/11/2019	Telephone		Lawson, April, CPNP	Test <u>Results</u> (LABS); Patient Returning Call

CHILDRENS MEDICAL OFFICE BLDG-WVUPC

01/11/2019

Telephone Encounter - Tanner, Jennifer Suzanne, RN - 01/14/2019 4:59 PM EST

Returned call - will forward to April for review

Electronically Signed by Tanner, Jennifer Suzanne, RN on 01/14/2019 4:59 PM EST

Telephone Encounter - Lawson, April, CPNP - 01/15/2019 3:38 PM EST

Man answered phone, said mother was not there. He will let her know :I called.
Thanks

Electronically Signed by Lawson, April, CPNP on 01/15/2019 3:38 PM EST

Telephone Encounter - Carroll, Brittany A - 01/16/2019 10:59 AM EST

Kelli calling back for **results**

She's not available between 3:30 - 4:15 because she's getting kids from school.

Thank you

Electronically Signed by Carroll, Brittany A on 01/16/2019 10:59 AM EST

01/03/2019 Telephone **Lawson April CPNP** Has Questions

CHILDRENS MEDICAL OFFICE BLDG-WVUPC

01/03/2019

Telephone Encounter - Tipney, Pamela S - 01/03/2019 9:50 AM EST

Mom said April wanted stool sample gave mom a cup and told her that stool would be good in the cup for 24hrs, mom was able to get sample after they left appt she then took it and dropped it off at Welch Emergency, mom as told that Lab Corp would pick up and she should have results in about 72 hours, mom said received call before she could get home stating that the cup was no good she would have to get a sample cup from them and so another sample

Electronically Signed by Tinney, Pamela S on 01/03/2019 9:50 AM EST

Telephone Encounter - Tanner, Jennifer Suzanne, RN - 01/03/2019 2:21 PM EST

Left message returning call

Electronically Signed by Tanner, Jennifer Suzanne, RN on 01/03/2019 2:21 PM EST

Telephone Encounter - Skeens Meghan Kathleen - 01/04/2019 10:42 AM EST

Mom is returning call

Electronically Signed by Skeens Meghan Kathleen on 01/04/2019 10:42 AM EST

Telephone Encounter - Edens, Katie M, CMA - 01/04/2019 3:10 PM EST

Date	Type	Specialty	Care Team	Description
		CALLED GUARDIAN BACK SHE STATED THAT SHE TOOK THE STOOL TO THE LAB AND DUE TO NOT BEING IN THEIR CONTAINERS SHE IS AGGRAVATED THAT SHE HAD TO BREAK UP THE POOP AND SEPARATE IT INTO CONTAINERS THE LAB REQUIRED AND SHE STATED THAT IT WAS NOT HER JOB TO DO THAT SHE DIDN'T KNOW HOW MUCH OR WHAT TO DO AND HOPES SHE DID IT RIGHT I ASKED HER IF SHE WAS ABLE TO DROP IT OFF SHE SAID THAT TOOK IT		EXHIBIT NO. B12F PAGE: 4 OF 27
01/02/2019	Office Visit	I ADVISED HER TO CALL IF SHE HAD ANY PROBLEMS	Lawson, April, CPNP	Chronic diarrhea (Primary Dx)

CHILDRENS MEDICAL OFFICE BLDG-WVUPC
01/02/2019

Nursing Note - Lawson, April, CPNP - 01/02/2019 1:00 PM EST

Formatting of this note might be different from the original.

CHILDRENS MEDICAL OFFICE BLDG-WVUPC
WVUPC-PEDS GI
830 Pennsylvania Ave
Charleston WV 25302-3302
304-388-1552

Name: Nevaeh Adams Referring Provider: Dye, Amanda, MD

MRN: E2228804 **PCP:** Rahmet Muzaffer, MD

Date of Birth: 7/21/2015

Date of Service: 1/2/2019

Informant:

Chief Complaint:

Chief Complaint

Patient presents with

- Diarrhea
- Rash

History of Present Illness:

Nevaeh Adams is a 3 y.o. female who comes to our clinic for .

Mother was 12 weeks pregnant when Nevaeh was noted to have Turner syndrome. They confirmed this immediately after birth. No complications otherwise.

Currently: Per mother she has never had a solid stool. She has loose to mushy stools at least 5 times a day, sometimes more. + strong odor, and seems acidic. Causes rash immediately to skin. No visible mucous or oily appearance. They see undigested food frequently. Weight gain has been good per mother, but she was lagging behind in the linear growth. She had repair of hip dysplasia and was cleared to start growth hormone. She started this on Sunday. She complains of "belly hurting" multiple times a day. Sometimes before stooling. She has texture issues because of her palate. She eats the same things over and over.

She stays thirsty, diabetes work up is negative.

Past history & specialist.

Work up so far:

Review of Systems:

Constitutional: No unexplained weight loss, fever

Eyes: No discharge, no pain

ENT: No ear pain, discharge, throat pain

CVS: No chest pain

Resp: No breathing problems

GI: Per HPI

GU: No urinary complaints

MS: No injuries

Date	Type	Specialty	Care Team	Description
	Skin: No rash Imm: No frequent infections Heme: No easy bruising or bleeding Neuro: No headache, no seizures, no weakness Behavioral/Psych iatric: No problems			EXHIBIT NO. B12F PAGE: 5 OF 27
	Past Medical History Past Medical History: Diagnosis Date			
	<ul style="list-style-type: none"> • Bicuspid aortic valve • Developmental delay • Heart defect • Hip dysplasia, congenital • Otitis media • Turner syndrome <p>45, X0</p> <ul style="list-style-type: none"> • Visual impairment esotropia 			
	Past Surgical History Past Surgical History: Procedure Laterality Date			
	<p>• Orif congenital hip dislocation 2017</p>			
	Family History Family Medical History: Problem Relation (Age of Onset) No Known Problems Mother, Father			
	Social History: Social History			
	Socioeconomic History <ul style="list-style-type: none"> • Marital status: Single 			
	<p>Spouse name: Not on file</p> <ul style="list-style-type: none"> • Number of children: Not on file • Years of education: Not on file • Highest education level: Not on file 			
	Social Needs <ul style="list-style-type: none"> • Financial resource strain: Not on file • Food insecurity - worry: Not on file • Food insecurity - inability: Not on file • Transportation needs - medical: Not on file • Transportation needs - non-medical: Not on file 			
	Occupational History <ul style="list-style-type: none"> • Not on file 			
	Tobacco Use <ul style="list-style-type: none"> • Smoking status: Never Smoker • Smokeless tobacco: Never Used 			
	Substance and Sexual Activity <ul style="list-style-type: none"> • Alcohol use: Not on file • Drug use: Not on file • Sexual activity: Not on file 			
	Other Topics Concern <ul style="list-style-type: none"> • Not on file 			
	Social History Narrative <ul style="list-style-type: none"> • Not on file 			
	PHYSICAL EXAM: Ht 0.901 m (2' 11.47") Wt 15.7 kg (34 lb 9.8 oz) BMI 19.34 kg/m ² 99 %ile (Z= 2.17) based on CDC (Girls, 2-20 Years) BMI-for-age based on BMI available as of 1/2/2019.			
	69 %ile (Z= 0.50) based on CDC (Girls, 2-20 Years) weight-for-age data using vitals from 1/2/2019. 4 %ile (Z= -1.72) based on CDC (Girls, 2-20 Years) Stature-for-age data based on Stature recorded on 1/2/2019.			

Date	Type	Specialty	Care Team	Description
	General: Awake and alert Skin: No rashes Head: Non-traumatic. Nose: No nasal congestion Neck: Supple, No lymphadenopathy Eyes: PERRLA, No redness, icterus Ears: External ear normal, no drainage, tags, or pits Respiratory: Clear to auscultation bilaterally. Cardiovascular: S1 and S2 present with no extra sounds or murmur GI: Abdomen soft, flat, non distended, bowel sounds normal, no organomegaly, masses or tenderness. Musculoskeletal: Moves all 4 extremities well, no joint swelling, erythema, and tenderness Neurologic: No focal deficits			EXHIBIT NO. B12F PAGE: 6 OF 27

ASSESSMENT:

Patient Active Problem List

Diagnosis

- Turner syndrome karyotype 45, x
- Esotropia
- Aortic valve insufficiency
- Personal history of congenital hip dysplasia

PLAN:

No follow-ups on file.

No orders of the defined types were placed in this encounter.

Outpatient Encounter Medications as of 1/2/2019

Medication Sig Dispense Refill

- Insulin Needles, Disposable, (NANO PEN NEEDLE) 32 gauge x 5/32" Needle Use to inject growth hormone daily 100 Each 1
- NORDITROPIN FLEXPRO 10 mg/1.5 mL (6.7 mg/mL) Subcutaneous Pen Injector Inject 0.7 mg SQ daily 2 Syringe 5

No facility-administered encounter medications on file as of 1/2/2019.

It was our pleasure to see Nevaeh Adams in our GI clinic. Should you have any questions/concerns, please do not hesitate to contact us.

Time Spent: 45 minutes, more than 50% of the time spent in education, counseling, explanation of management, review of lab results/medical records, documentation and coordination of care.

Sincerely,

April D. Lawson, APRN
Pediatric Gastroenterology
Department of Pediatrics
WVU Physicians of Charleston

Electronically Signed by Lawson, April, CPNP on 01/02/2019 1:00 PM EST

01/02/2019 Documentation Only

Dye, Amanda, MD

01/02/2019 Telephone

Wriston, Alyssa, PA

Appointment Request (follow up needed after GH started)

CHILDRENS MEDICAL OFFICE BLDG-WVUPC
01/02/2019

Telephone Encounter - Lowery, Elisabeth L, RN - 01/02/2019 8:51 AM EST

LVM for mother that we received fax from Nordicare that injection training was completed on 12/30/2018

Need to schedule follow up appt with Alyssa or Dr Dye 4-6 weeks after injections started

Left main number for call back to schedule appt

Electronically Signed by Lowery, Elisabeth L, RN on 01/02/2019 8:51 AM EST

Date	Type	Specialty	Care Team	Description
	Telephone Encounter - Lowery, Elisabeth L, RN - 01/10/2019 2:01 PM EST			EXHIBIT NO. B12F
	LVM again for mother that we need to make appt with office			PAGE: 7 OF 27
	Notified mother will need to schedule appt, as Nevaeh has started GH			
	Left my direct number for call back			
	Electronically Signed by Lowery, Elisabeth L, RN on 01/10/2019 2:01 PM EST			
01/02/2019	Documentation Only		Dye, Amanda, MD	
12/21/2018	Documentation Only		Dye, Amanda, MD	
12/20/2018	Documentation Only		Dye, Amanda, MD	
12/20/2018	Documentation Only		Dye, Amanda, MD	
12/20/2018	Documentation Only		Dye, Amanda, MD	
12/20/2018	Refill		Dye, Amanda, MD	
from 12/20/2018 to 01/16/2019				

PROCED

Procedures

Non-identified Provider

Date	Procedure/Encounter Type [Code]
01/09/2019	OVA AND PARASITE SCREEN [1164]
01/09/2019	LACTOFERRIN [10235855]
01/09/2019	CALPROTECTIN, FECES [10235638]
01/09/2019	PANCREATIC ELASTASE-1 [10221478]
01/03/2019	ENDOMYSIAL ANTIBODIES (IGA), SERUM [10221310]
01/03/2019	GLIADIN (DEAMIDATED) ANTIBODIES, IGA, SERUM [10229034]
01/03/2019	GLIADIN (DEAMIDATED) ANTIBODY, IGG, SERUM [10229035]
01/03/2019	TISSUE TRANSGLUTAMINASE (TTG) ANTIBODY, IGG, SERUM [10229033]
01/03/2019	TISSUE TRANSGLUTAMINASE (TTG) ANTIBODY, IGA, SERUM [10250495]
01/03/2019	IMMUNOGLOBULIN A (IGA), SERUM [794]
01/02/2019	THYROID STIMULATING HORMONE (SENSITIVE TSH) [906]
01/02/2019	THYROXINE, FREE (FREE T4) [902]
01/02/2019	SEDIMENTATION RATE [1754]
01/02/2019	C-REACTIVE PROTEIN(CRP),INFLAMMATION [10222676]
01/02/2019	LIPASE [846]
01/02/2019	HCHGCOMPRE METAB PANEL [80053]
01/02/2019	AMYLASE [744]
01/02/2019	CBC/DIFF [1696]

Narrative Text

Procedure Name	Priority	Date/Time	Associated Diagnosis	Comments
PANCREATIC ELASTASE-1	Routine	01/09/2019	Chronic diarrhea	
CALPROTECTIN, FECES	Routine	01/09/2019	Chronic diarrhea	
LACTOFERRIN	Routine	01/09/2019	Chronic diarrhea	
OVA AND PARASITE SCREEN	Routine	01/09/2019	Chronic diarrhea	

Procedure Name	Priority	Date/Time	Associated Diagnosis	Comments
ENDOMYSIAL ANTIBODIES (IGA), SERUM	Routine	01/03/2019 3:37 PM EST	Chronic diarrhea	Results for this procedure are in the EXHIBIT NO. B12F PAGE: 8 OF 27 results section
GLIADIN (DEAMIDATED) ANTIBODIES, IGA, SERUM	Routine	01/03/2019 3:23 PM EST	Chronic diarrhea	Results for this procedure are in the results section
GLIADIN (DEAMIDATED) ANTIBODY, IGG, SERUM	Routine	01/03/2019 3:23 PM EST	Chronic diarrhea	Results for this procedure are in the results section
TISSUE TRANSGLUTAMINASE (TTG) ANTIBODY, IGG, SERUM	Routine	01/03/2019 3:23 PM EST	Chronic diarrhea	Results for this procedure are in the results section
TISSUE TRANSGLUTAMINASE (TTG) ANTIBODY, IGA, SERUM	Routine	01/03/2019 3:23 PM EST	Chronic diarrhea	Results for this procedure are in the results section
IMMUNOGLOBULIN A (IGA), SERUM	Routine	01/03/2019 6:06 AM EST	Chronic diarrhea	Results for this procedure are in the results section
THYROID STIMULATING HORMONE (SENSITIVE TSH)	Routine	01/02/2019 5:16 PM EST	Chronic diarrhea	Results for this procedure are in the results section
THYROXINE, FREE (FREE T4)	Routine	01/02/2019 5:06 PM EST	Chronic diarrhea	Results for this procedure are in the results section
SEDIMENTATION RATE	Routine	01/02/2019 4:21 PM EST	Chronic diarrhea	Results for this procedure are in the results section
C-REACTIVE PROTEIN(CRP), INF LAMMATION	Routine	01/02/2019 4:08 PM EST	Chronic diarrhea	Results for this procedure are in the results section
LIPASE	Routine	01/02/2019 4:08 PM EST	Chronic diarrhea	Results for this procedure are in the results section
COMPREHENSIVE METABOLIC PANEL, NON-FASTING	Routine	01/02/2019 4:07 PM EST	Chronic diarrhea	Results for this procedure are in the results section
AMYLASE	Routine	01/02/2019 4:07 PM EST	Chronic diarrhea	Results for this procedure are in the results section

Procedure Name	Priority	Date/Time	Associated Diagnosis	Comments
CBC/DIFF	Routine	01/02/2019 4:01 PM EST	Chronic diarrhea	Results for this procedure are in the EXHIBIT NO. B12F PAGE: 9 OF 27 results section

from 12/20/2018 to 01/16/2019

LABS

Laboratory Results

Date	Test				
01/09/2019	O+P Stl Tri Stn				
	Associated Procedure: O+P Stl Tri Stn				
	Unknown	Text: OVA AND PARASITE SCREEN (01/09/2019)	Specimen Other	Narrative This result has an attachment that is not available.	Performed At
				Performing Organization CHARLESTON AREA MEDICAL CENTER	Address 3200 MacCorkle Avenue, S.E.
					City/State/Zipco de Charleston, PA 25304
					Phone Number
01/09/2019	10221478				
	Associated Procedure: #Result237724580 Procedure				
	Unknown	Text: PANCREATIC ELASTASE-1 (01/09/2019)	Specimen Stool	Narrative This result has an attachment that is not available.	Performed At
				Performing Organization CHARLESTON AREA MEDICAL CENTER	Address 3200 MacCorkle Avenue, S.E.
					City/State/Zipco de Charleston, PA 25304
					Phone Number
01/09/2019	10235638				
	Associated Procedure: #Result237724579 Procedure				
	Unknown	Text: CALPROTECTIN, FECES (01/09/2019)	Specimen Stool		

Date	Test	Narrative This result has an attachment that is not available.	Performing Organization CHARLESTON AREA MEDICAL CENTER	Address 3200 MacCorkle Avenue, S.E.	City/State/Zipcode Charleston, PA 25304	Phone Number	Performed At
01/09/2019	Lactoferrin Stl QI						EXHIBIT NO. B12F PAGE: 10 OF 27
	Associated Procedure: Lactoferrin Stl QI						
	Unknown	Text: LACTOFERRIN (01/09/2019) Specimen Stool					Performed At
		Narrative This result has an attachment that is not available.					
01/03/2019	10221310	Performing Organization CHARLESTON AREA MEDICAL CENTER	Address 3200 MacCorkle Avenue, S.E.	City/State/Zipcode Charleston, PA 25304	Phone Number		
	Associated Procedure: #Result237724390 Procedure	Text: ENDOMYSIAL ANTIBODIES (IGA), SERUM (01/03/2019 3:37 PM EST) Component Value Ref Range Performed At ENDOMYSIAL IGA Negative Negative CHARLESTON AREA MEDICAL CENTER Specimen Blood - Serum					Pathologist Signature
		Narrative Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304					Performed At CHARLESTON AREA MEDICAL CENTER
		Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432 Performing Organization CHARLESTON AREA MEDICAL CENTER	Address 3200 MacCorkle Avenue, S.E.	City/State/Zipcode Charleston, PA 25304	Phone Number		
	ENDOMYSIAL IGA ANTIB.	Value: Negative Ref Range: Negative Text: ENDOMYSIAL IGA ANTIB. Negative Negative CHARLESTON AREA MEDICAL CENTER					
01/03/2019	10229034	Text: GLIADIN (DEAMIDATED) ANTIBODIES, IGA, SERUM (01/03/2019 3:23 PM EST) Component Value Ref Range Performed At GLIADIN (DEAMIDATED) <2.8 0.1 - 7.0 CHARLESTON AREA MEDICAL CENTER ANTIBODIES EVALUATION, IGA, SERUM EU/mL					Pathologist Signature
		 Specimen Blood - Blood					
		Narrative Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304					Performed At CHARLESTON AREA MEDICAL CENTER
		Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432 Performing Organization CHARLESTON AREA MEDICAL CENTER	Address 3200 MacCorkle Avenue, S.E.	City/State/Zipcode Charleston, PA 25304	Phone Number		
		CHARLESTON AREA MEDICAL CENTER					

<u>Date</u>	<u>Test</u>						EXHIBIT NO. B12F PAGE: 11 OF 27
	GLIADIN (DEAMIDATED) ANTIBODIES EVALUATION, IGA, SERUM	Value: <2.8 Ref Range: 0.1 - 7.0 EU/mL Text: GLIADIN (DEAMIDATED) ANTIBODIES EVALUATION, IGA, SERUM	<2.8	0.1 - 7.0 EU/mL	CHARLESTON AREA MEDICAL CENTER		
01/03/2019	10229035	Associated Procedure: #Result237724389 Procedure	Text: GLIADIN (DEAMIDATED) ANTIBODY, IGG, SERUM (01/03/2019 3:23 PM EST) Component Value Ref Range Performed At Pathologist Signature GLIADIN (DEAMIDATED) <6.3 0.4 - 7.0 EU/mL CHARLESTON AREA MEDICAL CENTER ANTIBODIES EVALUATION, IGG, SERUM				
	GLIADIN (DEAMIDATED) ANTIBODIES EVALUATION, IGG, SERUM	Text: GLIADIN (DEAMIDATED) ANTIBODIES EVALUATION, IGG, SERUM	<6.3	0.4 - 7.0 EU/mL	CHARLESTON AREA MEDICAL CENTER		
01/03/2019	10229033	Associated Procedure: #Result237724393 Procedure	Text: TISSUE TRANSGLUTAMINASE (TTG) ANTIBODY, IGG, SERUM (01/03/2019 3:23 PM EST) Component Value Ref Range Performed At Pathologist Signature TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGG, SERUM <6.0 0.6 - 7.0 EU/mL CHARLESTON AREA MEDICAL CENTER				
	TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGG, SERUM	Text: TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGG, SERUM	<6.0	0.6 - 7.0 EU/mL	CHARLESTON AREA MEDICAL CENTER		
01/03/2019	10250495	Associated Procedure: #Result237724392 Procedure	Text: TISSUE TRANSGLUTAMINASE (TTG) ANTIBODY, IGA, SERUM (01/03/2019 3:23 PM EST) Component Value Ref Range Performed At Pathologist Signature TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGA, SERUM <2.4 0.1 - 7.0 EU/mL CHARLESTON AREA MEDICAL CENTER				
	TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGA, SERUM	Text: TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGA, SERUM	<2.4	0.1 - 7.0 EU/mL	CHARLESTON AREA MEDICAL CENTER		

Date	Test	Narrative Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304 Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432 Performing Organization Address City/State/Zip Phone Number CHARLESTON AREA MEDICAL 3200 MacCorkle Avenue, S.E. Charleston, PA 25304				Performed At EXHIBIT NO. B12F CHARLESTON AREA MEDICAL CENTER PAGE: 12 OF 27
	TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGA, SERUM	Value: <2.4 Ref Range: 0.1 - 7.0 EU/mL Text: TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGA, SERUM <2.4 0.1 - 7.0 EU/mL				CHARLESTON AREA MEDICAL CENTER
01/03/2019	IgA SerPl-mCnc	Value: 77.6 mg/dL Ref Range: 27.0 - 195.0 mg/dL Text: IMMUNOGLOBULIN A 77.6 27.0 - 195.0 mg/dL CHARLESTON AREA MEDICAL CENTER				
	Associated Procedure: IgA SerPl-mCnc	Text: IMMUNOGLOBULIN A (IGA), SERUM (01/03/2019 6:06 AM EST) Component Value Ref Range Performed At Pathologist Signature IMMUNOGLOBULIN A 77.6 27.0 - 195.0 mg/dL CHARLESTON AREA MEDICAL CENTER Specimen Blood - Blood	Narrative Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304 Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432 Performing Organization Address City/State/Zip Phone Number CHARLESTON AREA MEDICAL 3200 MacCorkle Avenue, S.E. Charleston, PA 25304			
01/02/2019	906	Associated Procedure: #Result237724387 Text: THYROID STIMULATING HORMONE (SENSITIVE TSH) (01/02/2019 5:16 PM EST) Component Value Ref Range Performed At Pathologist Signature TSH 2.970 0.400 - 6.000 mIU/mL CHARLESTON AREA MEDICAL CENTER Comment: Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely lowered results for the TSH assay. Specimen Blood - Blood				

Date	Test	Narrative Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304 Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432 Performing Organization CHARLESTON AREA MEDICAL CENTER	Performed At EXHIBIT NO. B12F CHARLESTON AREA MEDICAL CENTER PAGE: 13 OF 27
	TSH	Value: 2.970 mIU/mL Ref Range: 0.400 - 6.000 mIU/mL Text: TSH2.970 Comment: Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely lowered results for the TSH assay.	0.400 - 6.000 mIU/mL CHARLESTON AREA MEDICAL CENTER
01/02/2019	T4 Free SerPl-mCnc	Associated Procedure: T4 Free SerPl-mCnc Text: THYROXINE, FREE (FREE T4) (01/02/2019 5:06 PM EST) Component Value Ref Range Performed At Pathologist Signature THYROXINE, FREE (FREE T4) 1.3 0.9 - 1.8 ng/dL CHARLESTON AREA MEDICAL CENTER Comment: Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely elevated results for the Free T4 assay.	
	THYROXINE, FREE (FREE T4)	Specimen Blood - Blood Narrative Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304 Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432 Performing Organization CHARLESTON AREA MEDICAL CENTER	Performed At CHARLESTON AREA MEDICAL CENTER
		Address 3200 MacCorkle Avenue, S.E. Charleston, PA 25304	City/State/Zipcode Phone Number

Date	Test	THYROXINE, FREE (FREE T4) 1.3 Comment: Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely elevated results for the Free T4 assay.	EXHIBIT NO. B12F 00 CHARLESTON 18 AREA MEDICAL ng/dL CENTER																		
01/02/2019	ESR Bld Qn	Associated Procedure: ESR Bld Qn Text: SEDIMENTATION RATE (01/02/2019 4:21 PM EST) <table> <thead> <tr> <th>Component</th> <th>Value</th> <th>Ref Range</th> <th>Performed At</th> <th>Pathologist Signature</th> </tr> </thead> <tbody> <tr> <td>SEDIMENTATION RATE</td> <td>9</td> <td>0 - 13 mm/hr</td> <td>CHARLESTON AREA MEDICAL CENTER</td> <td></td> </tr> </tbody> </table> <p>Blood - Blood</p> <p>Narrative</p> <p>Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302</p> <p>Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432</p> <table> <thead> <tr> <th>Performing Organization</th> <th>Address</th> <th>City/State/Zipcode</th> <th>Phone Number</th> </tr> </thead> <tbody> <tr> <td>CHARLESTON AREA MEDICAL CENTER</td> <td>3200 MacCorkle Avenue, S.E.</td> <td>Charleston, PA 25304</td> <td></td> </tr> </tbody> </table>	Component	Value	Ref Range	Performed At	Pathologist Signature	SEDIMENTATION RATE	9	0 - 13 mm/hr	CHARLESTON AREA MEDICAL CENTER		Performing Organization	Address	City/State/Zipcode	Phone Number	CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304		
Component	Value	Ref Range	Performed At	Pathologist Signature																	
SEDIMENTATION RATE	9	0 - 13 mm/hr	CHARLESTON AREA MEDICAL CENTER																		
Performing Organization	Address	City/State/Zipcode	Phone Number																		
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304																			
	SEDIMENTATION RATE	Value: 9 mm/hr Ref Range: 0 - 13 mm/hr Text: SEDIMENTATION RATE 9 0 - 13 mm/hr CHARLESTON AREA MEDICAL CENTER																			
01/02/2019	10222676	Associated Procedure: #Result237724382 Procedure Text: C-REACTIVE PROTEIN(CRP), INF LAMMATION (01/02/2019 4:08 PM EST) <table> <thead> <tr> <th>Component</th> <th>Value</th> <th>Ref Range</th> <th>Performed At</th> <th>Pathologist Signature</th> </tr> </thead> <tbody> <tr> <td>C-REACTIVE PROTEIN HIGH SENSITIVITY (INFLAMMATION)</td> <td><2.9</td> <td>0.0 - 2.9 mg/L</td> <td>CHARLESTON AREA MEDICAL CENTER</td> <td></td> </tr> </tbody> </table> <p>Blood - Blood</p> <p>Narrative</p> <p>Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302</p> <p>Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432</p> <table> <thead> <tr> <th>Performing Organization</th> <th>Address</th> <th>City/State/Zipcode</th> <th>Phone Number</th> </tr> </thead> <tbody> <tr> <td>CHARLESTON AREA MEDICAL CENTER</td> <td>3200 MacCorkle Avenue, S.E.</td> <td>Charleston, PA 25304</td> <td></td> </tr> </tbody> </table>	Component	Value	Ref Range	Performed At	Pathologist Signature	C-REACTIVE PROTEIN HIGH SENSITIVITY (INFLAMMATION)	<2.9	0.0 - 2.9 mg/L	CHARLESTON AREA MEDICAL CENTER		Performing Organization	Address	City/State/Zipcode	Phone Number	CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304		
Component	Value	Ref Range	Performed At	Pathologist Signature																	
C-REACTIVE PROTEIN HIGH SENSITIVITY (INFLAMMATION)	<2.9	0.0 - 2.9 mg/L	CHARLESTON AREA MEDICAL CENTER																		
Performing Organization	Address	City/State/Zipcode	Phone Number																		
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304																			
	C-REACTIVE PROTEIN HIGH SENSITIVITY (INFLAMMATION)	Value: <2.9 Ref Range: 0.0 - 2.9 mg/L Text: C-REACTIVE PROTEIN HIGH SENSITIVITY <2.9 0.0 - 2.9 mg/L CHARLESTON AREA MEDICAL CENTER																			
01/02/2019	Lipase SerPI-cCnc	LIPASE Value: 84 unit/L Ref Range: 145 - 209 unit/L Interpretation: L																			

Date	Test	Text: LIPASE 84 145 - 209 unit/L (L)				CHARLESTON AREA MEDICAL CENTER		EXHIBIT NO. B12F PAGE: 15 OF 27	
	Associated Procedure: Lipase SerPl-cCnc	Text: LIPASE (01/02/2019 4:08 PM EST)	Component	Value	Ref Range	Performed At	Pathologist Signature		
		LIPASE	84	145 - 209 (L)	unit/L	CHARLESTON AREA MEDICAL CENTER	Specimen		
		Blood - Blood	Narrative		Performed At		CHARLESTON AREA MEDICAL CENTER		
		Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302					CHARLESTON AREA MEDICAL CENTER		
		Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432	Performing Organization		Address	City/State/Zipco de	Phone Number		
		CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.		Charleston, PA		25304		
01/02/2019	10212164	Associated Procedure: #Result237724384 Procedure	Text: COMPREHENSIVE METABOLIC PANEL, NON-FASTING (01/02/2019 4:07 PM EST)	Component	Value	Ref Range	Performed At	Pathologist Signature	
		BUN	11	4 - 18 mg/dL	CHARLESTON AREA MEDICAL CENTER				
		AST (SGOT)	43	11 - 47 unit/L	CHARLESTON AREA MEDICAL CENTER				
		ALT (SGPT)	28	5 - 39 unit/L	CHARLESTON AREA MEDICAL CENTER				
		ALKALINE PHOSPHATASE	181	59 - 291 unit/L	CHARLESTON AREA MEDICAL CENTER				
		CO2 TOTAL	22	18 - 29 mmol/L	CHARLESTON AREA MEDICAL CENTER				
		CALCIUM	9.2	8.0 - 10.4 mg/dL	CHARLESTON AREA MEDICAL CENTER				
		POTASSIUM	4.5	3.5 - 4.9 mmol/L	CHARLESTON AREA MEDICAL CENTER				
		SODIUM	137	134 - 142 mmol/L	CHARLESTON AREA MEDICAL CENTER				
		CREATININE	0.4	0.1 - 0.7 mg/dL	CHARLESTON AREA MEDICAL CENTER				
		BILIRUBIN, TOTAL	0.2	0.2 - 0.9 mg/dL	CHARLESTON AREA MEDICAL CENTER				
		CHLORIDE	104	96 - 111 mmol/L	CHARLESTON AREA MEDICAL CENTER				
		ALBUMIN	3.6	3.5 - 5.5 g/dL	CHARLESTON AREA MEDICAL CENTER				
		GLUCOSE	84	67 - 138 mg/dL	CHARLESTON AREA MEDICAL CENTER				
		TOTAL PROTEIN	6.8	4.9 - 8.3 g/dL	CHARLESTON AREA MEDICAL CENTER				
		Blood - Blood	Narrative		Performed At		CHARLESTON AREA MEDICAL CENTER		
		Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302					CHARLESTON AREA MEDICAL CENTER		
		Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432					CHARLESTON AREA MEDICAL CENTER		

Date	Test	Performing Organization	Address	City/State/Zip	EXHIBIT NO. B12F PAGE: 16 OF 27
		CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	Number
	ALBUMIN	Value: 3.6 g/dL Ref Range: 3.5 - 5.5 g/dL Text: ALBUMIN 3.6 3.5 - 5.5 g/dL	CHARLESTON AREA MEDICAL CENTER		
	ALKALINE PHOSPHATASE	Value: 181 unit/L Ref Range: 59 - 291 unit/L Text: ALKALINE PHOSPHATASE 181 59 - 291 unit/L	CHARLESTON AREA MEDICAL CENTER		
	ALT (SGPT)	Value: 28 unit/L Ref Range: 5 - 39 unit/L Text: ALT (SGPT) 28 5 - 39 unit/L	CHARLESTON AREA MEDICAL CENTER		
	AST (SGOT)	Value: 43 unit/L Ref Range: 11 - 47 unit/L Text: AST (SGOT) 43 11 - 47 unit/L	CHARLESTON AREA MEDICAL CENTER		
	BILIRUBIN, TOTAL	Value: 0.2 mg/dL Ref Range: 0.2 - 0.9 mg/dL Text: BILIRUBIN, TOTAL 0.2 0.2 - 0.9 mg/dL	CHARLESTON AREA MEDICAL CENTER		
	BUN SerPl-mCnc	Value: 11 mg/dL Ref Range: 4 - 18 mg/dL Text: BUN 11 4 - 18 mg/dL	CHARLESTON AREA MEDICAL CENTER		
	CO2 Bld-sCnc	Value: 22 mmol/L Ref Range: 18 - 29 mmol/L Text: CO2 TOTAL 22 18 - 29 mmol/L	CHARLESTON AREA MEDICAL CENTER		
	CREATININE	Value: 0.4 mg/dL Ref Range: 0.1 - 0.7 mg/dL Text: CREATININE 0.4 0.1 - 0.7 mg/dL	CHARLESTON AREA MEDICAL CENTER		
	Calcium SerPl-mCnc	Value: 9.2 mg/dL Ref Range: 8.0 - 10.4 mg/dL Text: CALCIUM 9.2 8.0 - 10.4 mg/dL	CHARLESTON AREA MEDICAL CENTER		
	Chloride SerPl-sCnc	Value: 104 mmol/L Ref Range: 96 - 111 mmol/L Text: CHLORIDE 104 96 - 111 mmol/L	CHARLESTON AREA MEDICAL CENTER		
	Glucose Bld-mCnc	Value: 84 mg/dL Ref Range: 67 - 138 mg/dL Text: GLUCOSE 84 67 - 138 mg/dL	CHARLESTON AREA MEDICAL CENTER		
	Potassium SerPl-sCnc	Value: 4.5 mmol/L Ref Range: 3.5 - 4.9 mmol/L Text: POTASSIUM 4.5 3.5 - 4.9 mmol/L	CHARLESTON AREA MEDICAL CENTER		
	Sodium SerPl-sCnc	Value: 137 mmol/L Ref Range: 134 - 142 mmol/L Text: SODIUM 137 134 - 142 mmol/L	CHARLESTON AREA MEDICAL CENTER		
	TOTAL PROTEIN	Value: 6.8 g/dL Ref Range: 4.9 - 8.3 g/dL Text: TOTAL PROTEIN 6.8 4.9 - 8.3 g/dL	CHARLESTON AREA MEDICAL CENTER		
01/02/2019	Amylase XXX-cCnc				

Date	Test	EXHIBIT NO. B12F PAGE: 17 OF 27			
	AMYLASE	Value: 56 unit/L Ref Range: 6 - 105 unit/L Text: AMYLASE 56 6 - 105 unit/L	CHARLESTON AREA MEDICAL CENTER		
	Associated Procedure: Amylase XXX-cCnc	Text: AMYLASE (01/02/2019 4:07 PM EST) Component Value Ref Range	Performed At	Pathologist Signature	
		AMYLASE 56 6 - 105 unit/L	CHARLESTON AREA MEDICAL CENTER		
			Specimen		
		Blood - Blood			
			Narrative	Performed At	
			Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302	CHARLESTON AREA MEDICAL CENTER	
			Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432		
			Performing Organization	Address	City/State/Zipco de Phone Number
			CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304
01/02/2019	CBC W Auto Diff Bld				
	ABSOLUTE NEUTROPHIL COUNT	Value: 3.70 x10 Ref Range: 1.34 - 12.01 x10 Text: ABSOLUTE NEUTROPHIL COUNT	3.70 1.34 - 12.01 x10	CHARLESTON AREA MEDICAL CENTER	
	BASOPHILS	Value: 0.6 % Ref Range: 0.0 - 4.0 % Text: BASOPHILS 0.6 0.0 - 4.0 %		CHARLESTON AREA MEDICAL CENTER	
	BASOS ABS	Value: 0.00 x10 Ref Range: 0.00 - 0.53 x10 Text: BASOS ABS 0.00 0.00 - 0.53 x10		CHARLESTON AREA MEDICAL CENTER	
	Associated Procedure: CBC W Auto Diff Bld	Text: CBC/DIFF (01/02/2019 4:01 PM EST)	Component	Value	Ref Range
			PLATELET COUNT	202	163 - 461 x10
			RDW	13.1	CHARLESTON AREA MEDICAL CENTER
			MCHC	34.3	10.7 - 14.0 %
			MPV	7.6	CHARLESTON AREA MEDICAL CENTER
			MCH	29.4	32.3 - 34.8 g/dL
			HGB	12.5	6.4 - 9.2 CHARLESTON fL
			MCV	85.5	CHARLESTON AREA MEDICAL CENTER

<u>Date</u>	<u>Test</u>				
	HCT	36.4	34.0 - 43.8 %	CHARLESTON AREA MEDICAL CENTER	EXHIBIT NO. B12F PAGE: 18 OF 27
	RBC	4.26	3.96 - 5.36 x10	CHARLESTON AREA MEDICAL CENTER	
	WBC	7.0	4.2 - 13.2 x10	CHARLESTON AREA MEDICAL CENTER	
		Comment:			
		Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302 Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432			
	LYMPHOCYTES	36.4	7.0 - 55.0 %	CHARLESTON AREA MEDICAL CENTER	
	PMN'S	52.7	32.0 - 91.0 %	CHARLESTON AREA MEDICAL CENTER	
	EOS ABS	0.20	0.00 - 0.92 x10	CHARLESTON AREA MEDICAL CENTER	
	MONOS ABS	0.60	0.13 - 1.98 x10	CHARLESTON AREA MEDICAL CENTER	
	LYMPHS ABS	2.50	0.29 - 7.26 x10	CHARLESTON AREA MEDICAL CENTER	
	BASOPHILS	0.6	0.0 - 4.0 % AREA MEDICAL CENTER		
	BASOS ABS	0.00	0.00 - 0.53 x10	CHARLESTON AREA MEDICAL CENTER	
	EOSINOPHIL	2.4	0.0 - 7.0 % AREA MEDICAL CENTER		
	ABSOLUTE NEUTROPHIL COUNT	3.70	1.34 - 12.01 x10	CHARLESTON AREA MEDICAL CENTER	
	MONOCYTES	7.9	3.0 - 15.0 %	CHARLESTON AREA MEDICAL CENTER	
		Specimen			
		Blood - Blood			
		Narrative		Performed At	
		Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302		CHARLESTON AREA MEDICAL CENTER	
		Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432			
		Performing Organization	Address	City/State/Zipco de	Phone Number
		CHARLESTON AREA MEDICAL CENTER		3200 MacCorkle Avenue, S.E.	
				Charleston, PA 25304	
	EOS ABS	Value: 0.20 x10 Ref Range: 0.00 - 0.92 x10 Text: EOS ABS 0.20 0.00 - 0.92 x10 CHARLESTON AREA MEDICAL CENTER			

<u>Date</u>	<u>Test</u>		EXHIBIT NO. B12F PAGE: 19 OF 27
	EOSINOPHIL	Value: 2.4 % Ref Range: 0.0 - 7.0 % Text: EOSINOPHIL 2.4 0.0 - 7.0 %	CHARLESTON AREA MEDICAL CENTER
	HCT	Value: 36.4 % Ref Range: 34.0 - 43.8 % Text: HCT 36.4 34.0 - 43.8 %	CHARLESTON AREA MEDICAL CENTER
	HGB	Value: 12.5 g/dL Ref Range: 11.2 - 14.7 g/dL Text: HGB 12.5 11.2 - 14.7 g/dL	CHARLESTON AREA MEDICAL CENTER
	LYMPHOCYTES	Value: 36.4 % Ref Range: 7.0 - 55.0 % Text: LYMPHOCYTES 36.4 7.0 - 55.0 %	CHARLESTON AREA MEDICAL CENTER
	LYMPHS ABS	Value: 2.50 x10 Ref Range: 0.29 - 7.26 x10 Text: LYMPHS ABS 2.50 0.29 - 7.26 x10	CHARLESTON AREA MEDICAL CENTER
	MCH	Value: 29.4 pg Ref Range: 25.1 - 30.7 pg Text: MCH 29.4 25.1 - 30.7 pg	CHARLESTON AREA MEDICAL CENTER
	MCHC	Value: 34.3 g/dL Ref Range: 32.3 - 34.8 g/dL Text: MCHC 34.3 32.3 - 34.8 g/dL	CHARLESTON AREA MEDICAL CENTER
	MCV	Value: 85.5 fL Ref Range: 76.0 - 90.0 fL Text: MCV 85.5 76.0 - 90.0 fL	CHARLESTON AREA MEDICAL CENTER
	MONOCYTES	Value: 7.9 % Ref Range: 3.0 - 15.0 % Text: MONOCYTES 7.9 3.0 - 15.0 %	CHARLESTON AREA MEDICAL CENTER
	MONOS ABS	Value: 0.60 x10 Ref Range: 0.13 - 1.98 x10 Text: MONOS ABS 0.60 0.13 - 1.98 x10	CHARLESTON AREA MEDICAL CENTER
	MPV	Value: 7.6 fL Ref Range: 6.4 - 9.2 fL Text: MPV 7.6 6.4 - 9.2 fL	CHARLESTON AREA MEDICAL CENTER
	PLATELET COUNT	Value: 202 x10 Ref Range: 163 - 461 x10 Text: PLATELET COUNT 202 163 - 461 x10	CHARLESTON AREA MEDICAL CENTER
	PMN'S	Value: 52.7 % Ref Range: 32.0 - 91.0 % Text: PMN'S 52.7 32.0 - 91.0 %	CHARLESTON AREA MEDICAL CENTER
	RBC	Value: 4.26 x10 Ref Range: 3.96 - 5.36 x10 Text: RBC 4.26 3.96 - 5.36 x10	CHARLESTON AREA MEDICAL CENTER
	RDW	Value: 13.1 % Ref Range: 10.7 - 14.0 % Text: RDW 13.1 10.7 - 14.0 %	CHARLESTON AREA MEDICAL CENTER
	WBC	Value: 7.0 x10	

Date	Test	Ref Range: 4.2 - 13.2 x10 Text: WBC 7.0 Comment: Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302 Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432	EXHIBIT NO. B12F PAGE: 20 OF 27 4.2 - 13.2 x10 MEDICAL CENTER CHARLESTON AREA
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Narrative Text

- LACTOFERRIN (01/09/2019)

Specimen

Stool

Narrative

This result has an attachment that is not available.

Performed At**Performing Organization**CHARLESTON AREA MEDICAL 3200 MacCorkle Avenue, S.E.
CENTER**Address****City/State/Zipco-de**

Charleston, PA 25304

Phone Number

- CALPROTECTIN, FECES (01/09/2019)

Specimen

Stool

Narrative

This result has an attachment that is not available.

Performed At**Performing Organization**CHARLESTON AREA MEDICAL 3200 MacCorkle Avenue, S.E.
CENTER**Address****City/State/Zipco-de**

Charleston, PA 25304

Phone Number

- PANCREATIC ELASTASE-1 (01/09/2019)

Specimen

Stool

Narrative

This result has an attachment that is not available.

Performed At**Performing Organization**CHARLESTON AREA MEDICAL 3200 MacCorkle Avenue, S.E.
CENTER**Address****City/State/Zipco-de**

Charleston, PA 25304

Phone Number

- OVA AND PARASITE SCREEN (01/09/2019)

Specimen

Other

Narrative

This result has an attachment that is not available.

Performed At**Performing Organization**CHARLESTON AREA MEDICAL 3200 MacCorkle Avenue, S.E.
CENTER**Address****City/State/Zipco-de**

Charleston, PA 25304

Phone Number

- TISSUE TRANSGLUTAMINASE (TTG) ANTIBODY, IGA, SERUM (01/03/2019 3:23 PM EST)

Component Value Ref Range

TISSUE <2.4 0.1 - 7.0 EU/mL

TRANSGLUTAMINASE
(TTG) ANTIBODIES,
IGA, SERUM**Performed At**CHARLESTON
AREA MEDICAL
CENTER**Pathologist Signature****Specimen**

Blood-Blood

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Performed AtCHARLESTON AREA
MEDICAL CENTER

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
• GLIADIN (DEAMIDATED) ANTIBODY, IGG, SERUM (01/03/2019 3:23 PM EST)			
EXHIBIT NO. B12F			
PAGE: 21 OF 27			
Component	Value	Ref Range	Performed At
GLIADIN (DEAMIDATED)	<6.3	0.4 - 7.0 EU/mL	CHARLESTON AREA MEDICAL CENTER
ANTIBODIES EVALUATION, IGG, SERUM			
Specimen			
Blood—Blood			
Narrative			
Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304			
Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432			
Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
• GLIADIN (DEAMIDATED) ANTIBODIES, IGA, SERUM (01/03/2019 3:23 PM EST)			
Component	Value	Ref Range	Performed At
GLIADIN (DEAMIDATED)	<2.8	0.1 - 7.0 EU/mL	CHARLESTON AREA MEDICAL CENTER
ANTIBODIES EVALUATION, IGA, SERUM			
Specimen			
Blood—Blood			
Narrative			
Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304			
Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432			
Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
• TISSUE TRANSGLUTAMINASE (TTG) ANTIBODY, IGG, SERUM (01/03/2019 3:23 PM EST)			
Component	Value	Ref Range	Performed At
TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGG, SERUM	<6.0	0.6 - 7.0 EU/mL	CHARLESTON AREA MEDICAL CENTER
Specimen			
Blood—Blood			
Narrative			
Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304			
Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432			
Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
• C-REACTIVE PROTEIN(CRP), INF LAMMATION (01/02/2019 4:08 PM EST)			
Component	Value	Ref Range	Performed At
C-REACTIVE PROTEIN HIGH SENSITIVITY (INFLAMMATION)	<2.9	0.0 - 2.9 mg/L	CHARLESTON AREA MEDICAL CENTER
Specimen			
Blood—Blood			
Narrative			
Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302			
Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432			
Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	

- ENDOMYSIAL ANTIBODIES (IGA), SERUM (01/03/2019 3:37 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
ENDOMYSIAL IGA Negative ANTIB.		Negative	CHARLESTON AREA MEDICAL CENTER	

Specimen

Blood—Serum

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

- COMPREHENSIVE METABOLIC PANEL, NON-FASTING (01/02/2019 4:07 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
BUN	11	4–18 mg/dL	CHARLESTON AREA MEDICAL CENTER	
AST (SGOT)	43	11–47 unit/L	CHARLESTON AREA MEDICAL CENTER	
ALT (SGPT)	28	5–39 unit/L	CHARLESTON AREA MEDICAL CENTER	
ALKALINE PHOSPHATASE	181	59–291 unit/L	CHARLESTON AREA MEDICAL CENTER	
CO2 TOTAL	22	18–29 mmol/L	CHARLESTON AREA MEDICAL CENTER	
CALCIUM	9.2	8.0–10.4 mg/dL	CHARLESTON AREA MEDICAL CENTER	
POTASSIUM	4.5	3.5–4.9 mmol/L	CHARLESTON AREA MEDICAL CENTER	
SODIUM	137	134–142 mmol/L	CHARLESTON AREA MEDICAL CENTER	
CREATININE	0.4	0.1–0.7 mg/dL	CHARLESTON AREA MEDICAL CENTER	
BILIRUBIN, TOTAL	0.2	0.2–0.9 mg/dL	CHARLESTON AREA MEDICAL CENTER	
CHLORIDE	104	96–111 mmol/L	CHARLESTON AREA MEDICAL CENTER	
ALBUMIN	3.6	3.5–5.5 g/dL	CHARLESTON AREA MEDICAL CENTER	
GLUCOSE	84	67–138 mg/dL	CHARLESTON AREA MEDICAL CENTER	
TOTAL PROTEIN	6.8	4.9–8.3 g/dL	CHARLESTON AREA MEDICAL CENTER	

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

EXHIBIT NO. B12F**PAGE: 22 OF 27**

Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
• SEDIMENTATION RATE (01/02/2019 4:21 PM EST)			EXHIBIT NO. B12F PAGE: 23 OF 27
Component	Value	Ref Range	Performed At
SEDIMENTATION RATE	9	0 - 13 mm/hr	CHARLESTON AREA MEDICAL CENTER
Specimen			
Blood - Blood			
Narrative			
Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302			
Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432			
Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
• CBC/DIFF (01/02/2019 4:01 PM EST)			
Component	Value	Ref Range	Performed At
PLATELET COUNT	202	163 - 461 x10 ³	CHARLESTON AREA MEDICAL CENTER
RDW	13.1	10.7 - 14.0 %	CHARLESTON AREA MEDICAL CENTER
MCHC	34.3	32.3 - 34.8 g/dL	CHARLESTON AREA MEDICAL CENTER
MPV	7.6	6.4 - 9.2 fL	CHARLESTON AREA MEDICAL CENTER
MCH	29.4	25.1 - 30.7 pg	CHARLESTON AREA MEDICAL CENTER
HGB	12.5	11.2 - 14.7 g/dL	CHARLESTON AREA MEDICAL CENTER
MCV	85.5	76.0 - 90.0 fL	CHARLESTON AREA MEDICAL CENTER
HCT	36.4	34.0 - 43.8 %	CHARLESTON AREA MEDICAL CENTER
RBC	4.26	3.96 - 5.36 x10 ¹² /L	CHARLESTON AREA MEDICAL CENTER
WBC	7.0	4.2 - 13.2 x10 ³ /L	CHARLESTON AREA MEDICAL CENTER
Comment:			
Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302			
Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432			
LYMPHOCYTES	36.4	7.0 - 55.0 %	CHARLESTON AREA MEDICAL CENTER
PMN'S	52.7	32.0 - 91.0 %	CHARLESTON AREA MEDICAL CENTER

Component	Value	Ref Range	Performed At	Pathologist Signature
EOS-ABS	0.20	0.00 – 0.92 x10	CHARLESTON AREA MEDICAL CENTER	EXHIBIT NO. B12F PAGE: 24 OF 27
MONOS-ABS	0.60	0.13 – 1.98 x10	CHARLESTON AREA MEDICAL CENTER	
LYMPHS-ABS	2.50	0.29 – 7.26 x10	CHARLESTON AREA MEDICAL CENTER	
BASOPHILS	0.6	0.0 – 4.0 %	CHARLESTON AREA MEDICAL CENTER	
BASOS-ABS	0.00	0.00 – 0.53 x10	CHARLESTON AREA MEDICAL CENTER	
EOSINOPHIL	2.4	0.0 – 7.0 %	CHARLESTON AREA MEDICAL CENTER	
ABSOLUTE NEUTROPHIL COUNT	3.70	1.34 – 12.01 x10	CHARLESTON AREA MEDICAL CENTER	
MONOCYTES	7.9	3.0 – 15.0 %	CHARLESTON AREA MEDICAL CENTER	

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	

• THYROID STIMULATING HORMONE (SENSITIVE TSH) (01/02/2019 5:16 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
TSH	2.970	0.400 – 6.000 mIU/mL	CHARLESTON AREA MEDICAL CENTER	

Comment:

Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely lowered results for the TSH assay.

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL CENTER	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	

• THYROXINE, FREE (FREE T4) (01/02/2019 5:06 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
THYROXINE, FREE (FREE T4)	1.3	0.9 – 1.8 ng/dL	CHARLESTON AREA MEDICAL CENTER	EXHIBIT NO. B12F PAGE: 25 OF 27
Comment:				
Specimens from patients who are undergoing biotin therapy and/or ingesting biotin supplements may contain high levels of biotin. Higher biotin concentration in these specimens may interfere with the assay design. Specimens that contain high levels of biotin may cause falsely elevated results for the Free T4 assay.				

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Performed At
CHARLESTON AREA
MEDICAL CENTER

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Phone Number

Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
CENTER			

- LIPASE (01/02/2019 4:08 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
LIPASE	84 (L)	145 – 209 unit/L	CHARLESTON AREA MEDICAL CENTER	

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302

Performed At
CHARLESTON AREA
MEDICAL CENTER

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Phone Number

Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
CENTER			

- IMMUNOGLOBULIN A (IGA), SERUM (01/03/2019 6:06 AM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
IMMUNOGLOBULIN A	77.6	27.0 – 195.0 mg/dL	CHARLESTON AREA MEDICAL CENTER	

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Memorial Hospital, 3200 MacCorkle Ave SE, Charleston, WV 25304

Performed At
CHARLESTON AREA
MEDICAL CENTER

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Phone Number

Performing Organization	Address	City/State/Zipcode	Phone Number
CHARLESTON AREA MEDICAL	3200 MacCorkle Avenue, S.E.	Charleston, PA 25304	
CENTER			

- AMYLASE (01/02/2019 4:07 PM EST)

Component	Value	Ref Range	Performed At	Pathologist Signature
AMYLASE	56	6 – 105 unit/L	CHARLESTON AREA MEDICAL CENTER	

Specimen

Blood—Blood

Narrative

Test Performed at: CAMC Women and Children's, 800 Pennsylvania Avenue, Charleston, WV 25302

Performed At
CHARLESTON AREA
MEDICAL CENTER

Medical Director: Milton J. Plata, M.D. Phone: (304)388-5432

Performing Organization

CHARLESTON AREA MEDICAL CENTER
3200 MacCorkle Avenue, S.E.

Address

Charleston, PA 25304
CITY/STATE/ZIPCODE

Phone Number

EXHIBIT NO. B12F
PAGE: 26 OF 27

from 12/20/2018 to 01/16/2019

VITALS

Vital Signs

Type	Date	Interpretation	Value	Ref Range
Bdy height	01/02/2019		90.1 cm	
Weight	01/02/2019		15.7 kg	

Narrative Text

Vital Sign	Reading	Time Taken
Blood Pressure	-	-
Pulse	-	-
Temperature	-	-
Respiratory Rate	-	-
Oxygen Saturation	-	-
Inhaled Oxygen Concentration	-	-
Weight	15.7 kg (34 lb 9.8 oz)	01/02/2019 1:09 PM EST
Height	90.1 cm (2' 11.47")	01/02/2019 1:09 PM EST
Body Mass Index	19.34	01/02/2019 1:09 PM EST

MEDS

Medication Information

Non-identified Provider

Date	Product	Indication	Status	Dose	Frequency	Quantity
12/20/2018	0169-7705-21		Active		Unknown	2
12/20/2018	8290-320122		Active		Unknown	100

Narrative Text

Medication	Sig	Dispensed	Refills	Start Date	End Date	Status
NORDITROPIN FLEXPRO 10 mg/1.5 mL (6.7 mg/mL) Subcutaneous Pen Injector	Inject 0.7 mg SQ daily	2 Syringe	5	12/20/2018		Active
Insulin Needles, Disposable, (NANO PEN NEEDLE) 32 gauge x daily 5/32" Needle	Use to inject growth hormone	100 Each	1	12/20/2018		Active

CARE PLAN

Plan of Care

Narrative Text

Upcoming Encounters

Date Type
02/06/2019 Office Visit

Specialty

Care Team
Dye, Amanda, MD

Description

830 PENNSYLVANIA AVE
SUITE 103
CHARLESTON, WV 25302
304-388-1552

304-388-1587 (Fax)

Last Done

Health Maintenance **Due Date**
Hepatitis B Vaccine (1 of 3 - 3- dose primary series) **07/21/2015**

DTaP-Tdap-Td Series (1 - DTaP) **09/21/2015**
IPV Vaccines (1 of 4 - All-IPV series)

Hepatitis A Vaccine (1 of 2 - 2- dose series) **07/21/2016**

HIB Vaccines (1 of 1 - Start at 15 months series) **10/21/2016**

MMR Vaccines (1 of 2 - Standard series) **11/21/2016**

Pneumococcal 0-5 Years (1 of 1 - Start at 24 months series) **07/21/2017**

Influenza Vaccine (1 of 2) **09/01/2018**

Varicella Vaccine (2 of 2 - 2-dose childhood series) 07/21/2019 **10/24/2016**

Meningococcal Vaccine (1 - 2- dose series) 07/21/2026

Rotavirus vaccine Aged Out 12/17/2015

Comments

No longer eligible based on patient's age to complete this topic

PROV LIST

Healthcare Providers

West Virginia University Medicine (05/09/2018 - No Date Available)

Provider Name

Rahmet Muzaffer, MD

Address

Telecom

MRN

EXHIBIT NO. B13F
PAGE: 1 OF 10


PEDS CARDIOLOGY
RADFORD
2900 LAMB CIRCLE, SUITE
250

Adams, Nevaeh Hope
MRN: 7444644, DOB: 7/21/2015, Sex: F
Encounter date: 1/15/2019

Reason for Visit

Heart Problem

Medical History**Medical as of 1/15/2019****Past Medical History**

Diagnosis	Date	Comments	Source Provider
Cardiac abnormality [Q24.9]	—	—	—

Surgical History**Surgical as of 1/15/2019**

None

Problem List as of 1/15/2019

Reviewed: 8/4/2015 2:14 PM by Bulkeley, Julia A, MD

	ICD-10-CM	Priority	Class	Noted - Resolved
Single liveborn infant delivered vaginally	Z38.00			7/21/2015 - Present Entered by McClendon, Ashleigh K, DO
Bicuspid aortic valve	Q23.1			7/22/2015 - Present Entered by Miller, Joelle D, MD
Turner syndrome	Q96.9			7/22/2015 - Present Entered by Doherty, Emily S, MD
Term birth of female newborn	Z37.0			7/24/2015 - Present Entered by Sherman, James M Jr., MD
Aortic valve insufficiency	I35.1			5/9/2018 - Present Entered by Herold, Steven E, MD
Esotropia	H50.00			5/9/2018 - Present Entered by Herold, Steven E, MD
Personal history of congenital hip dysplasia	Z87.76			5/9/2018 - Present Entered by Herold, Steven E, MD

Overview Signed 1/15/2019 3:42 PM by Herold, Steven E, MD

Overview:

S/p open reduction

ALL AMBULATORY NOTES**Progress Notes**

Author: Herold, Steven E, MD
Filed: 1/15/2019 3:55 PM
Editor: Herold, Steven E, MD (Physician)

Specialty: Pediatric Cardiology
Encounter Date: 1/15/2019

Author Type: Physician
Status: Signed



Carilion Children's Hospital Pediatric Cardiology Clinic
102 Highland Avenue, Suite 101
Roanoke, VA 24013
Office - 540.224.4545, Fax - 540.985.5304

Chief, Steven E. Herold, MD
William M. Gay, MD
Asma S. Habib, MD
Herbert G. Whitley, MD

EXHIBIT NO. B13F
PAGE: 2 OF 10


PEDS CARDIOLOGY
RADFORD
2900 LAMB CIRCLE, SUITE
250

Adams, Nevaeh Hope
MRN: 7444644, DOB: 7/21/2015, Sex: F
Encounter date: 1/15/2019

ALL AMBULATORY NOTES (continued)
Progress Notes (continued)

Al-Attar, Inas Hassan, MD
143 Undercliff Ter
Princeton, WV 24740

1/15/2019

Patent Name: Nevaeh Hope Adams
Date of Birth: 7/21/2015
MRN: 7444644

Dear Dr. Al-Attar,

I had the pleasure of seeing your patient, Nevaeh, in our New River Valley clinic. This is a 3 y.o. 5 m.o. old young lady who is accompanied in the office today by her mother. She has been followed in our clinic with an underlying diagnosis of Turner syndrome and secondary cardiac abnormalities including a bicuspid aortic valve. She was last seen in our clinic by Dr. Miller in November 2016. At that time, there was no significant aortic valve stenosis or insufficiency. The aortic root was normal in appearance. Since her last evaluation, she has had no overt cardiac symptoms. She is an active young lady with no history of an increase in the work of breathing with activity, cyanosis, or diaphoresis. She continues to have a growth delay. She is due to start growth hormone later this year. Since her last evaluation, she had her bilateral hip surgery and tolerated it well. She has otherwise had no significant illnesses or surgeries.

PMH:
Patient Active Problem List
Diagnosis

- Single liveborn infant delivered vaginally
- Bicuspid aortic valve
- Turner syndrome
- Term birth of female newborn
- Aortic valve insufficiency
- Esotropia
- Personal history of congenital hip dysplasia

Outpatient Prescriptions as of 1/15/2019

Medication	Indication(s)	Sig
• Insulin Needles, Disposable, (NANO PEN NEEDLE) 32 gauge x 5/32" Needle		Use to inject growth hormone daily
• Somatropin (NORDITROPIN FLEXPRO) 10 mg/1.5 mL (6.7 mg/mL) Pen Injector		Inject 0.7 mg SQ daily

Allergies

Allergen	Reactions
• Amoxicillin	Hives and Rash

EXHIBIT NO. B13F
PAGE: 3 OF 10


PEDS CARDIOLOGY
RADFORD
2900 LAMB CIRCLE, SUITE
250

Adams, Nevaeh Hope
MRN: 7444644, DOB: 7/21/2015, Sex: F
Encounter date: 1/15/2019

ALL AMBULATORY NOTES (continued)
Progress Notes (continued)

Significant family History: No family history on file.

Social History:
Social History

Other Topics

- Not on file

Concern
Social History Narrative

- No narrative on file

Review of Systems:

General: Denies fatigue.

Eyes: Denies vision loss.

Ears/Nose/Throat: Denies decreased hearing.

Cardiovascular: Complains of: see HPI.

Respiratory: Denies dyspnea.

Gastrointestinal: Denies vomiting, diarrhea.

Genitourinary: voiding well

Musculoskeletal: Denies joint swelling.

Skin: Denies rash.

Neurologic: Denies seizures.

Developmental: delayed

Heme/Lymphatic: Denies history of anemia.

Allergic/Immunologic: Denies environmental allergies.

Objective:

BP (!) 137/75 | Pulse 101 | Resp 23 | Ht 0.914 m (3') | Wt 15.6 kg (34 lb 8 oz) | SpO2 99% | BMI 18.72 kg/m²

67 %ile (Z= 0.45) based on CDC 2-20 Years weight-for-age data using vitals from 1/15/2019.

8 %ile (Z= -1.43) based on CDC 2-20 Years stature-for-age data using vitals from 1/15/2019.

97 %ile (Z= 1.93) based on CDC 2-20 Years BMI-for-age data using vitals from 1/15/2019.

Blood pressure percentiles are >99 % systolic and >99 % diastolic based on the August 2017 AAP Clinical Practice Guideline. This reading is in the Stage 2 hypertension range (BP >= 95th percentile + 12 mmHg). Her blood pressure was obtained during extreme agitation.

Exam:

General :alert, active, no distress; small stature for age

Neuro: Awake and alert, mental status normal, no cranial nerve deficits, normal strength and tone

Head/Eyes/Ears/Nose/Throat: Head NC/AT, OP clear, neck soft and supple; dysmorphic facies are noted.

Neck: Supple with no lymphadenopathy noted. No bruits or JVD noted.

Chest: Symmetric. There is no evidence of sternal abnormalities.

Lungs: Clear to auscultation, unlabored breathing

CV: Precordium quiet to palpation, pulses equal and easily palpable in the upper and lower extremities.

**EXHIBIT NO. B13F
PAGE: 4 OF 10**


PEDS CARDIOLOGY
RADFORD
2900 LAMB CIRCLE, SUITE
250

Adams, Nevaeh Hope
MRN: 7444644, DOB: 7/21/2015, Sex: F
Encounter date: 1/15/2019

ALL AMBULATORY NOTES (continued)
Progress Notes (continued)

Normal S1, normal S2 with normal splitting.
Normal rate, regular rhythm, no ectopy heard; a faint ejection click is noted when she is sitting upright.
No heart murmur is noted on auscultation.
Abd: Normal appearance, soft, non-tender, without organ enlargement or masses.
Extremities: extremities warm and well perfused, brisk capillary refill, 2+
Musculoskeletal: Normal symmetric bulk and strength
Skin: No rashes or abnormal dyspigmentation

Studies

Echocardiogram (1/15/2019): 1. Bicuspid aortic valve with left/right cusp fusion - peak velocity 1.8 m/s; no insufficiency.
2. Mild dilation of the sinus of valsalva - AoV 1.5 cm (z score 1.5), SoV 2.2 cm (2.5), ST jxn 1.7 (1.8), AAo 1.8 cm (1.9).
3. No LV enlargement.
4. No coarctation of the aorta.

Assessment:
Encounter Diagnosis
ICD-10
CM

1. Bicuspid aortic valve	Q23.1
2. Turner syndrome	Q96.9
3. Congenital aortic valve stenosis	Q23.0

Neveah has had no interval change to her aortic valve. She continues to have no significant aortic stenosis or insufficiency. In addition, her aortic root demonstrates no significant dilation of there is some prominence of her sinus of Valsalva. I think that simple observation is all that is necessary at this time. From a cardiac standpoint, she is cleared for all activity. I recommended routine reevaluation in 2 years.

She was very agitated for her blood pressure evaluation. We were unable to obtain a measurement when she was calm. Given her potential risk for hypertension throughout childhood, I would recommend routine blood pressure assessments at well-child visits.

Plan:

Bacterial Endocarditis Prophylaxis: SBE prophylaxis is not indicated.

Exercise limitations: none

Follow up in 2 years., No activity restrictions and No cardiac medications

Medication list reviewed with patient and updated as indicated. Patient given a printed copy of current medication list. Patient verbalized understanding of instructions given.

Thank you for allowing me to participate in the care of this young lady. If I can be of further assistance in the management of this patient, please feel free to call my office at (540) 224-4545 or email me at seherold@carilionclinic.org.

Steven E Herold, MD
Pediatric Cardiology

Printed by AMPERDUE at 1/29/19 1:44 PM

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EXHIBIT NO. B13F
PAGE: 5 OF 10


PEDS CARDIOLOGY
RADFORD
2900 LAMB CIRCLE, SUITE
250

Adams, Nevaeh Hope
MRN: 7444644, DOB: 7/21/2015, Sex: F
Encounter date: 1/15/2019

ALL AMBULATORY NOTES (continued)
Progress Notes (continued)

Note: Parts or all of this document were prepared utilizing voice recognition software and may contain small irregularities and grammatical errors, which are unintentional.

Electronically signed by Herold, Steven E, MD at 1/15/2019 3:55 PM

Progress Notes

Author: Melkus-McGuire, Amy S, RN
Filed: 1/15/2019 3:55 PM
Editor: Melkus-McGuire, Amy S, RN (Registered Nurse)

Specialty: ,
Encounter Date: 1/15/2019

Author Type: Registered Nurse
Status: Signed

Patient identified by name and date of birth. Medication list has been reviewed and updated with the patient/caregiver. At the conclusion of today's visit, the patient will receive a copy of an after visit summary which includes any orders entered, current medications, and any future appointments. If the patient leaves without receiving the after visit summary, a copy of the above information will be mailed to them.

Child lives with both parents

Parents are married

Mother's Occupation: homemaker

Father's Occupation: coalminer

Electronically signed by Melkus-McGuire, Amy S, RN at 1/15/2019 3:55 PM

Patient Instructions

Author: Herold, Steven E, MD
Filed: 1/15/2019 3:55 PM
Editor: Herold, Steven E, MD (Physician)

Specialty: Pediatric Cardiology
Encounter Date: 1/15/2019

Author Type: Physician
Status: Signed

Assessment:
Encounter Diagnosis

ICD-10

CM

- | | |
|-------------------------------------|-------|
| 1. Bicuspid aortic valve | Q23.1 |
| 2. Turner syndrome | Q96.9 |
| 3. Congenital aortic valve stenosis | Q23.0 |

Neveah has had no interval change to her aortic valve. She continues to have no significant aortic stenosis or insufficiency. In addition, her aortic root demonstrates no significant dilation of there is some prominence of her sinus of Valsalva. I think that simple observation is all that is necessary at this time. From a cardiac standpoint, she is cleared for all activity. I recommended routine reevaluation in 2 years.

She was very agitated for her blood pressure evaluation. We were unable to obtain a measurement when she was calm. Given her potential risk for hypertension throughout childhood, I would recommend routine blood pressure assessments at well-child visits.

Plan:

Bacterial Endocarditis Prophylaxis: SBE prophylaxis is not indicated.

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**EXHIBIT NO. B13F
PAGE: 6 OF 10**


PEDS CARDIOLOGY
RADFORD
2900 LAMB CIRCLE, SUITE
250

Adams, Nevaeh Hope
MRN: 7444644, DOB: 7/21/2015, Sex: F
Encounter date: 1/15/2019

ALL AMBULATORY NOTES (continued)
Patient Instructions (continued)

Exercise limitations: none

Follow up in 2 years., No activity restrictions and No cardiac medications

Medication list reviewed with patient and updated as indicated. Patient given a printed copy of current medication list. Patient verbalized understanding of instructions given.

Thank you for allowing me to participate in the care of this young lady. If I can be of further assistance in the management of this patient, please feel free to call my office at (540) 224-4545 or email me at seherold@carilionclinic.org.

Steven E Herold, MD
Pediatric Cardiology

Electronically signed by Herold, Steven E, MD at 1/15/2019 3:55 PM

Encounter-Level Documents:

There are no encounter-level documents.

Vitals

BP	Pulse	Resp	Ht	Wt
(1) 137/75	101	23	0.914 m (3')	15.6 kg (34 lb 8 oz)

SpO2
99%

BMI Data

Body Mass Index: 18.72 kg/m²

Body Surface Area: 0.63 m²

Encounter Medications as of 1/15/2019
Outpatient Medications

	Quantity	Refills	Start	End
Insulin Needles, Disposable, (NANO PEN NEEDLE) 32 gauge x 5/32"			12/20/2018	
Needle				
Sig: Use to inject growth hormone daily				
Route: (none)				
Class: Historical Med				
Somatropin (NORDITROPIN FLEXPRO) 10 mg/1.5 mL (6.7 mg/mL)			12/20/2018	
Pen Injector				
Sig: Inject 0.7 mg SQ daily				
Route: (none)				
Class: Historical Med				

All Orders
Insulin Needles, Disposable, (NANO PEN NEEDLE) 32 gauge x 5/32" Needle

Electronically signed by: Melkus-McGuire, Amy S, RN on 01/15/19 1426
Ordering user: Melkus-McGuire, Amy S, RN 01/15/19 1426
Frequency: 12/20/18 - Until Discontinued

Status: Active

Authorized by: Provider, Historical

Somatropin (NORDITROPIN FLEXPRO) 10 mg/1.5 mL (6.7 mg/mL) Pen Injector

Electronically signed by: Melkus-McGuire, Amy S, RN on 01/15/19 1426
Ordering user: Melkus-McGuire, Amy S, RN 01/15/19 1426

Status: Active

Authorized by: Provider, Historical

EXHIBIT NO. B13F
PAGE: 7 OF 10


PEDS CARDIOLOGY
RADFORD
2900 LAMB CIRCLE, SUITE
250

Adams, Nevaeh Hope
MRN: 7444644, DOB: 7/21/2015, Sex: F
Encounter date: 1/15/2019

All Orders (continued)
Somatropin (NORDITROPIN FLEXPRO) 10 mg/1.5 mL (6.7 mg/mL) Pen Injector (continued)

Frequency: 12/20/18 - Until Discontinued

All Results

No results found

Allergies as of 1/15/2019

Reviewed on: 1/15/2019

Name	Noted	Reaction Type	Reactions
Amoxicillin	09/29/2016	Allergy	Hives, Rash

Immunizations

Never Reviewed

Name	Date	Dose	VIS Date	Route
Hepatitis B Vaccine	7/22/2015	5 mcg	2/2/2012	Intramuscular

Letters

Letter on 1/15/2019 by HEROLD, STEVEN E [SEHEROLD] Status: Sent



Carilion Children's Pediatric Cardiology, A Department of Roanoke Memorial Hospital
2900 Lamb Circle
Christiansburg VA 24073
Phone: 540-731-2612
Fax: 540-731-2908

1/15/2019

RE:
Nevaeh Hope Adams
Po Box 46
Big Sandy WV 24816

To Whom it May Concern:

This is to certify that Nevaeh Hope Adams was seen in my clinic on 1/15/2019.

She may return to work/school on 1/16/2019 with Full duty, No restrictions.

Please feel free to contact my office if you have any questions or concerns. Thank you for your assistance in this matter.

Sincerely,

EXHIBIT NO. B13F
PAGE: 8 OF 10


PEDS CARDIOLOGY
RADFORD
2900 LAMB CIRCLE, SUITE
250

Adams, Nevaeh Hope
MRN: 7444644, DOB: 7/21/2015, Sex: F
Encounter date: 1/15/2019

Steven E Herold, MD

Diagnoses

Bicuspid aortic valve [168958] - Primary
Turner syndrome [206959]
Congenital aortic valve stenosis [209981]

Comments
Disposition

Return in about 2 years (around 1/15/2021).

Level of Service

Level of Service
OFFICE/OUTPT VISIT,EST,LEVEL III [99213]

Modifiers

Significant, Separately Identifiable Evaluation And Management Service By The Same Physician
On The Same Day Of The Procedure Or Other Service [25]

Results

ECHO PEDIATRIC COMPLETE (Accession 314173011) (Order
287321018)

Patient Information

Patient Name Adams, Nevaeh Hope (355228)	HAR 306077518	Sex Female	DOB 7/21/2015	SSN 999-99-9999
---	------------------	---------------	------------------	--------------------

Code Status
Encounter Info

1/15/2019 3:00 PM	Provider NRV Echo Room 2	Department Echo Chrv	CSN 174714631
-------------------	-----------------------------	-------------------------	------------------

Result Information

Status: Final result (Exam End: 1/15/2019 14:39) Provider Status: Reviewed

Reviewed by List

Herold, Steven E, MD on 1/15/2019 15:49

Component Results

Component ECHO LVEF	65 to 70%
------------------------	-----------

Study Result

Carilion New River Valley Medical Center
IAC Accredited Lab
PEDIATRIC ECHOCARDIOGRAM REPORT

Patient Name: NEVAEH HOPE ADAMS Date of Exam: 1/15/2019
MPI: 3636988 Acct #: 314173011
Site Name: Carilion New River Valley MRN: 355228
Medical Center
IAC Accredited Lab
Date of Birth: 7/21/2015 Height: 36.0 in
Patient Age: 3 years Weight: 34.4 lb
Patient Gender: F BSA: 0.61 m²½



NEW RIVER VALLEY
MEDICAL CENTER
2900 Lamb Circle

Adams, Nevaeh Hope
MRN: 355228, DOB: 7/21/2015, Sex: F
Adm: 1/15/2019, D/C: 1/15/2019

EXHIBIT NO. B13F
PAGE: 9 OF 10

Study Result (continued)

Authorizing Provider: 129502 STEVEN E HEROLD BP: /
Referring Provider: Sonographer: Christina
Griffith
Indication:

Summary:

1. Bicuspid aortic valve with left/right cusp fusion - peak velocity 1.8 m/s; no insufficiency.
2. Mild dilation of the sinus of valsalva - AoV 1.5 cm (z score 1.5), SoV 2.2 cm (2.5), ST jxn 1.7 (1.8), AAo 1.8 cm (1.9).
3. No LV enlargement.
4. No coarctation of the aorta.

Segmental Cardiotype, Cardiac Position, and Situs:

(S,D,S). The heart position is within the left hemithorax. The cardiac apex is oriented leftward. The aorta is to the right of the pulmonary artery. There is visceral situs solitus.

Systemic Veins:

The superior vena cava is right-sided and drains to the right atrium. The inferior vena cava is right-sided and inserts into the right atrium normally.

Pulmonary Veins:

Four pulmonary veins drain to the left atrium.

Atria:

No atrial septal defect is detected. There is no evidence of patent foramen ovale. The right atrium is normal in size. The left atrium is normal in size.

Mitral Valve:

The mitral valve is normal. There is normal laminar forward flow. The papillary muscle configuration appears normal. There is no evidence of mitral valve insufficiency.

Tricuspid Valve:

The tricuspid valve is normal. There is normal laminar forward flow. There is no tricuspid valve regurgitation.

AV Canal/Complex Inlet/Single Ventricle:
The crux of the heart is normal.

Left Ventricle:

Overall left ventricular ejection fraction is estimated at 65 to 70%. The left ventricle is normal in size. Left ventricular systolic function is normal.

Right Ventricle:

The right ventricle is normal in size. Right ventricular systolic function is normal.

Conotruncal Anatomy:

The outflow tracts cross in the usual manner.

Left Ventricular Outflow Tract and Aortic Valve:

There is no evidence of left ventricular outflow obstruction. The aortic valve is mildly bicuspid with fusion of the right and left cusp commissure. Based on Doppler velocities, there is mild aortic transvalvular flow obstruction. There is no evidence of aortic valve insufficiency.

Right Ventricular Outflow Tract and Pulmonary Valve:

There is no evidence of right ventricular outflow obstruction. The pulmonary valve is normal. Transpulmonary flow is laminar, with normal Doppler velocity pattern. There is trivial (physiologic) pulmonary valve insufficiency.

Aorta:

The (aortic) sinuses of Valsalva segment is mildly dilated. The ascending aorta is normal. The transverse aortic arch segment is normal.

Pulmonary Arteries:

The main pulmonary artery is normal. The left branch pulmonary artery is normal. The right branch pulmonary artery is normal.

Coronary Arteries:

The proximal coronary arteries appear to be normal.

**EXHIBIT NO. B13F
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NEW RIVER VALLEY
MEDICAL CENTER
2900 Lamb Circle

Adams, Nevaeh Hope
MRN: 355228, DOB: 7/21/2015, Sex: F
Adm: 1/15/2019, D/C: 1/15/2019

Study Result (continued)

Pericardium:
There is no evidence of pericardial effusion.

Electronically signed by Steven Herold,
Signature Date/Time: 1/15/2019/3:48:03 PM

*** Final ***

Lab and Collection

ECHO PEDIATRIC COMPLETE (Order #287321018) on 1/15/2019 - Lab and Collection Information

Result History

ECHO PEDIATRIC COMPLETE (Order #287321018) on 1/15/2019 - Order Result History Report

END OF REPORT



Logan Pediatrics, Inc.

300 PROSPERITY LANE
#100
Logan, WV 25601-3494
(304)831-0073

EXHIBIT NO. B14F
PAGE: 1 OF 5
Patient Visit Record

Page 1

February 14, 2019

Neveah Adams
Po Box 46
Big Sandy, WV 24816

Date/Time In: 02/12/2019
Date/Time Out: 02/14/2019

Patient ID: ADAM000299

Birth Date: 07/21/2015
Age: 3 Years
Sex: Female

Attending Provider: Nnachi, Okpani
Vitals Recorded By: Nnachi, Okpani
Accompanied By: Kelli Adams (Mother)

Chief Complaint: NP Disability Exam / Pediatric Consultation / Case Site : WV/S55

Accompanied By: Kelli Adams, mother
Allegations: Turners syndrome, heart issues, hip problems, lazy eye, joint problems, vision problems, and developmental delay
DR. NNACHI LICENSE # 21990

Vitals:

Height: 39.00 in, 99.06 cm
Temperature: 97.50 F, 36.39 C (Tempanic)

Weight: 34 lbs, 15.59 kg

BMI: 15.9

History of Present Illness:

E/M Elements

Neveah is a 3 year old caucasian girl brought in by her mother with the above allegations for disability physical examination. She was diagnosed with Turners syndrome in utero with genetic testing showing 47XO karyotype . At birth she was diagnosed with aortic valvular defect by Dr Miller in Roanoke and she also underwent open reduction and internal fixation of her hips at 1 year of age for the diagnosis of congenital hip dysplasia at Shriners Hospital. She has had dental crowning for brittle teeth and a history of recurrent ear infections. She also takes growth hormone therapy for growth retardation managed by Dr Amanda Dye. She also follows with gastroenterologist for recurrent encorpresis and an ophthalmologist for the diagnosis of strabismus at 8 months of age.

She is developmentally delayed based on the various milestones . She has poor cognitive and motor skills and was enrolled with the Birth to Three program in her first three years for which she has aged out of. Mother understands about 40% of her speech and she is clumsy in the morning after waking up . However she knows her colors and can count to 10 and recites ABC alphabets. She can carry out two steps commands . Mother also notes some leg length discrepancy and poor gait.

My observation in the office showed an active and playful girl with poor eye contact and unable to engage in any meaningful interaction with me . However she can make sentences but mostly channelled towards what she wanted around my office , like the toys but unable to engage.

IMMUNIZATION: up to date according to mother

MEDICAL RECORDS: A record from outpatient Specialty Center in Shriners Hospital for Children by Alexander Kuzma MD dated 7/26/18 showed a diagnosis of a 3 year old with Turners syndrome and bilateral developmental dysplasia of the hips.

Another record from Dr Bendre Sachin MD, REFERRED BY PCP Rahmet Muzaffer MD dated 10/04/18 showed diagnosis of bicuspid aortic valve, developmental delay, heart defect, otitis media, Turners Syndrome 45, XO, Visual impairment , esotropia and short stature.

Review of Systems:
HEENT

No findings.

Logan Pediatrics, Inc.

Neveah Adams

EXHIBIT NO. B14F
PAGE: 2 OF 5
Patient Visit Record

Page 2

February 14, 2019

Chest	No findings.
Cardiac	No findings.
Abdomen	No findings.
Urinary Tract	No findings.
Genital	No findings.
Orthopedic	No findings.
Neurological	No findings.
Psychosocial	No findings.
Endocrine	No findings.

Physical Exam:

Appearance	Normal
Skin	Clear, pink no unusual pigmentation. No rashes or lesions seen.
Head	Atraumatic, normocephalic
Ears	Pinnae normal. Auditory canals clear. Tympanic membranes are normally mobile with landmarks and light reflexes intact.
Eyes	Pupils equal, round react to light and accomodation. Sclerae clear. No discharge or tearing. Extra ocular muscles full ROM.
Nose	Normal appearance. Septum undeviated. No discharge.
Throat	Clear, normal tongue. Tonsils not enlarged. No exudates.
Neck	Supple, thyroid normal size,no adenopathy.
Chest	Clear to auscultation and percussion. Normal appearance.
Cardiac	S1 and S2 with normal physiological split. No murmurs, rubs or heaves.
Abdomen	Soft, non-tender,no masses or organomegaly, bowel sounds normal
Genitalia	Normal
Extremities	No cyanosis or clubbing, peripheral pulses palpable,no orthopedic abnormalities.
Neurological	NORMAL

Anticipatory Guidance:

Diet:	Stop bottle	Reviewed
	Balanced diet	Reviewed
Development:	Speech	Reviewed
	Time out	Reviewed
	Preschool	Reviewed
	TV	Reviewed
Safety:	Car seats	Reviewed
	Seat belts	Reviewed
	Animals	Reviewed
	Helmets	Reviewed
	Firearms	Reviewed
Medical Education:	Role models	Reviewed
	Exercise	Reviewed
	First aid	Reviewed
	Dental	Reviewed

Problem List:

LACK OF NORMAL PHYSIOLOGICAL DEVELOPMENT, UNSPECIFIED
 ESOTROPIA UNSPECIFIED
 SHORT STATURE
 UNSPECIFIED OTITIS MEDIA
 TURNER SYNDROME
 AORTIC VALVE DISORDERS
 CONGENITAL HIP DYSPLASIA

Assessment:

758.6 TURNER SYNDROME, UNSPECIFIED
 424.1 CONGENITAL INSUFFICIENCY OF AORTIC VALVE

Logan Pediatrics, Inc.
Neveah Adams

EXHIBIT NO. B14F
PAGE: 3 OF 5
Patient Visit Record
Page 3
February 14, 2019

755.63 OTHER CONGENITAL DEFORMITY OF HIP
783.40 UNSPECIFIED LACK OF EXPECTED NORMAL PHYSIOLOGICAL DEVELOPMENT IN CHILDHOOD
378.00 ESOTROPIA UNSPECIFIED
783.43 SHORT STATURE
382.9 OTITIS MEDIA BILATERAL , UNSPECIFIED

Plan:

3 year old caucasian girl with Turners syndrome, congenital heart defect, developmental delay, developmental hip dysplasia, esotropia and recurrent otitis media.
DR. NNACHI LICENSE # 21990

Procedures:

DISABILITY DISABILITY

Signed:



Electronically Signed
Okpani M. Nnachi 02/14/2019 11:42AM

Okpani Nnachi

EXHIBIT NO. B14F
PAGE: 4 OF 5
RANGE OF MOTION FORM

CE VENDOR: LOGAN PEDIATRICS INC.
Re: ADAMS, NEVAEH HOPE
SSN: 794-01-8055

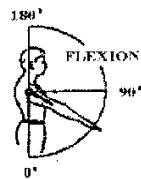
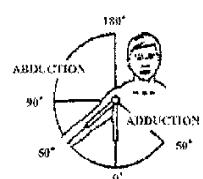
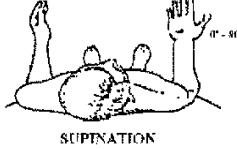
DMA Case: Y/S55



20190129600043/LARA

PAGE 1 of 2

WV0000089

SHOULDERA. Flexion (0° - 180°)
Right 180 Left 180B. Abduction (0° - 180°)
Right 180 Left 180C. Adduction (0° - 50°)
Right 50 Left 50D. Internal Rotation (0° - 40°)
Right 40 Left 40E. External Rotation (0° - 90°)
Right 90 Left 90**ELBOW**A. Flexion-Extension (0° - 150°)
Right 150 Left 150B. Supination (0° - 80°)
Right 80 Left 80C. Pronation (0° - 80°)
Right 80 Left 80**WRIST**A. Dorsiflexion (0° - 60°)
Right 60 Left 60B. Palmar Flexion (0° - 70°)
Right 70 Left 70C. Radial Deviation (0° - 20°)
Right 20 Left 20D. Ulnar Deviation (0° - 30°)
Right 30 Left 50A. Flexion-Extention (0° - 150°)
Right 150 Left 150Can the hand be fully extended? Yes NoCan a fist be made? Yes NoCan the fingers be Opposed? Yes No

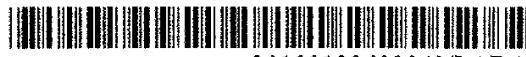
Upper Extremity Strength	Left	1	2	3	<u>4</u>	5
(Normal is 5/5)	Right	1	2	3	<u>4</u>	5

Grip Strength	Left	1	2	3	<u>4</u>	5
(Normal is 5/5)	Right	1	2	3	<u>4</u>	5

Fine Manipulation Normal ✓ Impaired _____

EXHIBIT NO. B14F
PAGE: 5 OF 5

Re: ADAMS, NEVAEH HOPE
SSN: 794-01-8055

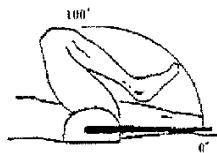

20190129600043/LARA

PAGE 2 OF 2

WV000089

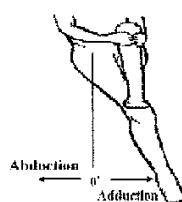
HIP

A. Forward Flexion (0° - 100°)
Right 80 Left 80

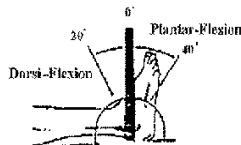


C. Abduction (0° - 40°)
Right 40 Left 40

D. Adduction (0° - 20°)
Right 20 Left 20

**ANKLE**

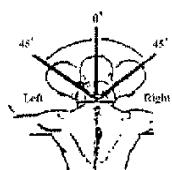
A. Dorsi-Flexion (0° - 20°)
Right 20 Left 20



B. Plantar-Flexion (0° - 40°)
Right 40 Left 40

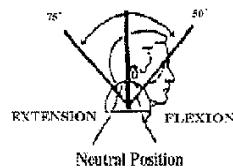
CERVICAL SPINE

A. Lateral Flexion (0° - 40°)
Right 40 Left 40



B. Flexion (0° - 60°) 60

C. Extension (0° - 75°) 75



D. Rotation (0° - 80°)
Right 80 Left 80

**LUMBAR SPINE**

A. Flexion-Extension (0° - 90°) 90



B. Lateral Flexion (0° - 25°)
Right 25 Left 25



Straight Leg Raising (0° - 90°) Sitting
Right 90 Left 90

Straight Leg Raising (0° - 90°) Supine
Right _____ Left _____

Lower Extremity Muscle Strength
(Normal is 5/5)

Right 1 2 3 4 5
Left 1 2 3 4 5

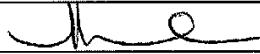
NOTE: When grading muscle strength,
use the following scale:

- 0 - no movement
- 1 - trace movement
- 2 - movement with the aid of gravity
- 3 - movement against gravity, but not resistance
- 4 - movement against resistance supplied by examiner
- 5 - normal strength

Effort?

Good Fair _____ Poor _____

- N (1) Your narrative report should include a discussion of sensory and/or reflex abnormalities including the extent of any loss.
 O (2) Please describe the ability to heel and toe walk; squat; get on and off the examining table; and gait and station.
 T (3) Describe the reason for any use of assistive devices.
 E (4) The testing method should be recorded.

Signature: Date: 2/13/19

**EXHIBIT NO. B15F
PAGE: 1 OF 233**



As required under 20 CFR §404.1512(a) and/or 20 CFR §416.912(a), we are obligated to submit non-redacted and complete copies of all documents we receive that relate to our client's claim.

Accordingly, please make the enclosed medical record a part of the record in this claim.

Please note that if the medical provider returned to us the copies of form SSA-1696, our client's medical release and our cover letter requesting records, we are not enclosing copies of those documents as they do not relate to the issue of our client's disability. We do have those pages available and will submit them upon your request.

Finally, please also make this letter a part of the record in this matter.

**EXHIBIT NO. B15F
PAGE: 2 OF 233**

Patient Encounter(s) History Report Dec 19, 2019@13:39

(From: 01/02/19 --- Thru: 01/03/19)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006428833
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02, 2019 17:59
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]
 Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B15F
PAGE: 3 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006428833
ADM: Jan 02,2019 17:59

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 4 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02, 2019 17:59
ATTENDING:

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (LICENSED PRACTICAL NURSE)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J

Observed/Historical: Historical

==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 5 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006428833
ADM: Jan 02,2019 17:59

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 6 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02, 2019 17:59
ATTENDING:

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- FAX COVER SHEET & CONFIRMATION (SCANNED) -----
DATE OF NOTE: JAN 9, 2019@16:17 ENTRY DATE: JAN 25, 2019@16:17:32
AUTHOR: HALE, DIANNE M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 01/25/2019 16:17

**EXHIBIT NO. B15F
PAGE: 7 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006428833
 ADM: Jan 02, 2019 17:59

TRANSMISSION VERIFICATION REPORT

TIME : 01/09/2019 10:35
 NAME : WELCH COMMUNITY LAB
 FAX : 3044366691
 TEL : 3044368600
 SER. #: BROE1J275225

DATE, TIME	01/09 10:34
FAX NO./NAME	13043881565-5259
DURATION	08:01:08
PAGE(S)	03
RESULT	OK
MODE	STANDARD

ORIGINAL

LabCorp


Patient Report

Specimen ID: 003-532-6140-0
 Control ID: B0084832839

Acct #: 47108865 Phone: (304) 436-8600 Rte: 10
 Welch Community Hosp *1*
 Interface Account
 454 McDowell Street
 Welch WV 24801

ADAMS, NEVAEH H.

388-1565

Patient Details
 DOB: 07/21/2015
 Age(y/m/d): 003/05/13
 Gender: F SSN: ***-**-8055
 Patient ID: WEL000138580

Specimen Details
 Date collected: 01/03/2019 1429 Local
 Date received: 01/03/2019
 Date entered: 01/03/2019
 Date reported: 01/08/2019 2006 ET

Physician Details
 Ordering: A LAWSON
 Referring:
 ID: NPI: 1568689160

General Comments & Additional Information
 Clinical Info: SRC:ST STOOL

Alternate Control Number: B0084832839
 Total Volume: Not Provided

Alternate Patient ID: WEL000138580
 Fasting: No

FAXED JAN 09 2019

Ordered Items
 Stool Culture: C difficile Toxins A+B, EIA; Lactoferrin, Fecal, Quant; Pancreatic Elastase, Fecal; Calprotectin, Fecal; Ova + Parasite
 Exam

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Stool Culture					
Salmonella/Shigella Screen					
Final report				01	
Result 1	No Salmonella or Shigella recovered.			01	
				01	
Campylobacter Culture					
Final report				01	
Result 1	No Campylobacter species isolated.			01	
				01	
E. coli Shiga Toxin EIA	Negative			Negative	01
				01	
C. difficile Toxins A+B, EIA					

**EXHIBIT NO. B15F
PAGE: 8 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02, 2019 17:59
ATTENDING:

----- FAX COVER SHEET & CONFIRMATION (SCANNED) -----
DATE OF NOTE: JAN 4, 2019@15:56 ENTRY DATE: JAN 8, 2019@15:56:41
AUTHOR: HALE, DIANNE M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 01/08/2019 15:56

EXHIBIT NO. B15F
PAGE: 9 OF 233

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006428833
 ADM: Jan 02, 2019 17:59

TRANSMISSION VERIFICATION REPORT

TIME : 01/04/2019 09:56
 NAME : WELCH COMMUNITY LAB
 FAX : 3044366591
 TEL : 3044368800
 SER. #: BRDE1J275225

DATE, TIME	01/04 09:55
FAX NO./NAME	13043881565-5259
DURATION	00:00:42
PAGE(S)	02
RESULT	OK
MODE	STANDARD

ORIGINAL

ADAMS, NEVAEH H WEL000138580

Lab Order Detail

7/21/2019 3:41

*** WORK COPY ONLY ***
 HEMOCULT-WEL HEMOCULT CARD FECES WC ONCE LR #324258

Printed: 03-Jan-2019 4:47

Collection time:	Jan 03, 2019@14:40:19			
Test Name	Result	Units	Range	Urine
HEMOCCULT-WEL	NEGATIVE			

Comments:
 Received at 1440
 Released by rc at 1444
 Fax to Dr. Lawson at 388-1565

Ordering Provider: Community Hospital Welch
 Report Released Date/Time: Jan 03, 2019@14:44

Performing Lab: WEL
 454 McDOWELL STREET WELCH, WV 24801

**EXHIBIT NO. B15F
PAGE: 10 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02, 2019 17:59
ATTENDING:

----- LAB RESULTS - CULTURES (SCANNED) -----
DATE OF NOTE: JAN 3, 2019@14:37 ENTRY DATE: JAN 18, 2019@14:37:18
AUTHOR: HALE, DIANNE M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned document(s) for test results.

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 01/18/2019 14:37

**EXHIBIT NO. B15F
PAGE: 11 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006428833
 ADM: Jan 02, 2019 17:59



Patient Report

Specimen ID: 003-532-6140-0
 Control ID: B0084832839

ADAMS, NEVAEH H.

Acct #: 47108865 Phone: (304) 436-8800 Rte: 10
 Welch Community Hosp *!
 Interface Account
 454 McDowell Street
 Welch WV 24801

FINAL

FAXED JAN 09 2019

Patient Details
 DOB: 07/21/2015
 Age(y/m/d): 003/05/13
 Gender: F SSN: ***-**-8055
 Patient ID: WEL000138580

Specimen Details
 Date collected: 01/03/2019 1429 Local
 Date received: 01/03/2019
 Date entered: 01/03/2019
 Date reported: 01/08/2019 2006 ET

Physician Details
 Ordering: A LAWSON
 Referring:
 ID:
 NPI: 1568689180

General Comments & Additional Information
 Clinical Info: SRC:ST STOOL

Alternate Control Number: B0084832839
 Total Volume: Not Provided

Alternate Patient ID: WEL000138580
 Fasting: No

Ordered Items

Stool Culture; C difficile Toxins A+B, EIA; Lactoferrin, Fecal, Quant.; Pancreatic Elastase, Fecal; Calprotectin, Fecal; Ova + Parasite
 Exam

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Stool Culture					
Salmonella/Shigella Screen					
Final report				01	
Result 1	No Salmonella or Shigella recovered.			01	
				01	
Campylobacter Culture					
Final report				01	
Result 1	No Campylobacter species isolated.			01	
				01	
E coli Shiga Toxin EIA	Negative			Negative	01
				01	
C difficile Toxins A+B, EIA	Negative			Negative	01
				01	
Lactoferrin, Fecal, Quant.	5.36		ug/mL(g)	0.00 - 7.24	02
			Baseline (normal)	0.00 - 7.24	
			Elevated	>7.24	
				An elevated result is indicative of the presence of fecal lactoferrin, a marker of intestinal inflammation. A normal result does not exclude the presence of intestinal inflammation.	
				The test can be used as an in vitro diagnostic aid to distinguish patients with active inflammatory bowel disease (IBD) from those with non-inflammatory irritable bowel syndrome (IBS).	
Pancreatic Elastase, Fecal	>500		ug Elast./g	>200	02
	Severe Pancreatic Insufficiency:			<100	
	Moderate Pancreatic Insufficiency:			100 - 200	

Date Issued: 01/08/19 2007 ET

FINAL REPORT

Page 1 of 2

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EXHIBIT NO. B15F
PAGE: 12 OF 233
**LabCorp****Patient Report**Patient: ADAMS, NEVAEH H.
DOB: 07/21/2015

Patient ID: WEL000138580

Control ID: 80084832839

Specimen ID: 003-532-6140-0
Date collected: 01/03/2019 1429 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
	Normal:			>200	
Calprotectin, Fecal Concentration	210	High	ug/g	0 - 120	02
<16 - 50 ug/g	Interpretation	Follow-Up			
>50 - 120 ug/g	Normal	None			
>120 ug/g	Borderline	Re-evaluate in 4-6 weeks			
	Abnormal	Repeat as clinically indicated			
Ova + Parasite Exam				FAXED JAN 09 2019	
Ova + Parasite Exam					01
Final report					
These results were obtained using wet preparation(s) and trichrome stained smear. This test does not include testing for Cryptosporidium parvum, Cyclospora, or Microsporidia.					
Result 1					01
No ova, cysts, or parasites seen.					
One negative specimen does not rule out the possibility of a parasitic infection.					

01 CB	LabCorp Dublin 6370 Wilcox Road, Dublin, OH 43016-1269	Dir. Vincent Ricchiuti, PhD
02 BN	LabCorp Burlington 1447 York Court, Burlington, NC 27215-3361	Dir. Sanjai Nagendra, MD

For inquiries, the physician may contact Branch: 800-742-2285 Lab: 800-282-7300

Date Issued: 01/08/19 2007 ET

FINAL REPORT

Page 2 of 2

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**EXHIBIT NO. B15F
PAGE: 13 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006428833
ADM: Jan 02,2019 17:59

----- INSURANCE CARD -----
DATE OF NOTE: JAN 2,2019@18:24 ENTRY DATE: JAN 2,2019@18:24:21
AUTHOR: STAPLES,ARETHA L EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.
INSURANCE CARD BACK (SCANNED):

/es/ ARETHA L STAPLES
OFFICE ASSISTANT
Signed: 01/02/2019 18:25

**EXHIBIT NO. B15F
PAGE: 14 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006428833
 ADM: Jan 02,2019 17:59

Eligibility Receipt

Page 1 of 2

Eligibility Receipt

Eligibility Inquiry verifies whether a member was eligible for a covered program on the date(s) of service submitted in the request. This information does not guarantee eligibility or payment for the service rendered.

Member

Name	Date of Birth	Member ID
ADAMS, NEVAEH	7/21/2015	00405164305
Tracking Number	19002WV00020318	
Date of Inquiry	1/2/2019 8:12:44 PM	
From Date of Service	1/2/2019	
To Date of Service	1/2/2019	
Procedure Codes		
HIPAA Category Code		

Enrollments

Program/Benefit Name	Coverage Status	Coverage Level	Plan Type	Effective Date	Termination Date	Member ID
- WV Mountain Health Trust Benefit Plan	Active	Primary	Medical	05/01/2018		00405164305
Rate Code	Coverage	Effective Date		Termination Date		
FCMGKF	Categorically Ready	05/01/2018				
FCMGKF	Tier 3 Copay	05/01/2018				

Other Insurance

No Co-ordination of Benefits information found

Copay

It is the member's responsibility to pay the copay to the provider at the time of the service. Copays are at the benefit level (individual service codes).

Beginning for claims with a Date of Service on or after January 02, 2019, copays for this member are

Service	Copay Amount	Effective Date	Termination Date	Tier
N/A	\$0	01/02/2019	01/02/2019	Member is exempt

PCP / Medical Home

Effective Date	Termination Date	Provider Id
PCP / Medical Home Name	UNICARE HEALTHPLAN OF WEST VIRGINIA, INC.	99000002000
Address	PO Box 91, Attn Claims, Charleston, WV 25321-0091	
Office Number	800-782-0095	Coverage Status
		Active

Lock-in

No Lock-in information found for DDS range requested

Spend Down

No Spend Down information found at this time.

**EXHIBIT NO. B15F
PAGE: 15 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02, 2019 17:59
ATTENDING:

----- REFERRAL (SCANNED) -----
DATE OF NOTE: JAN 2, 2019@18:24 ENTRY DATE: JAN 2, 2019@18:24:37
AUTHOR: STAPLES, ARETHA L EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Referral document attached as scanned image.

/es/ ARETHA L STAPLES
OFFICE ASSISTANT
Signed: 01/02/2019 18:25

**EXHIBIT NO. B15F
PAGE: 16 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006428833
 ADM: Jan 02, 2019 17:59

ORDER REQUISITION
 WVUPC-PEDS GI
 830 PENNSYLVANIA AVE
 SUITE 103
 CHARLESTON WV 25302
 304-388-1552
 Fax: 304-388-1565

Patient Name: Nevaeh Adams
 DOB: 7/21/2015 Gender: F
 MRN #: E2228804

Date: 1/2/2019
 Order Name: CLOSTRIDIUM DIFFICILE TOXIN DETECTION
 EPIC Order # 237724396

Refer to:
 Associated Diagnosis:
 Chronic diarrhea (K52.9)
 Status:Future [2] EXPIRES:3/4/2020 Class:External [60] ExpectedDate: Intervals: Original Count: 1
 Priority: Routine [6]

Date: 1/2/2019
 Order Name: ROUTINE STOOL CULTURE (INCLUDING E. COLI SHIGA TOXIN)
 EPIC Order # 237724397

Refer to:
 Associated Diagnosis:
 Chronic diarrhea (K52.9)
 Status:Future [2] EXPIRES:3/4/2020 Class:External [60] ExpectedDate: Intervals: Original Count: 1
 Priority: Routine [6]

Date: 1/2/2019
 Order Name: OCCULT BLOOD, STOOL
 EPIC Order # 237724398

Refer to:
 Associated Diagnosis:
 Chronic diarrhea (K52.9)
 Status:Future [2] EXPIRES:3/4/2020 Class:External [60] ExpectedDate: Intervals: Original Count: 1
 Priority: Routine [6]

Date: 1/2/2019
 Order Name: OVA AND PARASITE SCREEN
 EPIC Order # 237724399

Refer to:
 Associated Diagnosis:
 Chronic diarrhea (K52.9)
 Status:Future [2] EXPIRES:3/4/2020 Class:External [60] ExpectedDate: Intervals: Original Count: 1
 Priority: Routine [6]

ADAMS, NEVAEH
 ADM: 1/02/19
 DRB: 1/21/2015
 SEX: F
 SER: RPC
 ACT#: 006428833
 MED#: 138580
 FC: MD
 AGE: 3 yr
 DR: LAWSON, APRIL

Electronically signed by: Lawson, April, CPNP Lic # < Not on File > NPI: 1568689180
 Adams, Nevaeh (MR # E2228804) Printed at 1/2/19 1:36 PM Page 1 of 3

EXHIBIT NO. B15F
PAGE: 17 OF 233

ORDER REQUISITION
 WVUPC-PEDS GI
 830 PENNSYLVANIA AVE
 SUITE 103
 CHARLESTON WV 25302
 304-388-1552
 Fax: 304-388-1565

Patient Name: Nevaeh Adams
 DOB: 7/21/2015 Gender: F
 MRN #: E2228804

Date: 1/2/2019
 Order Name: CALPROTECTIN, FECES
 EPIC Order # 237724572

Refer to:
Associated Diagnosis:
 Chronic diarrhea (K52.9)
 Status:Future [2] EXPIRES:3/1/2020 Class:Lab Collect [4] ExpectedDate: Intervals: Original Count: 1
 Priority: Routine [6]

Date: 1/2/2019
 Order Name: PANCREATIC ELASTASE-1
 EPIC Order # 237724573

Refer to:
Associated Diagnosis:
 Chronic diarrhea (K52.9)
 Status:Future [2] EXPIRES:3/1/2020 Class:Lab Collect [4] ExpectedDate: Intervals: Original Count: 1
 Priority: Routine [6]

Date: 1/2/2019
 Order Name: LACTOFERRIN
 EPIC Order # 237724574

Refer to:
Associated Diagnosis:
 Chronic diarrhea (K52.9)
 Status:Future [2] EXPIRES:3/2/2020 Class:External [60] ExpectedDate: Intervals: Original Count: 1
 Priority: Routine [6]

Electronically signed by: Lawson, April, CPNP Lic # < Not on File > NPI: 1568689180
 PATIENT MUST TAKE THIS FORM WITH THEM TO THE LAB OR TESTING FACILITY.

ADAMS, NEVAEH
 ADM: 1/02/19 ACT#: 0008428833
 DOB: 7/21/2015 MED#: 138580
 SEX: F FC: MD
 SER: OPC AGE: 3 yr
 DR: LAWSON, APRIL

Adams, Nevaeh (MR # E2228804) Printed at 1/2/19 1:36 PM

Page 3 of 3

**EXHIBIT NO. B15F
PAGE: 18 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02, 2019 17:59
ATTENDING:

----- IDENTIFICATION CARD/DRIVERS LICENCE -----
DATE OF NOTE: JAN 2, 2019@18:24 ENTRY DATE: JAN 2, 2019@18:24:54
AUTHOR: STAPLES, ARETHA L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

ID Card /Drivers License attached as scanned image.
no id

/es/ ARETHA L STAPLES
OFFICE ASSISTANT
Signed: 01/02/2019 18:25

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----
DATE OF NOTE: JAN 2, 2019@18:23 ENTRY DATE: JAN 2, 2019@18:24:04
AUTHOR: STAPLES, ARETHA L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ ARETHA L STAPLES
OFFICE ASSISTANT
Signed: 01/02/2019 18:25

**EXHIBIT NO. B15F
PAGE: 19 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006428833
 ADM: Jan 02,2019 17:59



ADAMS, NEVAEH	
ADM : 1/02/19	ACT# : 0005428833
DOB : 7/21/2015	
MED# : 138580	FC : MD
SEX : F	AGE : 3 yr
SER : OPC	DR : LAWSON, APRIL

WELCH COMMUNITY HOSPITAL
 454 McDOWELL STREET
 WELCH, WV 24801

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

EXHIBIT NO. B15F
PAGE: 20 OF 233

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.

6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital. If for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

ADAMS, NEVAEH	ACT# : 00064728833
ADM : 10218	MED# : 139580
DOB : 7/21/2015	FC : MD
SEX : F	AGE : 3 yr
SER : OPC	DR : LAWSON, APRIL

EXHIBIT NO. B15F
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If you would like to opt out of HIV testing, please initial the line below. There may be some instances where patients are not allowed to opt out. For further information, please refer to the information sheet given to you upon registration.

Initials of patient/patient representative: MMS

- 8. RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: MMS

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

- 9. NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

- 10. PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

I object to having my name, location and general condition listed in the facility directory.

ADAMS, NEVAEH	
ADM : 1/02/19	ACT# : 0008428833
DOB : 7/21/2015	MED# : 138560
SEX : F	FC : MD
SER : OPC	AGE : 3 yr
DR : LAWSON, APRIL	

**EXHIBIT NO. B15F
PAGE: 22 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02, 2019 17:59
ATTENDING:

----- CODING ABSTRACT FORM (SCANNED) -----
DATE OF NOTE: JAN 2, 2019@12:16 ENTRY DATE: JAN 4, 2019@12:16:18
AUTHOR: PRUITT, STANLEY EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Coding Abstract Form(s).

/es/ STANLEY PRUITT
OFFICE ASSISTANT
Signed: 01/04/2019 12:16

**EXHIBIT NO. B15F
PAGE: 23 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02, 2019 17:59
ATTENDING:

DATE: 01/04/2019 WELCH HOSPITAL TIME: 11:37 AM
PAGE: 1 OF 1 CODING SUMMARY

ADAMS, NEVAEH H MR #: 000138580 PAT #: 0006428833

Sex: F Admitted: 1/02/19
Birthdate: 7/21/2015 Discharged: 1/02/19
Age at Admit: 003 LOS: 1
Attending Phys: 687359 LAWSON, APRIL UB92 Disp: 01
MR Coord Apprv: 1 - APP M/R Apprv Date: 1/04/19 Coder ID:NH
Outlier: 00 Current DRG:

Diagnoses POA MOD HAC Description

1. K52.9 Noninfective gastroenteritis and colitis, unspecified

To Attending Physician: Please review the above diagnoses and procedures and notify Health Information Management if there are any discrepancies or any inaccuracies. Thank you !!

**EXHIBIT NO. B15F
PAGE: 24 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

*** END ***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 25 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006428833
ADM: Jan 02,2019 17:59

***** CONFIDENTIAL ORDERS SUMMARY *****

Order Date: St: Requestor: Start Date: Stop Date:
Nature of Order: Signature:
Item Ordered:
=====

*** END ***** CONFIDENTIAL ORDERS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 26 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02,2019 17:59
ATTENDING:

***** CONFIDENTIAL LAB RESULTS SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL LAB RESULTS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 27 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02,2019 17:59
ATTENDING:

***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 28 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02,2019 17:59
ATTENDING:

***** CONFIDENTIAL DISCHARGE SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL DISCHARGE SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 29 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02, 2019 17:59
ATTENDING:

***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006428833
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 02, 2019 17:59
ATTENDING:
=====

ADRs: No ADRs on file.

Allergies: PENICILLIN
=====

****NO MEDICATIONS FOUND****

*** END ***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

{{{ END }}} Patient Encounter(s) History Report Dec 19, 2019@13:39

**EXHIBIT NO. B15F
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Patient Encounter(s) History Report Dec 19, 2019@13:40

(From: 01/14/19 --- Thru: 01/15/19)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B15F
PAGE: 32 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006429952
ADM: Jan 14,2019 18:46

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 33 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (LICENSED PRACTICAL NURSE)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J

Observed/Historical: Historical

==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- NON-WCH REPORTS (SCANNED) -----
DATE OF NOTE: JAN 26, 2019@14:49 ENTRY DATE: JAN 28, 2019@14:49:53
AUTHOR: PRUITT, STANLEY EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ STANLEY PRUITT
OFFICE ASSISTANT
Signed: 01/28/2019 14:51

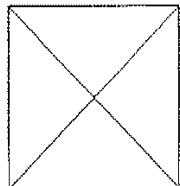
**EXHIBIT NO. B15F
PAGE: 36 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006429952
ADM: Jan 14,2019 18:46

Sent 01/26/2019 10:29:12. Page - 1

MEFF 138580



fax transmittal

To: Piayan Kobbah

From: MAIN LAB

Date: 1/26/2019

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Sent 01/26/2019 10:29:12, Page - 2

RUN DATE: 01/26/19	PRINCETON COMMUNITY HOSPITAL LABORATORY	PAGE 1	
RUN TIME: 1028	12TH STREET EXT. PRINCETON, WV 24740		
	DR. THOMAS MARTIN (304)487-7276		
	CLIA #51D0233640		
	Specimen Inquiry		
<i>NIC#138580</i>			
PATIENT: ADAMS,NEVAEH H	ACCT: PC0003303461 LOC: EM	U: PC326379	
REG DR: Miller D.O., Adam	AGE/SX: 3Y 05M/F ROOM:	REG: 01/20/19	
	DOB: 07/21/2015 BED:	DIS:	
	STATUS: DEP ER TLOC:		
SPEC #: 19:BC0000689S	COLL: 01/20/19-1957	STATUS: COMP	REQ #: 04148923
SOURCE: BLOOD	RECD: 01/20/19-2005	SUBM DR: Harmon P.A.C., Kristin	
SPDESC: PERIPHERAL	ENTR: 01/20/19-1947	OTHR DR: Kobbah M.D., Piayan	
ORDERED: BLCP		ER Physician	
Procedure	Result	Verified	
BLD CULTURE (PEDIATRIC) Final NO GROWTH AT 6 DAYS		01/26/19-0800	

** END OF REPORT **

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

----- PRESENTING SHEET (SCANNED) -----
DATE OF NOTE: JAN 14, 2019@19:08 ENTRY DATE: JAN 14, 2019@19:08:09
AUTHOR: MATNEY, MCKENNA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ MCKENNA M MATNEY
OFFICE ASSISTANT
Signed: 01/14/2019 19:08

EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006429952
 ADM: Jan 14, 2019 18:46

RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION FORM					
PLEASE FILL OUT TOP PORTION ONLY					
NAME: <u>Nevaeh Adams</u>			TODAY'S DATE: <u>1/14/19</u>		
TIME: <u>10:40</u>	AGE: <u>3</u>	BIRTHDAY: <u>7/21/15</u>			
CITY: <u>WELCH</u> STATE: <u>WV</u> ZIP: <u>26856</u>					
ADAMS, NEVAEH ADM: 1/14/19 ACT: 0006429952 DOB: 7/21/2015 MDA: 130580 SEX: F IC: MD AGE: 3 yr SER: WIC DR: PREGNANT DMDIVY					
TO BE FILLED OUT BY HOSPITAL STAFF					
DISPOSITION: <input checked="" type="checkbox"/> WIC <input type="checkbox"/> PEDS <input type="checkbox"/> IM <input type="checkbox"/> SURG <input type="checkbox"/> OBGYN					
Registration Complaint: <u>hives, diarrhea, earache</u>					
NURSE: <u>DR. Newell</u>			TIME: <u>18:40</u>		

**EXHIBIT NO. B15F
PAGE: 40 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006429952
ADM: Jan 14,2019 18:46

----- INSURANCE CARD -----
DATE OF NOTE: JAN 14, 2019@19:08 ENTRY DATE: JAN 14, 2019@19:08:25
AUTHOR: MATNEY,MCKENNA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.
INSURANCE CARD BACK (SCANNED):

/es/ MCKENNA M MATNEY
OFFICE ASSISTANT
Signed: 01/14/2019 19:08

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006429952
 ADM: Jan 14, 2019 18:46

2349230380

Elig Inquiry Date:

Eligibility Report

Elig Check: 01/14/2019 Print Date: 01/14/2019 06:59:46 PM

Patient

The patient is the subscriber or contract holder for the insurance plan.

Primary

Insured Number: 00405164305
 Name: ADAMS, NEVAEH H
 Address: PO BOX 46
 City, State Zip: BIG SANDY, WV 24816
 Date of Birth: 07/21/2015
 Gender: Female
 Insured Status: Active
 Effective Date: 01/14/2019
 Expire Date: 01/14/2019

Insurance

For Member Eligibility Verification and Claim Status inquiries, please contact the payor using the number on the back of the member's card.

Provider Number: 1134158900

Benefits

Benefit	Amount	Percent	Period	Quantity	Qualifier	In-Network	Insurance Type	Coverage Level	Date	Qualifier
HEALTH BENEFIT PLAN COVERAGE - 30							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY							Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793			
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY							Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797			
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY							Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES			
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY							Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797			
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY							Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793			
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY							Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES			
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY							Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES			

Page 1

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2340230350

Elg Inquiry Date:

Eligibility Report

Elg Check: 01/14/2019

Print Date: 01/14/2019 08:59:47 PM

Benefit	Amount	Percent	Period	Quantity	Qualifier	In-Network	Insurance Type	Coverage Level	Date	Date Qualifier
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALL										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALL										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
CO-PAYMENT	0.00						Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
MANAGED CARE COORDINATOR							Health Maintenance Organization (H)		01/14/2019-01/14/2019	PRIMARY CARE PROVIDER
Entity: PLAN SPONSOR, Name: UNICARE HEALTHPLAN OF WEST VIRGINIA , Phone: (800)782-0095										
MEDICAL CARE - 1										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALL										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALL										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALL										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALL										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALL										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALL										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										

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2340230350

Elg Inquiry Date:

Eligibility Report

Elg Check: 01/14/2019

Print Date: 01/14/2019 08:59:48 PM

Benefit	Amount	Percent	Period	Quantity	Qualifier	In-Network	Insurance Type	Coverage Level	Date	Date Qualifier
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
CHIROPRACTIC - 33										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICAL										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICAL										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICAL										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		01/14/2019-01/14/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICAL										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICAL										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICAL										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 3 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										

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**EXHIBIT NO. B15F
PAGE: 44 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

----- IDENTIFICATION CARD/DRIVERS LICENCE -----
DATE OF NOTE: JAN 14, 2019@19:08 ENTRY DATE: JAN 14, 2019@19:08:41
AUTHOR: MATNEY, MCKENNA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

ID Card /Drivers License attached as scanned image.

/es/ MCKENNA M MATNEY
OFFICE ASSISTANT
Signed: 01/14/2019 19:08

**EXHIBIT NO. B15F
PAGE: 45 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006429952
ADM: Jan 14, 2019 18:46

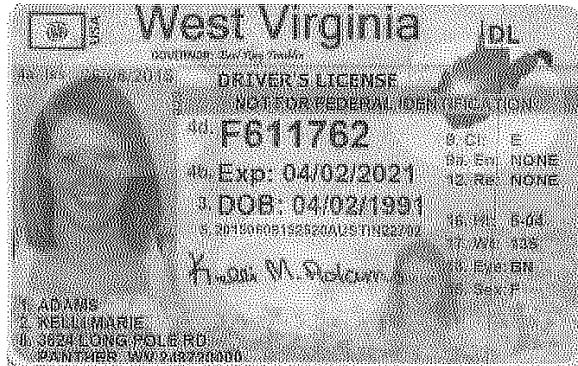
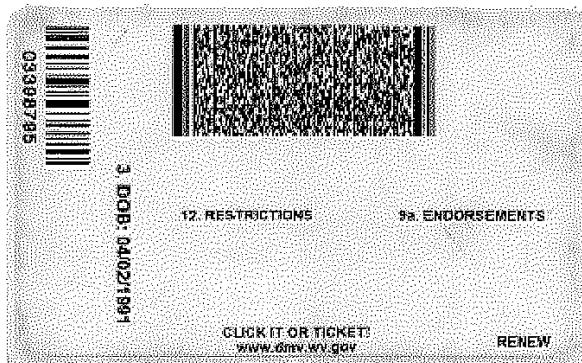


EXHIBIT NO. B15F
PAGE: 46 OF 233



**EXHIBIT NO. B15F
PAGE: 47 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006429952
ADM: Jan 14,2019 18:46

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----
DATE OF NOTE: JAN 14,2019@19:07 ENTRY DATE: JAN 14,2019@19:07:48
AUTHOR: MATNEY,MCKENNA M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ MCKENNA M MATNEY
OFFICE ASSISTANT
Signed: 01/14/2019 19:08

**EXHIBIT NO. B15F
PAGE: 48 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006429952
 ADM: Jan 14, 2019 18:46



ADAMS, NEVAEH	ACT# : 0006429952
ADM : 1/14/19	MED# : 138580
DOB : 7/21/2015	FC : MD
SEX : F	AGE : 3 yr
SER : VNC	DR : DOWANS RONNEY

WELCH COMMUNITY HOSPITAL
 454 McDOWELL STREET
 WELCH, WV 24801

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

**EXHIBIT NO. B15F
PAGE: 49 OF 233**

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.
7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

ADAMS, NEVAEH
ADM : 014/19 ACT# : 0008429852
DOB : 7/21/2015 MED# : 138580
SEX : F FC : MD
SER : WIC AGE : 3 yr
DR : COWANS, RODNEY

EXHIBIT NO. B15F
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If you would like to opt out of HIV testing, please initial the line below. There may be some instances where patients are not allowed to opt out. For further information, please refer to the information sheet given to you upon registration.

Initials of patient/patient representative: _____

- 8. RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: _____

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

- 9. NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

- 10. PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

I object to having my name, location and general condition listed in the facility directory.

ADAMS, NEVAEH	ACT# : 0006423952
ADM : 1/14/19	MED# : 138580
DOB : 7/21/2015	FC : MD
SEX : F	AGE : 3 yr
SER : WIC	DR : COWANS, RODNEY

**EXHIBIT NO. B15F
PAGE: 51 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

----- CODING ABSTRACT FORM (SCANNED) -----
DATE OF NOTE: JAN 14, 2019@14:41 ENTRY DATE: JAN 16, 2019@14:41:31
AUTHOR: THOMAS, KEVIN W EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Coding Abstract Form(s).

/es/ KEVIN W THOMAS
OFFICE ASSISTANT
Signed: 01/16/2019 14:41

**EXHIBIT NO. B15F
PAGE: 52 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006429952
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14,2019 18:46
 ATTENDING:

DATE: 01/16/2019 WELCH HOSPITAL TIME: 08:38 AM
 PAGE: 1 OF 1 CODING SUMMARY

ADAMS, NEVAEH H MR #: 000138580 PAT #: 0006429952

 Sex: F Admitted: 1/14/19
 Birthdate: 7/21/2015 Discharged: 1/14/19
 Age at Admit: 003 LOS: 1
 Attending Phys: 629574 COWANS, RODNEY UB92 Disp: 01
 MR Coord Apprv: 1 - APP N/R Apprv Date: 1/16/19 Coder ID:NJ
 Outlier: 00 Current DRG:

Diagnoses POA MOD HAC Description

 1. H66.91 Otitis media, unspecified, right ear
 2. H10.33 Unspecified acute conjunctivitis, bilateral
 3. H61.20 Impacted cerumen, unspecified ear

Date CPT Modifiers Description

 1. 01/14/19 99213 Office/outpatient visit est

To Attending Physician: Please review the above diagnoses and procedures and notify Health Information Management if there are any discrepancies or any inaccuracies. Thank you !!

**EXHIBIT NO. B15F
PAGE: 53 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

----- MEDICATION RECONCILIATION (SCANNED) -----
DATE OF NOTE: JAN 14, 2019@09:58 ENTRY DATE: JAN 15, 2019@09:58:12
AUTHOR: VAUGHN,MEGHAN T EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ MEGHAN T VAUGHN
OFFICE ASSISTANT
Signed: 01/15/2019 09:58

EXHIBIT NO. B15F
PAGE: 54 OF 233

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006429952
ADM: Jan 14, 2019 18:46

**WELCH COMMUNITY HOSPITAL
MEDICATION RECONCILIATION FORM**

ADAMS, NEVAEH
ADM : 11/14/18 ACT# : C008429852
DOB : 7/21/2015 MEDA : 108500
SEX : F FC : MO AGE : 3 yr
SER : WIC DR : COWANS, RODNEY

**EXHIBIT NO. B15F
PAGE: 55 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

----- PRESCRIPTION COPY (SCANNED) -----
DATE OF NOTE: JAN 14, 2019@09:58 ENTRY DATE: JAN 15, 2019@09:58:29
AUTHOR: VAUGHN,MEGHAN T EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned copy of Prescription(s).

/es/ MEGHAN T VAUGHN
OFFICE ASSISTANT
Signed: 01/15/2019 09:58

EXHIBIT NO. B15F
PAGE: 56 OF 233

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006429952
 ADM: Jan 14, 2019 18:46

ADAMS, NEVAEH
 ADM: 1/14/19 ACT: 0806429952
 MED: 138580
 DOB: 7/21/2015 FC: MD
 SEX: F AGE: 3 yr
 SSN: WMR DR: FOWANS ANDREW

43259 WELCH COMMUNITY HOSPITAL
 Supervisor: *Julietta Sison, PA-C*
Rebecca Sison, MD
 WV Lic#: *4344 MC-BW-001* NPI#: *1006843921*
 Exp.: *(304) 436-8461* DEA#: *MS2130718*

Name Nevaeh Adams Date 1-14-19
 Address _____
 PRESCRIPTIONS WILL BE VOID IF NOT PRESENTED WITH THIS CARD.
 THIS PRESCRIPTION MAY BE FILLED WITH A PHARMACY NEAREST THE PATIENT UNLESS THE PHYSICIAN INDICATES OTHERWISE ON THE PRESCRIPTION.
 THIS IS A SECURITY RX.

Cefdinir 250mg/5ml
 Sig: *2 ml PO q12h x10 day*
every 40 mg

1-24 25-49 50-74 75-100
 101-150 151 and over

Refill NP 1 2 3 4 5

JL

Prescription is valid if more than one (1) prescription is written per blank

EXHIBIT NO. B15F
PAGE: 57 OF 233

ADAMS, NEVAEH
ADM: 11419 ACT# : 0006429852
MEDF: 108580
DOB: 7/21/2015 FC: MD
SEX: F AGE: 3 yr
SSN: WIC DR: COWANS BROS KEY

43260 WELCH COMMUNITY HOSPITAL
Supervisor, *Michele Sison, PA-C* Michele Sison, PA-C
WV Lic#: *451 McDowell St., Welch, WV 24801 NPI: 13598839321* NPI: 13598839321
Ref: *(304) 436-6461* DR# *MSS2130719*

Name: *Nevaeh Adams* Date: *1-14-19*
Address: *100 Main Street, Welch, WV 24801*

THIS PRESCRIPTION MAY BE FILLED WITH A GENERIC AND EQUIVALENT DRUG PRODUCT UNLESS THE PHARMACIST NOTES ON THE PRESCRIPTION THAT THE PRESCRIBER MAY PRESCRIBE AND DIRECT IN THE PRESCRIPTION OTHER INFORMATION THAN PRESCRIBED BY LAW.

THIS IS A SECURITY TOX

Erythromycin ophthalmic 1-24
drop *out* 25-48
3rd *1/2 inch ribbon TIO-010* 50-74
Refill No. 1 2 3 4 5 *JL*

Prescription is void if more than one (1) prescription is written per blank

**EXHIBIT NO. B15F
PAGE: 58 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

----- CLINIC NOTE (SCANNED) -----
DATE OF NOTE: JAN 14, 2019@09:57 ENTRY DATE: JAN 15, 2019@09:57:39
AUTHOR: VAUGHN,MEGHAN T EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Clinic Note(s).

/es/ MEGHAN T VAUGHN
OFFICE ASSISTANT
Signed: 01/15/2019 09:58

**EXHIBIT NO. B15F
PAGE: 59 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006429952
 ADM: Jan 14, 2019 18:46

ADAMS, NEVAEH

ADM: 1/14/19 ACT# : 0006429952
 DOB: 7/21/2015 MED# : 138580
 SEX: F FC: MD
 SER: WIC AGE: 3 yr
 DR: COWANS, RODNEY

Circle or check affirmatives, backslash (/) negatives.		
14 Welch Community Hospital RHC URGENT CARE RECORD •Pediatric Illness•		
DATE: 1/14/19 TIME: 1910 ROOM: WLC		
HISTORIAN: patient parent caregiver		
MODE OF ARRIVAL: ambulatory other		
chief complaint: fever cough / congested fussy pulling ears not eating less active vomiting diarrhea rash ingestion <i>bilat. earache / drainage</i>		
HPI		
onset / duration:	min / hrs / days ago	continues in clinic <i>X 2 days</i>
context:	sick contacts home school other	<i>Eyelashes matted together yellow to green purulent drainage</i>
severity: fever to °F / °C oral rectal axillary TM not measured - subjective none noted		
associated symptoms: acting differently <i>fussy crying more not sleeping less active inconsolable drinking / eating less not drinking fast feeding / liquids decreased urination fast urinated sleeping more</i>		
Similar symptoms previously		
Recently seen / treated by doctor / hospitalized		

ROS	
EVN	CVS
<i>pulling at ears R/L</i>	palpitations
runny nose	NEURO
sore throat / mouth	seizure
EYES	MS
<i>red eyes / discharge</i>	extremity pain / swelling
RESPIRATORY	SKIN
cough	rash
trouble breathing	facial trunk extremities diffuse
GI	diaper rash
vomiting / diarrheas	LYMPH
abdominal distention	swollen glands
blood in stools	GU
GU	PSYCH
painful / swollen genital area	anxiety / depression
problems urinating	LMP
<i>LMP</i>	preg premenstrual
<input checked="" type="checkbox"/> except as marked positive, all systems above reviewed and found negative	

• CONST components also addressed in HPI		
reviewed and updated:	Past Hx	Family Hx
Location:	In chart	Date:
PAST HX		
Birth HX	birth wt	ear infection(s)
complications at birth		febrile seizure
premature birth	wks	pharyngitis
diabetes Type I insulin		pneumonia
asthma		seizure disorder
bronchitis / bronchiolitis		sickle cell disease
cardiac problems		urinary tract infection(s)
congenital heart disease		
development delay		
<i>Turner syndrome</i>		
<i>hip dysplasia</i>		
<i>leaking aortic valve</i>		
Surgeries / Procedures <i>none</i>		
VP shunt		
<i>Bilat. hips</i>		
Immunizations: UTD / referred to PC		
Medications	none	Allergies NKDA
aspirin ibuprofen acetaminophen	<i>see nurses note</i>	<i>see nurses note</i>
last dose		<i>Amox</i>

SOCIAL HX	
smoker / 2 nd hand exposure	
alcohol (recent / occasional)	drugs
attends daycare / school	caretaker / foster care
FAMILY HX	
adopted	

**EXHIBIT NO. B15F
PAGE: 60 OF 233**

PHYSICAL EXAM	
General Appearance	
<input checked="" type="checkbox"/> no acute distress	mild / moderate / severe distress
<input checked="" type="checkbox"/> active / playful / smiles	fussy / crying / cries on exam / irritable
<input checked="" type="checkbox"/> attentiveness nml	lethargic / weak cry
<input checked="" type="checkbox"/> good eye contact	
<input checked="" type="checkbox"/> sleeping/easily aroused	
INFANTS:	
<input checked="" type="checkbox"/> nml consolability	poor consolability / poor intake suck
<input checked="" type="checkbox"/> nml feeding / suck	poor muscle tone
<input checked="" type="checkbox"/> flat anter. fontanel	closed / bulging / sunken anter. fontanel
HEENT	
<input checked="" type="checkbox"/> conjunct. & lids nml	tenderness / swelling
<input checked="" type="checkbox"/> PERRL	scleral icterus / <i>injected conjunctiva</i>
<input checked="" type="checkbox"/> ears nml	EOM palsy / anisocoria / conjunctival exudate
<input checked="" type="checkbox"/> nose nml	sunken eyes / photophobia
<input checked="" type="checkbox"/> pharynx nml	TM erythema / dullness (R / L)
<input checked="" type="checkbox"/> moist mucous membranes	loss of TM landmarks (R / L)
NECK	
<input checked="" type="checkbox"/> supple	TM obscured by wax (R / L)
<input checked="" type="checkbox"/> no masses	rhinorrhea / purulent nasal drainage
RESPIRATORY	
<input checked="" type="checkbox"/> no resp. distress	pharyngeal erythema / tonsillar exudate
<input checked="" type="checkbox"/> breath sounds nml	ulcerations / vesicles
<input checked="" type="checkbox"/> CVS	drooling / trismus / mass
<input checked="" type="checkbox"/> reg. rate & rhythm	dry mucous membranes
<input checked="" type="checkbox"/> heart sounds nml	meningismus / Brudzinski / Kernig's
<input checked="" type="checkbox"/> strong periph pulses	lymphadenopathy <i>short, wetbed</i>
ABDOMEN	
<input checked="" type="checkbox"/> nml capillary refill	tenderness / guarding / rebound
<input checked="" type="checkbox"/> non-tender	hepatomegaly / splenomegaly / mass
<input checked="" type="checkbox"/> no distention	abnml bowel sounds
<input checked="" type="checkbox"/> no organomegaly	
GENITALIA	
<input checked="" type="checkbox"/> nml inspection	discharge / erythema / swelling / tenderness
<input checked="" type="checkbox"/> circumcised (male)	testes undescended
<input checked="" type="checkbox"/> uncircumcised (male)	hernia
EXTREMITIES	
<input checked="" type="checkbox"/> nontender	tenderness
<input checked="" type="checkbox"/> nml ROM	
SKIN	
<input checked="" type="checkbox"/> no rash / lesions	cyanosis / diaphoresis / pallor / icterus
<input checked="" type="checkbox"/> hypotrichiae	poor skin turgor
<input checked="" type="checkbox"/> normal color	diaper rash / skin rash
<input checked="" type="checkbox"/> warm, dry	urticaria / eczematous / impetiginous / vesicular form
NEURO	
<input checked="" type="checkbox"/> sensation nml	scarring / moniliform / erythematous vesicular crusted skin lesions
<input checked="" type="checkbox"/> motor nml	facial asymmetry
<input checked="" type="checkbox"/> CN's nml (2-10)	sensory loss / weakness
<input checked="" type="checkbox"/> mood / affect nml	depressed mood / affect
ADDITIONAL NOTES	
<hr/> <hr/> <hr/>	

Pediatric Illness - 14 * Reportable Measure

ADAMS, NEVAEH
ADM: 1/14/19 ACT# : 0006429952
MED# : 139580
DOB: 7/21/2015 FC: MD
SEX: F AGE: 3 yr
SER: WIC DR: COWANS, RODNEY

R Grey

CBC	UA
BMP	Prog.

XRAYS Interp. by me Viewed by me Discd w/ radiologist

CXR
nml / NAD no infiltrates nml heart size nml mediastinum

Other

PROCEDURES

LP	discussed risks, benefits, alternatives; parent/guardian consents
Time:	fluid color: RBC: WBC:
betadine prep	glucose: polys: lymph:
L3-4 L4-5	protein: monos: gm stn:

PROGRESS

Time	unchanged	improved	re-examined
<i>Takodol 10mg</i>	<i>10mg</i>	<i>8mg</i>	<i>8mg</i>

* Pharyngitis - 3y-18y / strep A test / antibiotic
* URI - 3m-18y / No antibiotic
measure exclusions: refused / not indicated / indicated / contraindicated / not available / dispensed

CLINICAL IMPRESSION

Fever	Meningitis
Vomiting / Diarrhea	Otitis Media - R/L <i>Impacted cerumen</i>
Dehydration	+ Pharyngitis - Strep / Mono
Asthma / Reactive Airway Disease	Pneumonia (location)
acute exacerb. status asthmaticus	Sepsis / SIRS - severe
Bronchitis / Bronchiolitis - RSV	Septic Shock
Croup	Sinusitis
Gastroenteritis / Enteritis	+ Upper Respiratory Infection
Hypoxemia	UTI / Pyelonephritis
Ingestion	Viral Syndrome
Influenza seasonal H1N1	
<i>Bacterial conjunctivitis - bilateral</i>	

TREATMENT PLAN / DISCHARGE MEDICATION

Knee brace error

Oral ciprofloxacin 250mg 15ml

Discussed with Dr. [Signature]

will see patient in: office / clinic / hospital

Counseled patient / family regarding:

lab results / diagnosis need for follow-up / smoking / drug / alcohol cessation

for any concerns

Time spent counseling: minutes Admit orders written

DISPOSITION: home admit transfer *7/15/19*

DISPO TIME: *7/15/19*

FOLLOW-UP: PCP return to clinic *if symptoms*

CONDITION: unchanged Improved stable *getting worse*

total face-to-face time: minutes

I have reviewed the chart and agree with the documentation as recorded by the MLP, including the assessment, treatment plan, and disposition.

I personally evaluated and examined the patient in conjunction with the MLP and agree with the management and disposition of the patient.

[Signature]

NP / PA

MD / DO

 Template Complete

Rev. 09 / 16

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**EXHIBIT NO. B15F
PAGE: 61 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----
DATE OF NOTE: JAN 14, 2019@09:57 ENTRY DATE: JAN 15, 2019@09:57:56
AUTHOR: VAUGHN,MEGHAN T EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ MEGHAN T VAUGHN
OFFICE ASSISTANT
Signed: 01/15/2019 09:58

**EXHIBIT NO. B15F
PAGE: 62 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006429952
 ADM: Jan 14, 2019 18:46

RURAL HEALTH

ADAMS, NEVAEH	ACT#: 0006429952
ADM: 1/14/19	MRN: 138580
DOB: 7/21/2015	FC: MD
SEX: F	AGE: 3 yr
SER: WIC	DR: COWANS, RODNEY

Name: Nevaeah Adams Age: 3 DOB: 7-21-15

Date/Time of Arrival: 1843

Reason for Visit: bil eye drainage, bil earache

ALLERGIES Amoxicillin

Vitals: BP _____ HR 127 RR 04 Temp 98.7 Pulse Ox 98% ipm
 Pain (0-10) _____ Location _____ Wt. 35 Ht. _____ LMP _____

Medical History:

Asthma Gout: CHF: COPD: CVA Diabetes
 HTN Hyperlipidemia: Psych: Renal: Seizures
 Other: Turner's syndrome, hip dysplasia, tenting aortic

Date of last mammogram: _____

Date of last pap smear: _____

Date of last colonoscopy: _____

Surgical History:

Appendix Cardiac/Stent Gallbladder Hysterectomy BTI
 Other: bil hip

Social History: smoker ppd/never/quit drugs none/recent/occasional

Primary Care Provider: Kabbah

Nurse Signature: YB Trent Jr

****PATIENT REQUIRES HIGHER LEVEL OF CARE****

Focus assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider _____ Date _____ Time _____

Original 2-2017

**EXHIBIT NO. B15F
PAGE: 63 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

*** END ***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

EXHIBIT NO. B15F
PAGE: 64 OF 233

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

***** CONFIDENTIAL ORDERS SUMMARY *****

Order Date: St: Requestor: Start Date: Stop Date:
Nature of Order: Signature:
Item Ordered:

***** END ***** CONFIDENTIAL ORDERS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 65 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

***** CONFIDENTIAL LAB RESULTS SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL LAB RESULTS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 66 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14,2019 18:46
ATTENDING:

***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 67 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14,2019 18:46
ATTENDING:

***** CONFIDENTIAL DISCHARGE SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL DISCHARGE SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 68 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:

***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 69 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006429952
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 14, 2019 18:46
ATTENDING:
=====

ADRs: No ADRs on file.

Allergies: PENICILLIN
=====

****NO MEDICATIONS FOUND****

*** END ***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

{{{ END }}} Patient Encounter(s) History Report Dec 19, 2019@13:40

**EXHIBIT NO. B15F
PAGE: 70 OF 233**

Patient Encounter(s) History Report Dec 19, 2019@13:40

(From: 05/02/19 --- Thru: 05/03/19)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006439886
 HOSP : WELCH COMMUNITY HOSPITAL ADM: May 02, 2019 09:21
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B15F
PAGE: 71 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006439886
ADM: May 02,2019 09:21

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 72 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006439886
ADM: May 02, 2019 09:21

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (LICENSED PRACTICAL NURSE)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J

Observed/Historical: Historical

==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 73 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006439886
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 02, 2019 09:21
ATTENDING:

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 74 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006439886
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 02, 2019 09:21
ATTENDING:

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- CLINIC NOTE (SCANNED) -----
DATE OF NOTE: MAY 2, 2019@10:51 ENTRY DATE: MAY 3, 2019@10:51:22
AUTHOR: HALE, DIANNE M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Clinic Note(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 05/03/2019 10:52

EXHIBIT NO. B15F
PAGE: 75 OF 233

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006439886
ADM: May 02, 2019 09:21

Δ Growth plotted on growth chart

ग्रन्थालय विभाग

Black feminism by Gwendolyn Ibsen

School Entry Requirements

EXHIBIT NO. B15F
PAGE: 76 OF 233

Screen Date _____		Name _____	
Nutrition/Physical Activity/Sleep Normal eating habits? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Fruit/vegetable/meat/protein per day _____		ADAMS, NEVAEH ADM : 590219 ACT# : COMPAK988B MED# : 108580 FC : E SEX : F AGE : 3 yr SER : PTC DR : KUBRAH, PAYMAN	
<p><input type="checkbox"/> Physical activity/resource on how most days</p> <p>Type of physical activity/condition?</p> <p>Normal sleeping patterns? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Hours of sleep each night? <u>10-11 hrs/night</u></p>		<p>See Protective Factors for Risk Factors</p> <p><input type="checkbox"/> Potential Risk (Homeopathic/Homotoxic)</p> <p><input type="checkbox"/> Low risk <input type="checkbox"/> High risk</p> <p><input type="checkbox"/> Safety Risk <input type="checkbox"/> Low risk <input type="checkbox"/> High risk</p> <p><input type="checkbox"/> Preference Risk <input type="checkbox"/> Low risk <input type="checkbox"/> High risk</p>	
<p>Physical Examination (Homeopathic/Autonomic)</p> <p>General Appearance <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Stomach <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Musculoskeletal <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Respiratory <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Head <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Neck <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Eyes <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Rest Relax <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Colder Alarmed <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Ears <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Nose <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Oral Cavity/Throat <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Lung <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Heart <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Pulses <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Abdomen <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Genitalia <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Back <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Hips <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p> <p>Extremities <input type="checkbox"/> Non <input checked="" type="checkbox"/> Abn</p>		<p>Anticipatory Guidance (Centers for Disease Control and Prevention) http://www.cdc.gov/parents.aspx</p> <p>Physical Determinants of Health</p> <p><input type="checkbox"/> Home situation and food security <input type="checkbox"/> Tobacco, alcohol, and drug abuse <input type="checkbox"/> Positive family interactions <input type="checkbox"/> Work-life balance</p> <p><input type="checkbox"/> Play opportunities and interactive games <input type="checkbox"/> Sibling relationships</p> <p>Encouraging Literacy Activities</p> <p><input type="checkbox"/> Reading, writing, and singing together <input type="checkbox"/> Language development</p> <p>Promoting Healthy Nutrition and Physical Activity</p> <p><input type="checkbox"/> Water, milk, and juice <input type="checkbox"/> Nutritious foods <input type="checkbox"/> Competence in motor skills and limits on inactivity <input type="checkbox"/> Car safety seats <input type="checkbox"/> Smoking prevention <input type="checkbox"/> Production safety and falls from windows <input type="checkbox"/> Water safety <input type="checkbox"/> Firearm safety</p> <p>Plan of Care Assessment, <input type="checkbox"/> Well Child <input type="checkbox"/> Other Diagnosis The Patient by Problem Treatment Labs <input type="checkbox"/> Hemoglobin/Hematocrit (High risk) <input type="checkbox"/> Blood lead (if not completed at 12 months/24 months or high risk) (either 5mg/dL or 10mg/dL) <input type="checkbox"/> TTB skin test (if high risk)</p> <p>Other</p>	
<p>See Protective Factors for Risk Factors</p> <p><input type="checkbox"/> Potential Risk (Homeopathic/Homotoxic)</p> <p><input type="checkbox"/> Low risk <input type="checkbox"/> High risk</p> <p><input type="checkbox"/> Safety Risk <input type="checkbox"/> Low risk <input type="checkbox"/> High risk</p> <p><input type="checkbox"/> Preference Risk <input type="checkbox"/> Low risk <input type="checkbox"/> High risk</p>		<p>Referrals See page 1, school requirements</p> <p>Prior Authorizations For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-625-9704 or http://www.germantowncheck.com.</p> <p>Follow Up/Next Visit: <u>14 years old</u></p> <p><input type="checkbox"/> Other _____</p> <p>D Screen has been reviewed and is complete See page 1, school requirements for required signature</p>	
<p>Possible Signs of Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Concerns and/or questions _____</p>			

**EXHIBIT NO. B15F
PAGE: 77 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006439886
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 02, 2019 09:21
ATTENDING:

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----
DATE OF NOTE: MAY 2, 2019@10:51 ENTRY DATE: MAY 3, 2019@10:51:43
AUTHOR: HALE, DIANNE M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 05/03/2019 10:51

**EXHIBIT NO. B15F
PAGE: 78 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006439886
 ADM: May 02, 2019 09:21

138580

RURAL HEALTH CLINIC

Name: Nevaeh Adams Age: 3 DOB: 7-21-15
 Date/Time of Arrival: 5-2-19 @ 9:15AM
 Reason for Visit: physical & due for vaccinations

ALLERGIES Amoxicillin

Vitals: BP _____ HR 115 RR 24 Temp 98.2 Pulse Ox _____ % _____ lpm
 Pain (0-10) _____ Location _____ Wt. 30 Ht. _____ LMP _____

Medical History:

Asthma Gout: CHF: COPD: CVA Diabetes
 HTN Hyperlipidemia: Psych: Renal: Seizures
 Other: Turner's Syndrome

Surgical History:

Appendix Cardiac/Stent Gallbladder Hysterectomy BTL
 Other: Hips

Social History: smoker 0 ppd/never/quit drugs 0 alcohol none/recent/occasional

Primary Care Provider:

DR. Habbich

Nurse Signature:

Sherry A. West, LPN

******PATIENT REQUIRES HIGHER LEVEL OF CARE******

Focus assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider _____ Date _____ Time _____

Original 2-2017

**EXHIBIT NO. B15F
PAGE: 79 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006439886
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 02, 2019 09:21
ATTENDING:

----- PRESENTING SHEET (SCANNED) -----
DATE OF NOTE: MAY 2, 2019@09:44 ENTRY DATE: MAY 2, 2019@09:44:16
AUTHOR: WALKER, JENNIFER R EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ JENNIFER R WALKER
OFFICE ASSISTANT
Signed: 05/02/2019 09:47

EXHIBIT NO. B15F
PAGE: 80 OF 233

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006439886
 ADM: May 02, 2019 09:21

NURSE:	TIME:	ADAMS, NEVAEH ADM: 5/02/19 ACT# : 0000439886 DOB: 7/21/2015 FC: E SEX: F SER: PDC DR: KOBBAH, PAYON AGE: 3 yr
RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION		
PLEASE FILL OUT TOP PORTION ONLY		
NAME: <u>Nevaeh Adams</u>	TODAY'S DATE: <u>5-2-19</u>	
TIME: <u>9:15</u>	AGE: <u>3</u>	BIRTHDAY: <u>7-21-15</u>
TO BE FILLED OUT BY HOSPITAL STAFF		
DISPOSITION: WIC PEDS IM SURG OBGYN <u>Physical & Vaccines</u>		
Registration Complaint: <u></u>		
NURSE: <u>Sherry Rh GPN</u>	TIME: <u>9:15 AM</u>	

**EXHIBIT NO. B15F
PAGE: 81 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006439886
ADM: May 02,2019 09:21

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----
DATE OF NOTE: MAY 2,2019@09:44 ENTRY DATE: MAY 2,2019@09:44:43
AUTHOR: WALKER,JENNIFER R EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ JENNIFER R WALKER
OFFICE ASSISTANT
Signed: 05/02/2019 09:47

**EXHIBIT NO. B15F
PAGE: 82 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006439886
 ADM: May 02, 2019 09:21



ADAMS, NEVAEH	ACT# : 0008439886
ADM : 5/02/19	MED# : 188580
DOB : 7/21/2015	FC : E
SEX : F	AGE : 3 yr
SER : PDC	DR : KOBBAH, PIAYON

WELCH COMMUNITY HOSPITAL
 454 McDOWELL STREET
 WELCH, WV 24801

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

**EXHIBIT NO. B15F
PAGE: 83 OF 233**

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.
7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital. If for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

ADAMS, NEVAEH
ADM : 5/02/19 ACT# : 0008439886
MED# : 138580
DOB : 7/21/2015 FC : E
SEX : F AGE : 3 yr
SER : PDC DR : KOBBAH, PAYON

EXHIBIT NO. B15F
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If you would like to opt out of HIV testing, please initial the line below. There may be some instances where patients are not allowed to opt out. For further information, please refer to the information sheet given to you upon registration.

Initials of patient/patient representative: KCA

- 8. RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: KCA

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

- 9. NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

- 10. PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

- I object to having my name, location and general condition listed in the facility directory.

ADAMS, NEVAEH

ADM: 5/02/19

DOB: 7/21/2015	ACT# : 0006439888
SEX: F	MR#: 138660
SFR: POC	FC: E
	AGE: 3y
	DR: KOBBAH, PIAYON

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006439886
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 02, 2019 09:21
ATTENDING:

----- IDENTIFICATION CARD/DRIVERS LICENCE -----
DATE OF NOTE: MAY 2, 2019@09:43 ENTRY DATE: MAY 2, 2019@09:43:40
AUTHOR: WALKER, JENNIFER R EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

ID Card /Drivers License attached as scanned image.

/es/ JENNIFER R WALKER
OFFICE ASSISTANT
Signed: 05/02/2019 09:47

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006439886
ADM: May 02, 2019 09:21

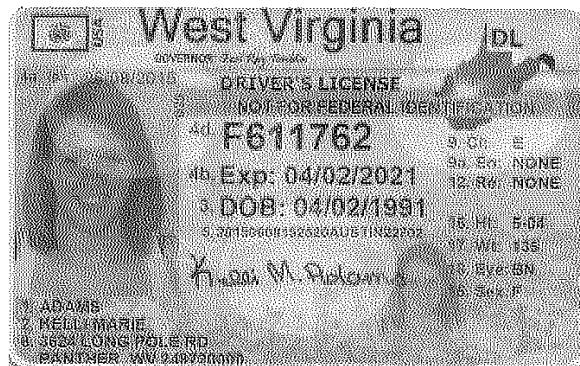
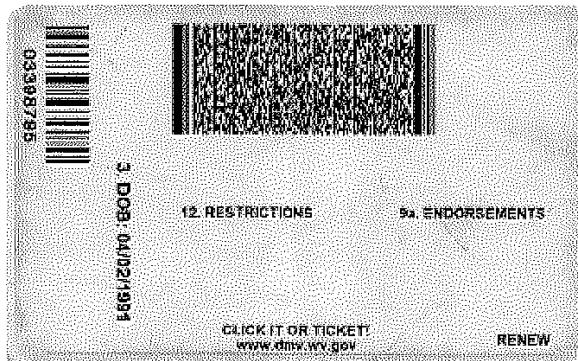


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**EXHIBIT NO. B15F
PAGE: 88 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006439886
ADM: May 02,2019 09:21

----- INSURANCE CARD -----
DATE OF NOTE: MAY 2,2019@09:43 ENTRY DATE: MAY 2,2019@09:43:55
AUTHOR: WALKER,JENNIFER R EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.
INSURANCE CARD BACK (SCANNED):

/es/ JENNIFER R WALKER
OFFICE ASSISTANT
Signed: 05/02/2019 09:47

**EXHIBIT NO. B15F
PAGE: 89 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006439886
 ADM: May 02, 2019 09:21

UNAUTHORIZED USE IS A CRIMINAL PRACTICE AND WILL BE PROSECUTED TO THE FULLEST EXTENT OF THE LAW		
West Virginia Medical ID Card		
MA ID	Member Name	Birth Date
00600205620	KELLI ADAMS	04/02/1991
00405209776	KYRA B ADAMS	07/16/2016
00405164305	NEVAEH H ADAMS	07/21/2015
00403605747	HAILEY DANIELS	05/04/2010
00202691194	NORMA BOLDEN	03/03/2008

This card does not guarantee coverage. Verify coverage at 800-642-9069 or 304-558-2400. Prior Authorization may be required for certain services.

For more information about Medicaid services, co-payments for certain services, Non-Emergency Medical Transportation (NEMT) for scheduled medical appointments and treatments, and more see 'Your Guide to Medicaid' at www.dhhr.wv.gov/csc.

If you have questions about your Medicaid Eligibility, call Client Services at 800-642-9069 or 304-558-2400; hearing impaired 304-558-3615.

If you have questions about Managed Care Organizations (MCO), call 800-447-8466. If you are enrolled in Managed Care, you will also receive an MCO card that must be shown to your healthcare provider. Questions about services or billing should be directed to the MCO you are enrolled in.

If you are not in Managed Care and have questions about services or billing, call Member Services at 800-483-0791.

For more information about NEMT, please contact the Broker at 844-549-8252.

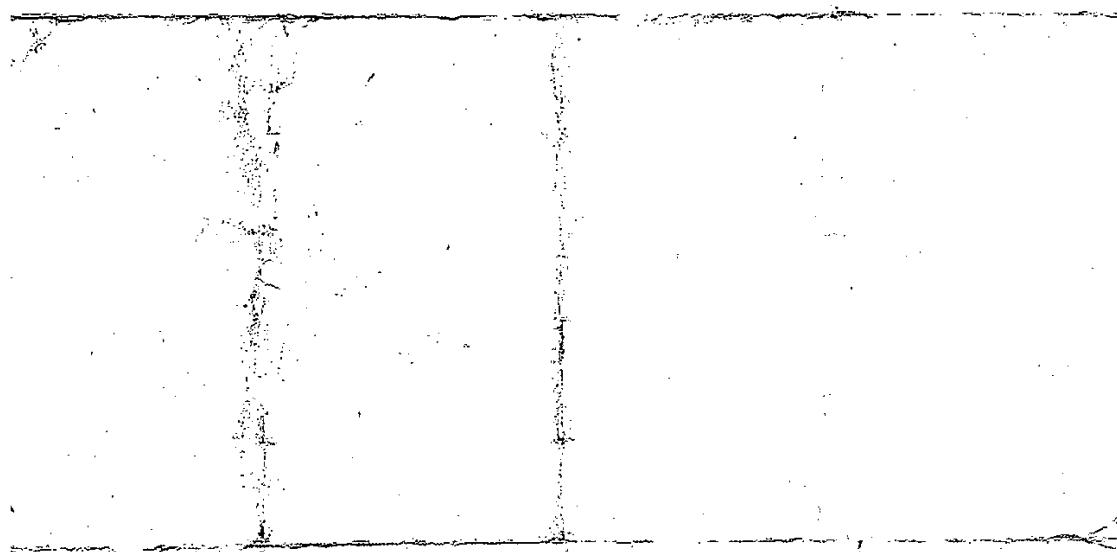
Case: 4016414547

Date: 10/03/18

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Continued on back

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PAGE: 90 OF 233



**EXHIBIT NO. B15F
PAGE: 91 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006439886
 ADM: May 02,2019 09:21

Health PAS-OnLine

Page 1 of 1

Member Management System																										
Home	Form Entry	Account Maintenance	For Exchange	Contact Us	Provider Inquiry																					
Reference Material																										
Verify Member Eligibility	View Patient Record	View PCP Roster	Provider Response Payment																							
Eligibility Verification																										
Verifying Member Eligibility Your inquiry indicates this member was eligible for a covered service on the date of service indicated in your request. This individual is not pre-authorized for the service requested.																										
Member <table border="1"> <tr> <td>Name</td> <td>Date of Birth</td> <td>Gender</td> <td colspan="3">Address</td> </tr> <tr> <td>ADAMS, NEVAEH</td> <td>2015-07-21</td> <td>Female</td> <td>810158492</td> <td>Eastgate</td> <td>Country</td> </tr> <tr> <td colspan="6">Tracking Number: 19122W000000001</td> </tr> </table>						Name	Date of Birth	Gender	Address			ADAMS, NEVAEH	2015-07-21	Female	810158492	Eastgate	Country	Tracking Number: 19122W000000001								
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Tracking Number: 19122W000000001																										
Eligibility Inquiry Date of Service: <input type="text" value="5/2/2019"/> From Date Of Service: <input type="text" value="5/2/2019"/> To Date Of Service: <input type="text" value="5/2/2019"/> Inquiry Type: <input type="checkbox"/> Date Spec Only <input checked="" type="checkbox"/> All Services																										
Enrollments <table border="1"> <thead> <tr> <th>Employer/Insurer Name</th> <th>Coverage Status</th> <th>Coverage Effect</th> <th>Policy Type</th> <th>Effective Date</th> <th>Termination Date</th> <th>Periodic</th> </tr> </thead> <tbody> <tr> <td>WV Department of Health Direct Plan</td> <td>Active</td> <td>Generations</td> <td>Standard</td> <td>05/01/2019</td> <td>05/31/2019</td> <td>No</td> </tr> <tr> <td colspan="7"> Policy Dates: Coverage Dates: 05/01/2019 - 05/31/2019 F21019F: Generations Dates: 05/01/2019 - 05/31/2019 F21019F: Tier 3 Dates: 05/01/2019 - 05/31/2019 </td> </tr> </tbody> </table>						Employer/Insurer Name	Coverage Status	Coverage Effect	Policy Type	Effective Date	Termination Date	Periodic	WV Department of Health Direct Plan	Active	Generations	Standard	05/01/2019	05/31/2019	No	Policy Dates: Coverage Dates: 05/01/2019 - 05/31/2019 F21019F: Generations Dates: 05/01/2019 - 05/31/2019 F21019F: Tier 3 Dates: 05/01/2019 - 05/31/2019						
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Other Insurance <table border="1"> <tr> <td>PIN</td> <td>Plan Type</td> <td>Policy ID</td> <td>Group #</td> <td>Master</td> <td>Carrier Client</td> <td>Coverage Status</td> <td>Effective Date</td> <td>Termination Date</td> <td>Periodic</td> </tr> <tr> <td>1234567890</td> <td>Hospital</td> <td>1234567890</td> <td>1234567890</td> <td>1234567890</td> <td>1234567890</td> <td>Active</td> <td>05/01/2019</td> <td>05/31/2019</td> <td>No</td> </tr> </table>						PIN	Plan Type	Policy ID	Group #	Master	Carrier Client	Coverage Status	Effective Date	Termination Date	Periodic	1234567890	Hospital	1234567890	1234567890	1234567890	1234567890	Active	05/01/2019	05/31/2019	No	
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1234567890	Hospital	1234567890	1234567890	1234567890	1234567890	Active	05/01/2019	05/31/2019	No																	
Copy Enter insurance information to copy this to the profile of the line of service. Copying will not affect the original member's benefits. Benefits for lines with a date of service on or after May 02, 2019, apply to this member.																										
Service: <input type="checkbox"/> Copy Amt Due <input type="checkbox"/> Effective Date <input type="checkbox"/> Termination Date <input type="checkbox"/> FSA 123 30 05/02/2019 05/31/2019 Active																										
PCP / Medical Home <table border="1"> <tr> <td>Effective Date</td> <td>Termination Date</td> </tr> <tr> <td>PCP/Medical Home Name: UNINSURE HEALTH PLAN OF WESI</td> <td>Physician ID: 809910002</td> </tr> <tr> <td>Address: PO Box 11 Attn: Claims Charleston, WV 25324-0021</td> <td></td> </tr> <tr> <td>Phone Number: 866-282-0005</td> <td>Operating Status: Active</td> </tr> </table>						Effective Date	Termination Date	PCP/Medical Home Name: UNINSURE HEALTH PLAN OF WESI	Physician ID: 809910002	Address: PO Box 11 Attn: Claims Charleston, WV 25324-0021		Phone Number: 866-282-0005	Operating Status: Active													
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Lock-In No lock-in information found for this line of service.																										
Spend Down No spend down information found for this line of service.																										

<https://www.wvmmis.com/MhpViewer.aspx?Url=https%3A%2F%2Fwww.wvmmis.com%...>

5/2/2019

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Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

*** END ***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006439886
ADM: May 02, 2019 09:21

***** CONFIDENTIAL ORDERS SUMMARY *****

Order Date: St: Requestor: Start Date: Stop Date:
Nature of Order: Signature:
Item Ordered:
=====

*** END ***** CONFIDENTIAL ORDERS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 94 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006439886
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 02, 2019 09:21
ATTENDING:

***** CONFIDENTIAL LAB RESULTS SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL LAB RESULTS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 95 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006439886
ADM: May 02,2019 09:21

***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
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MRN: WEL000138580
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ADM: May 02,2019 09:21

***** CONFIDENTIAL DISCHARGE SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL DISCHARGE SUMMARY *****

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006439886
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 02, 2019 09:21
ATTENDING:

***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006439886
HOSP : WELCH COMMUNITY HOSPITAL ADM: May 02, 2019 09:21
ATTENDING:
=====

ADRs: No ADRs on file.

Allergies: PENICILLIN
=====

****NO MEDICATIONS FOUND****

*** END ***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

{{{ END }}} Patient Encounter(s) History Report Dec 19, 2019@13:40

**EXHIBIT NO. B15F
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Patient Encounter(s) History Report Dec 19, 2019@13:42

(From: 06/05/19 --- Thru: 06/06/19)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006442827
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 05, 2019 11:15
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B15F
PAGE: 100 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006442827
ADM: Jun 05,2019 11:15

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 101 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006442827
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 05, 2019 11:15
ATTENDING:

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (LICENSED PRACTICAL NURSE)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J

Observed/Historical: Historical

==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 102 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006442827
ADM: Jun 05,2019 11:15

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 103 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006442827
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 05,2019 11:15
 ATTENDING:

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- CLINIC NOTE (FREE TEXT) -----
 DATE OF NOTE: JUN 5,2019@12:16 ENTRY DATE: JUN 5,2019@12:16:20
 AUTHOR: KOBBAH,PIAYON E EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

Dr. kobbah dictating a clinic note on Nevaeh Adams.

Chief complaint well child care and immunizations update.

History of present illness this is a 3-year-old female who is here to update her immunizations well child care. The patient had the last EPSDT in May 2019. She has no other complaints.

Past medical history Turner's syndrome. Coarctation of the aorta. Bilateral hip dysplasia. Congenital short stature

Past surgical history she had surgery and bilateral hip surgeries.

Social history she lives at home with her parents

PCP Dr. kobbah

Immunizations at the lid due to illness.

Medications she takes growth home on injections.

Allergies penicillin.

Review of systems 12 systems were reviewed and were negative except as indicated in the history of present illness.

Physical exam temperature 90 hr 8 pulse 98 respirations 16 oxygen saturation 99% on room air weight 37 pounds.

The patient is awake alert active in no acute distress.

Head atraumatic normocephalic

Neck is supple without meningismus the patient does have webbing of her neck secondary to Turner's syndrome.

Throat is clear

TMs are clear

Pupils equal reactive to light sclera conjunctiva clear

Chest is clear to auscultation no rales no rhonchi no wheezing no retractions

Heart no murmurs

Skin no rash good turgor moist mucous membrane she appears well hydrated well-perfused nontoxic appearing.

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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006442827
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 05,2019 11:15
ATTENDING:

Assessment well child care.

Plan patient immunizations updated. She is to return in August for a second round of immunizations.

Return to the pediatric clinic immediately if condition worsens

/es/ PIAYON E KOBBAH, MD

Signed: 06/05/2019 12:34

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----
DATE OF NOTE: JUN 5,2019@11:49 ENTRY DATE: JUN 5,2019@11:49:15
AUTHOR: GREEN, LAURA C EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ LAURA C GREEN
OFFICE ASSISTANT
Signed: 06/05/2019 11:50

**EXHIBIT NO. B15F
PAGE: 105 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006442827
 ADM: Jun 05, 2019 11:15



ADAMS, NEVAEH	ACT# : 0006442827
ADM : 6/05/19	MED# : 138580
DOB : 7/21/2015	FC : E
SEX : F	AGE : 3 yr
SER : PDC	DR : KOBBAH, PHAYON

WELCH COMMUNITY HOSPITAL
 454 McDOWELL STREET
 WELCH, WV 24801

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

**EXHIBIT NO. B15F
PAGE: 106 OF 233**

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf and to act as my agent in pursuing such appeals.
- ADAMS, NEVAEH
ADM : 606518 ACT# : 0066442827
BDR : 7/21/2015 MED# : 138580
SEX : F FC : E
SER : PDC AGE : 3 yr It cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.
6. **OUTPATIENT DRUGS:** SER : PDC DR : KOBRAH, PRAYON
7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital. If for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

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If you would like to opt out of HIV testing, please initial the line below. There may be some instances where patients are not allowed to opt out. For further information, please refer to the information sheet given to you upon registration.

X

Initials of patient/patient representative: KMA

8. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

X

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I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

9. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

10. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

I object to having my name, location and general condition listed in the facility directory.

ADAMS, NEVAEH	ACT# : 0006442827
ADM : 6/05/18	MED# : 138580
DOB : 2/21/2015	FC : E
SEX : F	AGE : 3 yr
SFR : PNC	DR : KORRAH, PIAYIN

**EXHIBIT NO. B15F
PAGE: 108 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006442827
 ADM: Jun 05, 2019 11:15



ADAMS, NEVAEH	ACT# : 0006442827
ADM : 6/05/19	MED# : 138580
DOB : 7/21/2015	FC : E
SEX : F	AGE : 3 yr
SER : PDC	DR : KOBBAH, PHAYON

WELCH COMMUNITY HOSPITAL
 454 McDOWELL STREET
 WELCH, WV 24801

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2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
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**EXHIBIT NO. B15F
PAGE: 109 OF 233**

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EXHIBIT NO. B15F
PAGE: 110 OF 233

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I object to having my name, location and general condition listed in the facility directory.

ADAMS, NEVAEH	ACT# : 0006442827
ADM : 6/05/18	MED# : 138580
DOB : 2/21/2015	FC :
SEX : F	AGE : 3 yr
SFR : PNC	DR : KORRAH, PIAYIN

**EXHIBIT NO. B15F
PAGE: 111 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006442827
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 05,2019 11:15
ATTENDING:

----- IDENTIFICATION CARD/DRIVERS LICENCE -----
DATE OF NOTE: JUN 5,2019@11:48 ENTRY DATE: JUN 5,2019@11:48:10
AUTHOR: GREEN, LAURA C EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

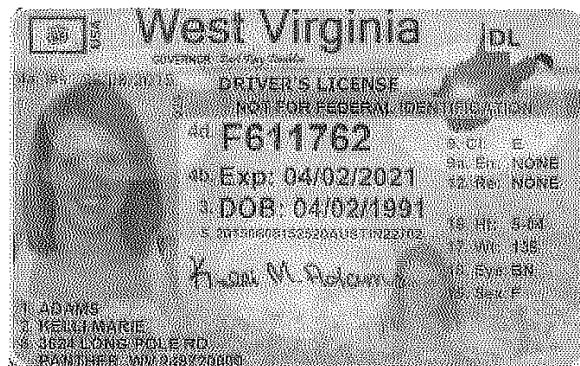
ID Card /Drivers License attached as scanned image.

/es/ LAURA C GREEN
OFFICE ASSISTANT
Signed: 06/05/2019 11:50

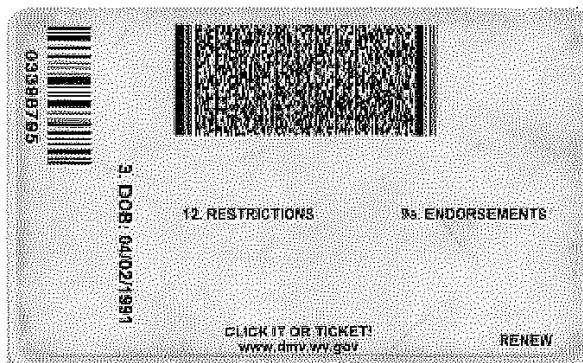
**EXHIBIT NO. B15F
PAGE: 112 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006442827
ADM: Jun 05,2019 11:15



**EXHIBIT NO. B15F
PAGE: 113 OF 233**



**EXHIBIT NO. B15F
PAGE: 114 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006442827
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 05, 2019 11:15
ATTENDING:

----- PRESENTING SHEET (SCANNED) -----
DATE OF NOTE: JUN 5, 2019@11:48 ENTRY DATE: JUN 5, 2019@11:48:26
AUTHOR: GREEN, LAURA C EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ LAURA C GREEN
OFFICE ASSISTANT
Signed: 06/05/2019 11:50

**EXHIBIT NO. B15F
PAGE: 115 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006442827
 ADM: Jun 05,2019 11:15

<u>RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION FORM</u>			
PLEASE FILL OUT TOP PORTION ONLY			
NAME: <u>Neveah Adams</u>	TODAY'S DATE: <u>6-5-19</u>		
TIME: <u>10:54</u>	AGE: <u>3</u>	BIRTHDAY: <u>7-21-15</u>	
TO BE FILLED OUT BY HOSPITAL STAFF			
DISPOSITION: WIC <input checked="" type="checkbox"/> PEDS <input type="checkbox"/> IM <input type="checkbox"/> SURG <input type="checkbox"/> OBGYN			
Registration Complaint: <u>Immunization</u>			
NURSE: <u>m</u>	TIME: <u>1127</u>		

ADAMS, NEVAEH
 ADM: 500519
 ACT# 0306442827
 DOB: 7/21/2015
 DOB# 1538389
 ED: E
 FZ: F
 AGE: 3 Y
 SEX: F
 SSN: 500519
 MRN: WEL000138580
 HOSP: WELCH COMMUNITY HOSPITAL

**EXHIBIT NO. B15F
PAGE: 116 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006442827
ADM: Jun 05,2019 11:15

----- INSURANCE CARD -----
DATE OF NOTE: JUN 5,2019@11:47 ENTRY DATE: JUN 5,2019@11:47:45
AUTHOR: GREEN, LAURA C EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.
INSURANCE CARD BACK (SCANNED) :

/es/ LAURA C GREEN
OFFICE ASSISTANT
Signed: 06/05/2019 11:50

**EXHIBIT NO. B15F
PAGE: 117 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006442827
 ADM: Jun 05,2019 11:15

Eligibility Receipt

Page 1 of 2

Eligibility Receipt

This highly secure verifies whether a member was eligible for a selected benefit on the date(s) of service submitted in the request. This information does not guarantee payment for the service rendered.

Member

Name	Date of Birth	Member ID
ADAMS, NEVAEH	7/21/2015	09405164305
Tracking Number	101561090369054	
Date of Inquiry	05/20/19 13:33:28 AM	
From Date of Service	05/20/19	
To Date of Service	05/20/19	
Procedure Codes		
HIPAA Category Code		

Enrollments

Program/Benefit Name	Coverage Status	Coverage Level	Plan Type	Effective Date	Termination Date	Member ID
WV Mountain Health Trust Benefit Port	Active	Secondary	Medical	06/01/2018		09405164305
Rate Code	Coverage	Effective Date				
AMIGE	Categorically Needy	06/01/2018				
EDIGE	Tier 2 Copay	06/01/2018				

Other Insurance

Plan	Plan Type	Policy Type	Policy #	Group #	Status	Carrier Name	Coverage Status	Effective Date	Termination Date
GDG Vision	Vision		NO POLICY		Primary	8420 - GDGS VISION / EASHMEN EPLUS	Active	06/01/2019	

Copay

It is the member's responsibility to pay the copay to the provider at the time of the service. Copays are at the benefit level (individual service codes).

Regarding for claims with a Date of Service on or after June 05, 2019, copays for this member are:

Service	Copay Amount	Effective Date	Termination Date	Tier
N/A	\$0	06/05/2019	06/30/2019	Member is exempt

PCP / Medical Home

Eligible Date	Eligibility Date
PCP / Medical Home Name	UNICARE HEALTHPLAN OF WEST VIRGINIA, INC.
Address	PO Box 91, Attn: Claims, Charleston WV 25321-0091
TIN/Number	030-782-0096
	Coverage Status Active

Lock-In

No lock-in information found for DGS copay exemption

Spend Down

No Spend Down information found at this time

ADAMS, NEVAEH
 ADM: 0005164305
 ACT: 0006442827
 MEDN: 139580
 IC: E
 AGE: 3 YR
 DOB: 7/21/2015
 SEX: F
 CTR: PNC DE - KONTAKI MANDI

**EXHIBIT NO. B15F
PAGE: 118 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006442827
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 05, 2019 11:15
ATTENDING:

----- MEDICATION RECONCILIATION (SCANNED) -----
DATE OF NOTE: JUN 5, 2019@08:58 ENTRY DATE: JUN 6, 2019@08:58:29
AUTHOR: HALE, DIANNE M EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 06/06/2019 08:58

**EXHIBIT NO. B15F
PAGE: 119 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006442827
 ADM: Jun 05, 2019 11:15

**WELCH COMMUNITY HOSPITAL
MEDICATION RECONCILIATION FORM**

ADAMS, NEVAEH
 ACT# : 0006442827
 MED# : 138580
 DOB : 7/21/2015
 FC : E
 SEX : F AGE : 3 yr
 SSN : POC DR : KARRAH PIAYIN

Name:	DOB:
Allergies/Describe Reaction:	

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER-THE-COUNTER AND HERBAL MEDS

Name of Medication/Dose	Route/ Frequency	Last Dose	Reason for Medication	Continue on Admission	Continue on Transfer	Continue After Surgery	Continu- on Discharge
1. Growth Hormone Injection q.D				Y N	Y N	Y N	Y N
2.				Y N	Y N	Y N	Y N
3.				Y N	Y N	Y N	Y N
4.				Y N	Y N	Y N	Y N
5.				Y N	Y N	Y N	Y N
6.				Y N	Y N	Y N	Y N
7.				Y N	Y N	Y N	Y N
8.				Y N	Y N	Y N	Y N
9.				Y N	Y N	Y N	Y N
10.				Y N	Y N	Y N	Y N
11.				Y N	Y N	Y N	Y N
12.				Y N	Y N	Y N	Y N
13.				Y N	Y N	Y N	Y N
14.				Y N	Y N	Y N	Y N
15.				Y N	Y N	Y N	Y N
16.				Y N	Y N	Y N	Y N
17.				Y N	Y N	Y N	Y N
18.				Y N	Y N	Y N	Y N
19.				Y N	Y N	Y N	Y N
20.				Y N	Y N	Y N	Y N
21.				Y N	Y N	Y N	Y N
22.				Y N	Y N	Y N	Y N
23.				Y N	Y N	Y N	Y N
24.				Y N	Y N	Y N	Y N

New Medications Added

Date	Name of Medication/Dose	Route/Frequency/Duration	Reason	Provider Name

Source of Medication List

- Patient Medication List
- Patient/Family Recall
- Pharmacy:
- Primary Care Physician List
- Previous Discharge Paperwork
- Reconciling Prescriber (MD/DO)

Medication List Recorded/Reviewed by RN/MD/DO/PA/NP/PA/RPN

By: _____ Date: _____ 6-5-19
 By: _____ Date: _____
 By: _____ Date: _____
 By: _____ Date: _____
 By: _____ Date: _____

Physician

Date

Physician

Date

**EXHIBIT NO. B15F
PAGE: 120 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006442827
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 05, 2019 11:15
ATTENDING:

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----
DATE OF NOTE: JUN 5, 2019@08:57 ENTRY DATE: JUN 6, 2019@08:58:03
AUTHOR: HALE, DIANNE M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ DIANNE M HALE
OFFICE ASSISTANT
Signed: 06/06/2019 08:58

**EXHIBIT NO. B15F
PAGE: 121 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006442827
 ADM: Jun 05, 2019 11:15

ADAMS, NEVAEH
 ADM: 6/05/19 ACT#: 0006442827
 MED#: 138580
 DOB: 7/21/2015 FC: E
 SEX: F AGE: 3 yr
 SER: POC DR: KOBBAK, PIAYON

Name: Nevaeh Adams Age: 3 DOB: 7-21-15
 Date of Arrival: _____ Time: 1120

Reason for Visit:

Immunizations - MMR

ALLERGIES: NKDA Iodine Latex IV Contrast Sulfa PCN / Antibiotic

Other

BP 98 HR 98 Temp 98.4 temp RR 14 Pulse Ox 99 % Ht _____ Wt 37
 Pain (0-10) _____ Location _____ LMP _____ PREGNANT _____ months/weeks

Medical History: No chronic medical conditions

HTN Hyperlipidemia Diabetes Heart Disease (A-fib MI CHF) CVA / TIA
 Seizures Migraines Gout GERD Chronic Pain _____
 COPD Asthma Thyroid Psych (Anxiety / Depression) Cancer _____

Other: Turmeric Symptom Leaking Aorta

Surgical History: No Surgeries

Appendix Gallbladder Cardiac (Stent / Bypass) Hysterectomy BTx C-section Hernia
 Tonsil/Adenoids Dental Ear Tubes Ortho Open Reduction

Other: (B) tlp

Social History: Denies tobacco/alcohol/drug use

Cigarettes PPD / Quit Smokeless Tobacco Vape Alcohol Drugs IVDU (current/former)

Primary Care Provider: Kobba No PCP

Nurse Signature: M. Wellman, CRN

**** PATIENT REQUIRES HIGHER LEVEL OF CARE ****

Focused assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider: _____ Date: _____ Time: _____

**EXHIBIT NO. B15F
PAGE: 122 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006442827
ADM: Jun 05,2019 11:15

*** END ***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 123 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006442827
ADM: Jun 05,2019 11:15

***** CONFIDENTIAL ORDERS SUMMARY *****

Order Date: St: Requestor: Start Date: Stop Date:
Nature of Order: Signature:
Item Ordered:
=====

*** END ***** CONFIDENTIAL ORDERS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 124 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006442827
ADM: Jun 05,2019 11:15

***** CONFIDENTIAL LAB RESULTS SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL LAB RESULTS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 125 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006442827
ADM: Jun 05,2019 11:15

***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 126 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006442827
ADM: Jun 05,2019 11:15

***** CONFIDENTIAL DISCHARGE SUMMARY *****

No data available.

*** END ***** CONFIDENTIAL DISCHARGE SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 127 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006442827
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 05, 2019 11:15
ATTENDING:

***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 128 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006442827
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jun 05, 2019 11:15
ATTENDING:
=====

ADRs: No ADRs on file.

Allergies: PENICILLIN
=====

****NO MEDICATIONS FOUND****

*** END ***** CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY *****

{{{ END }}} Patient Encounter(s) History Report Dec 19, 2019@13:42

**EXHIBIT NO. B15F
PAGE: 129 OF 233**

Patient Encounter(s) History Report Dec 19, 2019@13:42

(From: 07/21/19 --- Thru: 07/21/19)

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39
 ATTENDING:

***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

Insomnia |
 SNOMED-CT: Insomnia
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Turner syndrome |
 SNOMED-CT: Turner syndrome
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G
 Updated: 6/5/17

==== END ===

Anorexia symptom |
 SNOMED-CT: Anorexia symptom
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:
 Status: ACTIVE
 SC Cond: UNKNOWN
 Exposure: None

Provider:
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B15F
PAGE: 130 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006446847
ADM: Jul 21,2019 16:39

Updated: 6/5/17

==== END ===

Hallucinations |
SNOMED-CT: Hallucinations
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:
Status: ACTIVE
SC Cond: UNKNOWN
Exposure: None

Provider:
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G
Entered: 6/5/17, by HAMPTON,CHARLOTTE G
Updated: 6/5/17

==== END ===

*** END ***** CONFIDENTIAL PROBLEM LIST SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 131 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39
ATTENDING:

***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

Causative agent: PENICILLIN
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS
PENICILLIN-G RELATED PENICILLINS
PENICILLINS, AMINO DERIVATIVES
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (LICENSED PRACTICAL NURSE)
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J

Observed/Historical: Historical

==== END ===

*** END ***** CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY *****

**EXHIBIT NO. B15F
PAGE: 132 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006446847
ADM: Jul 21,2019 16:39

***** CONFIDENTIAL VITALS SUMMARY *****

*** END ***** CONFIDENTIAL VITALS SUMMARY *****

EXHIBIT NO. B15F
PAGE: 133 OF 233

Name : ADAMS,NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006446847
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21,2019 16:39
 ATTENDING:

***** CONFIDENTIAL CLINICAL NOTES SUMMARY *****

----- ER DISCHARGE SHEET -----
 DATE OF NOTE: JUL 21,2019@20:35 ENTRY DATE: JUL 21,2019@20:35:32
 AUTHOR: LESTER,TRACEY L EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

Welch Community Hospital
 ER DISCHARGE SHEET

Patient Name: ADAMS,NEVAEH H DOB: JUL 21,2015 Age: 4
 Sex: FEMALE Race: WHITE MR#: WEL000138580

DISCHARGED/TRANSFERRED:

Patient's Outcome: Improved

To: Home []Referred to Social Services
 []Nursing Home:

- []Cobra Form completed
- []Copy of Transfer Form
- []Labs/X-ray/Notes given

Via: Released with adult

EDUCATION: Discharge with written instruction on:

Headache

Voiced understanding of instructions, Copy of Med Rec Sheet

DISCHARGE:

Discharge: Date/Time: 21-Jul-2019 20:33

Comments:

98.6-100-20-90/50-99% RA

/es/ TRACEY L LESTER, RN

Signed: 07/21/2019 20:36

----- ER DISCHARGE INSTRUCTIONS -----
 DATE OF NOTE: JUL 21,2019@20:25 ENTRY DATE: JUL 21,2019@20:25:41
 AUTHOR: LESTER,TRACEY L EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

Welch Community Hospital
 Discharge Instructions

Patient Name: ADAMS,NEVAEH H DOB: JUL 21,2015 Age: 4
 Sex: FEMALE MR#: WEL000138580

Physician: Eells, David Acevedo, MD

Date / Time: 21-Jul-2019 20:25

Diagnosis: Headache

EXHIBIT NO. B15F
PAGE: 134 OF 233

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006446847
 ADM: Jul 21,2019 16:39

Procedures performed During Visit: N/A
 Venipuncture/IV Placement Wound Care
 IV Fluids Eye Exam
 Urinary Catheterization Splint/Immobilization
 Breathing Treatment Cardiac Monitoring
 EKG Oxygen Therapy
 Laceration Repair Ear Exam
 Medications:

Other:

Labs Performed During Visit:
 Complete Blood Count Urine Drug Screen
 Comprehensive Metabolic Profile Pregnancy Test
 Basic Metabolic Profile Arterial Blood Gas
 Cardiac Enzymes Strep Screen
 Amylase RSV Screen
 Lipase Flu A&B Screen
 PT/INR-PTT Urine Culture
 D-Dimer Wound Culture
 Urinalysis
 Other:

Radiology Tests Performed During Visit:
 Chest Xray
 Abdominal Xray
 Extremity:
 Spine:
 CT Scan: Head
 Ultrasound/Doppler:
 Other:

Return to ER For:
 Symptoms persist, worsen or as need for emergencies.

Follow Up With:
 Peds Clinic Tuesday 7/23/19 with Dr. Kobbah at 11:00 AM.

Medication Reconciliation Form Given
 Prescription given: Fill and take as Directed

Special Instructions to Follow:
 Rest, increase clear liquids, further instructions per Headache handout provided.

BP: 90/50 P: 100 R: 20 Temp: 98.6 Sat: 99% RA:
 O2: L

I have had these discharge instructions reviewed with me and I understand them.

**EXHIBIT NO. B15F
PAGE: 135 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006446847
ADM: Jul 21,2019 16:39

I will call my Doctor or return to the hospital if my condition does not improve or becomes worse.

Patient/Representative Signature

Nurse's Signature

/es/ TRACEY L LESTER, RN

Signed: 07/21/2019 20:30

**EXHIBIT NO. B15F
PAGE: 136 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39
 ATTENDING:

MEDICAL RECORD	Progress Notes
STATUS: COMPLETED	

NOTE DATED: 07/21/2019 20:25
 LOCAL TITLE: ER DISCHARGE INSTRUCTIONS
 VISIT: 07/21/2019 16:39 ER
 Welch Community Hospital
 Discharge Instructions

Patient Name: ADAMS, NEVAEH H DOB: JUL 21, 2015 Age: 4
 Sex: FEMALE MRN: WEL000138580

Physician: Eells, David Acevedo, MD

Date / Time: 21-Jul-2019 20:25

Diagnosis: Headache

Procedures performed During Visit: N/A
 Venipuncture/IV Placement Wound Care
 IV Fluids Eye Exam
 Urinary Catheterization Splint/Immobilization
 Breathing Treatment Cardiac Monitoring
 EKG Oxygen Therapy
 Laceration Repair Ear Exam
 Medications:
 Other:

Labs Performed During Visit:
 Complete Blood Count Urine Drug Screen
 Comprehensive Metabolic Profile Pregnancy Test
 Basic Metabolic Profile Arterial Blood Gas
 Cardiac Enzymes Strep Screen
 Amylase RSV Screen
 Lipase Flu A&B Screen
 PT/INR-PTT Urine Culture
 D-Dimer Wound Culture
 Urinalysis
 Other:

Radiology Tests Performed During Visit:
 Chest Xray
 Abdominal Xray
 Extremity:
 Spine:
 CT Scan: Head
 Ultrasound/Doppler:
 Other:

Return to ER For:
 Symptoms persist, worsen or as need for emergencies.
 ** THIS NOTE CONTINUED ON NEXT PAGE **

ADAMS, NEVAEH H	WVDRHR	Printed:07/21/2019 20:31
WEL000138580 DOB:07/21/2015	Pt Loc: OUTPATIENT	Vice SF 509

**EXHIBIT NO. B15F
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MEDICAL RECORD
STATUS: COMPLETED

Progress Notes

07/21/2019 20:25 ** CONTINUED FROM PREVIOUS PAGE **

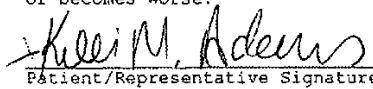
Follow Up With:
Peds Clinic Tuesday 7/23/19 with Dr. Kobbah at 11:00 AM.

[X]Medication Reconciliation Form Given
[]Prescription given: Fill and take as Directed

Special Instructions to Follow:
Rest, increase clear liquids, further instructions per Headache handout provided.

BP: 90/50 P: 100 R: 20 Temp: 98.6 Sat: 99% RA: [X]
O2: L

I have had these discharge instructions reviewed with me and I understand them.
I will call my Doctor or return to the hospital if my condition does not improve or becomes worse.


Patient/Representative Signature

Nurse's Signature

Signed by: /es/ TRACEY L LESTER, RN
07/21/2019 20:30

ADAMS, NEVAEH H WVDHHR Printed:07/21/2019 20:31
WELO00138580 DOB:07/21/2015 Pt Loc: OUTPATIENT Vice SF 509

**EXHIBIT NO. B15F
PAGE: 138 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39
 ATTENDING:

----- NURSING PROGRESS NOTE -----
 DATE OF NOTE: JUL 21, 2019@19:57 ENTRY DATE: JUL 21, 2019@19:57:30
 AUTHOR: LESTER, TRACEY L EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

1900- Report received. Assumed care of pt. No distress noted. No complaints voiced.

1909- Mother taken pt to BR to attempt to collected urine.

1918- No urine collected.

1950- Pt transported to radiology for CT scan.

2007- Pt returned to ER. U-bag remains in placed per mother. No urine at this time. No distress noted. No complaints voiced.

2025- Orders to DC to home received.

2033- Mother carried child from ER. No distress noted. No complaints voiced. Child remarked "I'm all better".

/es/ TRACEY L LESTER, RN

Signed: 07/21/2019 20:35

----- ER NURSING FLOW SHEET -----
 DATE OF NOTE: JUL 21, 2019@16:55 ENTRY DATE: JUL 21, 2019@17:24:19
 AUTHOR: BLEVINS, JULIA L EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

Welch Community Hospital
ER NURSING FLOW SHEET

Patient Name: ADAMS, NEVAEH H DOB: JUL 21, 2015 Age: 4
 Sex: FEMALE Race: WHITE MR#: WEL000138580
 Physician: Ells, David Acevedo, MD

Date/Time: 21-Jul-2019 16:55

CHIEF COMPLAINT:

Grandmother states pt c/o headache and has fell twice (last fall x2 days ago) and c/o left ear ache. Pt noted to be pulling at left ear. bruise with scabbed area noted to right side of forehead.

 VISUAL: No complaints
 NEUROLOGICAL: No complaints
 Pupils: [X] Right: Brisk
 [X] Left: Brisk

EXHIBIT NO. B15F
PAGE: 139 OF 233

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006446847
 ADM: Jul 21, 2019 16:39

Pupil size: 3mm

Speech: Clear

Facial Droop: None

Actions:

Comments:

EARS:
 Pain Left
 Drainage Left
 Ringing
 Blood

Comments:

NOSE: No complaints
 MOUTH: No complaints
 THROAT: No complaints
 MUSCULOSKELETAL: No complaints
 RESPIRATORY: No complaints
 CARDIOVASCULAR: No complaints
 GI/GU: No complaints

/es/ JULIA L BLEVINS, RN

Signed: 07/21/2019 17:31

----- NURSING PROGRESS NOTE -----
 DATE OF NOTE: JUL 21, 2019@16:55 ENTRY DATE: JUL 21, 2019@18:58:53
 AUTHOR: BLEVINS, JULIA L EXP COSIGNER:
 URGENCY: STATUS: COMPLETED

1655- Patient to bed # 2 with grandmother. Hygeine good. Patient alert, playing, and smiling.

1725- Dr.Eells at bedside.

1745- Lab at bedside for blood specimens.

1815- Patient sitting up in bed eating and drinking. No s/s of acute distress noted.

1830- Attempted to straight cath patient per mother request, ok'd by Dr.Eells. Unsuccessful. Ped. U bag in place.

1900- No s/s of acute distress noted. Pt alert and playing.

1905- Report given to T Lester RN

**EXHIBIT NO. B15F
PAGE: 140 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006446847
ADM: Jul 21,2019 16:39

/es/ JULIA L BLEVINS, RN

Signed: 07/21/2019 19:07

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----
DATE OF NOTE: JUL 21,2019@16:53 ENTRY DATE: JUL 21,2019@16:53:09
AUTHOR: GREEN, LAURA C EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ LAURA C GREEN
OFFICE ASSISTANT
Signed: 07/21/2019 16:53

**EXHIBIT NO. B15F
PAGE: 141 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006446847
 ADM: Jul 21, 2019 16:39



ADAMS, NEVAEH	ACT# : 0008446847
ADM : 7/21/19	MED# : 138580
DOB : 7/21/2015	FC : E
SEX : F	AGE : 4 yr
SER : ERM	DR : ELLIS, DAVID

**WELCH COMMUNITY HOSPITAL
 454 McDOWELL STREET
 WELCH, WV 24801**

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

**EXHIBIT NO. B15F
PAGE: 142 OF 233**

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and appeals.
- ADAMS, NEVAEH
ADM : 7/21/19 ACT# : 0003446847
DOB : 7/21/2015 MED# : 139580
SEX : F FC : E
SER : ERN DR : EELLS, DAVID AGE : 4 yr
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescriptions, with a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.
7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital. If for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

EXHIBIT NO. B15F
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If you would like to opt out of HIV testing, please initial the line below. There may be some instances where patients are not allowed to opt out. For further information, please refer to the information sheet given to you upon registration.

Initials of patient/patient representative: _____

- 8. RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

ADAMS, NEVAEH
ADM : 7/21/19 ACT# : 0009446647
MED# : 138580
DOB : 7/21/2015 FC : E
SEX : F AGE : 4 yr
SER : ERML DR : FEU S. DAVID

Initials of patient/patient representative: _____

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

- 9. NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

- 10. PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

I object to having my name, location and general condition listed in the facility directory.

**EXHIBIT NO. B15F
PAGE: 144 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006446847
ADM: Jul 21,2019 16:39

----- INSURANCE CARD -----
DATE OF NOTE: JUL 21,2019@16:52 ENTRY DATE: JUL 21,2019@16:52:40
AUTHOR: GREEN, LAURA C EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.
INSURANCE CARD BACK (SCANNED):

/es/ LAURA C GREEN
OFFICE ASSISTANT
Signed: 07/21/2019 16:53

**EXHIBIT NO. B15F
PAGE: 145 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006446847
 ADM: Jul 21, 2019 16:39

2467981084

Elig Inquiry Date:

Eligibility Report

Elig Check: 07/21/2019 Print Date: 07/21/2019 04:41:13 PM

Patient

The patient is the subscriber or contract holder for the insurance plan.

Primary

Insured Number: 00405164305
 Name: ADAMS, NEVAEH H
 Address: PO BOX 46
 City, State Zip: BIG SANDY, WV 24816
 Date of Birth: 07/21/2015
 Gender: Female
 Insured Status: Active
 Effective Date: 07/21/2019
 Expire Date: 07/21/2019

Insurance

For Member Eligibility Verification and Claim Status inquiries, please contact the payer using the number on the back of the member's card.

Provider Number: 1134158909

Additional Payer Information

Payer Information Contacts
 8426 - DAVIS VISION / FASHION FOCUS

Name:	TPL
Identifier:	PLAN SPONSOR
Insurance Type:	C1 - Commercial
Dates:	07/21/2019 - 07/21/2019
ELIGIBILITY	MEMBER IDENTIFICATION NUMBER
ID Qualifier:	235376313
ID:	01/01/2019
PLAN BEGIN	MEMBER IDENTIFICATION NUMBER
ID Qualifier:	235376313
ID:	

Benefits

Benefit	Amount	Percent	Period	Quantity	Qualifier	In-Network	Insurance Type	Coverage Level	Date	Date Qualifier
HEALTH BENEFIT PLAN COVERAGE - 30										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										

Page 1

**EXHIBIT NO. B15F
PAGE: 146 OF 233**

2467981004

Elg Inquiry Date:

Eligibility Report

Elg Check: 07/21/2019

Print Date: 07/21/2019 04:41:14 PM

Benefit	Amount	Percent	Period	Quantity	Qualifier	In-Network	Insurance Type	Coverage Level	Date	Date Qualifier
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES										
CO-PAYMENT	0.00						Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
MANAGED CARE COORDINATOR							Health Maintenance Organization (H)		07/21/2019-07/21/2019	PRIMARY CARE PROVIDER
Entity: PLAN SPONSOR, Name: UNCARE HEALTHPLAN OF WEST VIRGINIA , Phone: (800)710-0095										
<hr/>										
MEDICAL CARE - 1							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
ACTIVE COVERAGE										
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES										

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**EXHIBIT NO. B15F
PAGE: 147 OF 233**

2467981004

Elg Inquiry Date:

Eligibility Report

Elg Check: 07/21/2019

Print Date: 07/21/2019 04:41:15 PM

Benefit	Amount	Percent	Period	Quantity	Qualifier	In-Network	Insurance Type	Coverage Level	Date	Date Qualifier
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
CHIROPRACTIC -33							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
ACTIVE COVERAGE										
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										
ACTIVE COVERAGE							Medicaid		07/21/2019-07/21/2019	ELIGIBILITY
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793										
ACTIVE COVERAGE							Medicaid		06/01/2018	PLAN BEGIN
Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY										
Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797										

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**EXHIBIT NO. B15F
PAGE: 148 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006446847
ADM: Jul 21, 2019 16:39

----- PRESENTING SHEET (SCANNED) -----
DATE OF NOTE: JUL 21, 2019@16:52 ENTRY DATE: JUL 21, 2019@16:52:54
AUTHOR: GREEN, LAURA C EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ LAURA C GREEN
OFFICE ASSISTANT
Signed: 07/21/2019 16:53

**EXHIBIT NO. B15F
PAGE: 149 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006446847
ADM: Jul 21,2019 16:39

**Presenting Complaint Registration Form
Emergency Room**

Name: JULIA HADLEY Today's Date: 7-21-19
Time: _____ Age: 4 Birthdate: 7-21-2015

Chief Complaint (tell why you are here):
Back pain

Hospital Use Only:

Disposition: ER

Registration Complaint: None

Initials: (initials) Intake/Triage Time: 11:30

ADAMS, NEVAEH
ADM: 7/21/19 ACT#: 0006446847
DOB: 7/21/2015 MRN#: 138580
SEX: F TC: E
STATION: RD - ER/US - DMRD AGE: 4 yr

**EXHIBIT NO. B15F
PAGE: 150 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39
ATTENDING:

----- PATIENT EDUCATION DOCUMENTATION RECORD (SCANNED) -----
DATE OF NOTE: JUL 21, 2019@10:26 ENTRY DATE: JUL 23, 2019@10:26:31
AUTHOR: SCOTT, LATISHA EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Patient Education Documentation Record(s).

/es/ LATISHA COLLINS
OFFICE ASSISTANT
Signed: 07/23/2019 10:27

**EXHIBIT NO. B15F
PAGE: 151 OF 233**

Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21,2015, FEMALE
HOSPT : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006446847
ADM: Jul 21,2019 16:39

Welch Community Hospital

**Patient Education for
Acute Headache**

I acknowledge that I have received a teaching packet for **Acute Headache**. I will also receive education about any medications needed of discharge.

Kelli Nakem
Patient's Signature

7/21/19 2033
Date/Time

Jester Benson
Nurse's Signature

ADAMS, NEVAEH
ADM: 7/21/19
DOB: 7/21/2015
SEX: F
SGA: FSA
ra - FRI's name
ACID: 006446847
MED# : 138580
PC: E
AGE: 4 yr

**EXHIBIT NO. B15F
PAGE: 152 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39
ATTENDING:

----- PERMISSION TO TREAT MINOR (SCANNED) -----
DATE OF NOTE: JUL 21, 2019@10:26 ENTRY DATE: JUL 23, 2019@10:27
AUTHOR: SCOTT, LATISHA EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Permission to Treat Unemancipated Minor document(s).

/es/ LATISHA COLLINS
OFFICE ASSISTANT
Signed: 07/23/2019 10:27

**EXHIBIT NO. B15F
PAGE: 153 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21,2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006446847
 ADM: Jul 21,2019 16:39

PERMISSION TO TREAT UNEMANCIPATED MINOR

DATE: 7-21-19 TIME: 1645

NAME OF MINOR: Nevaeh Adams

ADDRESS: P.O. Box 46 Big Sandy, WV 24816

BIRTHDATE: 7-21-15

NAME OF PARENT OR GUARDIAN CALLED FOR CONSENT:

Rico Adams

TELEPHONE NUMBER CALLED: 304-938-1659

CONSENT WAS: ✓ GRANTED NOT GRANTED

SIGNATURE AND TITLE OF WITNESS:

Julie Glavin RN / Sherrita Dingman APN

SIGNATURE OF ATTENDING PHYSICIAN:

Minors presenting themselves to Welch Community Hospital for treatment should be accompanied by a parent or guardian. If the minor brings a non-notarized note by his/her parent or guardian, the physician (with a third party on an extension, preferably an RN) MUST call the minor's parent or guardian to verify the consent. The above form must then be completed in its entirety as proof of that conversation and made a permanent part of the record. The only exceptions to the above are:
 (1) Life Threatening Situation; (2) Family Planning; and (3) Treatment for Social Diseases

ADAMS, NEVAEH	ACT# : 0806446847
ADM : 7/21/19	MED# : 139580
DOB : 7/21/2015	FC : E
SEX : F	AGE : 4 yr
SER : ERN	DR : EELLS, DAVID

**EXHIBIT NO. B15F
PAGE: 154 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39
ATTENDING:

----- TRIAGE (SCANNED) -----
DATE OF NOTE: JUL 21, 2019@10:25 ENTRY DATE: JUL 23, 2019@10:25:21
AUTHOR: SCOTT, LATISHA EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

Triage Document(s) are attached as scanned image.

/es/ LATISHA COLLINS
OFFICE ASSISTANT
Signed: 07/23/2019 10:27

**EXHIBIT NO. B15F
PAGE: 155 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006446847
 ADM: Jul 21, 2019 16:39

Room		Time		Date: 7-21-19		Arrival Time: 1632		Triage Time 1632		
Patient Name: <i>Neveah Adams</i>		Age: 4	DOB: 7-21-15	<input type="checkbox"/> M	<input checked="" type="checkbox"/> F	Primary Care Physician <i>Unknown</i>				
Arrival Mode: <input type="checkbox"/> Walked <input type="checkbox"/> WIC <input type="checkbox"/> Carried <input type="checkbox"/> EMS		Treatment prior to arrival: <i>None</i>								
Stated Complaint: <i>Feel twice in last week and hit head Grandma states she was c/o headache today.</i>										
Temp: 98.7 B/P: <i>91/54</i>		Pulse: 109	Resp: 20	SpO2: 99.1	<input type="checkbox"/> Room Air	<input type="checkbox"/> O2 @	Weight Pounds: 37 lbs	Weight Kilograms: 17 kg		
Allergies: <input type="checkbox"/> MKA <input type="checkbox"/> PCN <input type="checkbox"/> ASA <input type="checkbox"/> Sulfa <input type="checkbox"/> Codeine <input type="checkbox"/> Latex <input type="checkbox"/> Iodine <input type="checkbox"/> Other: _____										
Medications: <input type="checkbox"/> None <input type="checkbox"/> See Medication List <input type="checkbox"/> Reviewed Medical History <input type="checkbox"/> Denies <input type="checkbox"/> Cardiac <input type="checkbox"/> HTN <input type="checkbox"/> Cancer <input type="checkbox"/> COPD/Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Liver Disease <input type="checkbox"/> CHF <input type="checkbox"/> Renal <input type="checkbox"/> Ulcers <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Thyroid <input type="checkbox"/> Seizures <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> Depression/Anxiety Other: <i>Turner's Syndrome</i>										
Previous Surgeries: <input type="checkbox"/> Denies <input type="checkbox"/> Appendectomy <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Cardiac/Stents <input type="checkbox"/> C-Section <input type="checkbox"/> Hysterectomy <input type="checkbox"/> BTL Other: <i>Both hips</i>										
Last Menstrual Period: _____										
Focus Assessment	GENERAL APPEARANCE <input type="checkbox"/> no acute distress <input checked="" type="checkbox"/> alert <input type="checkbox"/> anxious _____					NEURO/PSYCH <input type="checkbox"/> oriented x3 <input type="checkbox"/> sensation nml <input type="checkbox"/> motor nml <input type="checkbox"/> mood/affect nml <input type="checkbox"/> disoriented to: person / place / time <input type="checkbox"/> slurred / abnml speech <input type="checkbox"/> weakness / sensory loss <input type="checkbox"/> facial droop <input type="checkbox"/> depressed mood / affect _____				
	EENT <input checked="" type="checkbox"/> eyes nml <input type="checkbox"/> ENT inspection nml <input type="checkbox"/> pharynx nml <input type="checkbox"/> nasal drainage _____					SKIN <input type="checkbox"/> color nml, no rash <input type="checkbox"/> warm, dry <input type="checkbox"/> skin rash _____				
	RESPIRATORY <input type="checkbox"/> no respiratory distress <input type="checkbox"/> breath sound nml <input type="checkbox"/> wheeze / rhonchi / rales _____					EXTREMITIES <input type="checkbox"/> non-tender <input checked="" type="checkbox"/> full ROM <input type="checkbox"/> nml appearance <input type="checkbox"/> no pedal edema <input type="checkbox"/> calf tenderness <input type="checkbox"/> pedal edema _____				
	CARDIOVASCULAR <input type="checkbox"/> regular rate & rhythm <input type="checkbox"/> no murmur <input type="checkbox"/> no gallop <input type="checkbox"/> irregularly irregular rhythm <input type="checkbox"/> tachycardia <input type="checkbox"/> bradycardia _____					Long Bone Pain Management <input checked="" type="checkbox"/> NA <input type="checkbox"/> Refused Pain Medication <input type="checkbox"/> Medicated _____ Comments: _____				
	ABDOMEN <input type="checkbox"/> non-tender <input type="checkbox"/> no organomegaly <input type="checkbox"/> nml bowel sounds <input type="checkbox"/> no distension <input type="checkbox"/> tenderness/guarding/rebound _____ <input type="checkbox"/> abnml bowel sounds _____									
	BACK <input type="checkbox"/> nml inspection <input type="checkbox"/> CVA tenderness _____									

Medical Screening Examination Initiated By Qualified Medical Provider (QMP):	
<input checked="" type="checkbox"/> Continue evaluation in emergency department ESI Triage Level 1 2 3 <u>4</u> 5	
QMP Signature	<i>CWatkinson FNP-BC</i>
Date 7-21-19 Time 1632	

EMERGENCY DEPARTMENT TRIAGE / MSE FLOW SHEET
 Welch Community Hospital

Page 1-2

Original 9-2016 revised 2-2017, 3-2017, 4-2018, 1-2019

ADAMS, NEVAEH
 ADM: 7/21/19 ACT# : 0006448847
 MED# : 138580
 DOB : 7/21/2015 FC : E
 SEX : F AGE : 4 yr
 SFR : FRM... DR - FCL S. DIAON

EXHIBIT NO. B15F
PAGE: 156 OF 233

EMERGENCY DEPARTMENT TRIAGE/MSE FLOW SHEET
Welch Community Hospital

Original 9-2016 revised 3-2017 3-2017 4-2018 1-2018

Page 2-2

ADAMS, NEVAEH
ADM : 7/21/19 ACT# : 0008448847
DOB : 7/21/2015 MED# : 138580
SEX : F FG : E
SER : ERB AGE : 4 yr
DR : EELLS, DAVID

**EXHIBIT NO. B15F
PAGE: 157 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39
ATTENDING:

----- X-RAY PRELIMINARY REPORT (SCANNED) -----
DATE OF NOTE: JUL 21, 2019@10:25 ENTRY DATE: JUL 23, 2019@10:26:04
AUTHOR: SCOTT, LATISHA EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned X-ray Preliminary Report(s).

/es/ LATISHA COLLINS
OFFICE ASSISTANT
Signed: 07/23/2019 10:27

**EXHIBIT NO. B15F
PAGE: 158 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006446847
 ADM: Jul 21, 2019 16:39

Alta Vista Radiology
specializing in after-hours teleradiology

PRELIMINARY REPORT
 Welch Community Hospital WV

Patient Name: ADAMS, NEVAEH
Age: 4 **Patient MR NO:** 1138580 **Date Of Birth:** 7/21/2015
Referring Doctor: EELLS 138580 **Accession No:**
Patient Location: Emergency Department

CLINICAL INDICATION: patient fell twice hitting head c/o headache

CONTRAST: No Contrast

PROCEDURE DATE: 7/21/2019

CT HEAD

1. Limited examination due to extensive motion related artifacts.
2. No displaced skull fracture.
3. No definite acute intracranial injury. No intracranial hemorrhage is identified. If there is concern for occult hemorrhage, repeat imaging is recommended.
4. No discrete mass or fluid collection.
5. No mass effect or shift of midline structures.
6. Ventricle within normal limits.
7. No definite foci of abnormal attenuation within the brain.
8. Mastoid air cells and middle ear cavities clear.
9. Mucoperiosteal thickening within the visualized paranasal sinuses, suggestive of inflammatory disease.

AVR physician contact - for MEDICAL STAFF USE ONLY: 1-800-530-1925.

Jennifer Kottra M.D.
Electronically Signed

Date Of Exam Request: 7/21/2019 8:16:42 PM EDT

Date & Time Of Report: 7/21/2019 8:23:43 PM EDT

Patient Name: ADAMS, NEVAEH **MR NO:** 1138580 **Accession No:**

ADAMS, NEVAEH
 ADM: 7/21/18
 ACT# : 138580
 MRN: 1138580
 PT: F
 AGE: 4 Y
 DR: ER118.DAVIN
 DRN: 138580
 DOB: 7/21/2015
 SEX: F
 STR: ER118

**EXHIBIT NO. B15F
PAGE: 159 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39
ATTENDING:

----- ER T-SHEET (SCANNED) -----
DATE OF NOTE: JUL 21, 2019@10:24 ENTRY DATE: JUL 23, 2019@10:24:36
AUTHOR: SCOTT, LATISHA EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

ER T-Sheet attached as scanned image.

/es/ LATISHA COLLINS
OFFICE ASSISTANT
Signed: 07/23/2019 10:27

**EXHIBIT NO. B15F
PAGE: 160 OF 233**

Name : ADAMS, NEVAEH H
 DOB/SEX: JUL 21, 2015, FEMALE
 HOSP : WELCH COMMUNITY HOSPITAL
 ATTENDING:

MRN: WEL000138580
 ACT: WEL006446847
 ADM: Jul 21, 2019 16:39

Circle or check affirmatives, backslash (/) negatives. 14 Welch Community Hospital EMERGENCY PROVIDER RECORD • Pediatric Illness •	
Septic / Meningitis / Pneumonia / UTI / Hypoxemia / Dehydration / Kawasaki's Disease / Tick Born Disease	
TIME SEEN: <u>1715</u> ROOM: <u>2</u> EMS Arrival HISTORIAN: patient <input checked="" type="checkbox"/> guardian <input type="checkbox"/> custodian <input type="checkbox"/> EMS <input type="checkbox"/> other	
UNABLE TO OBTAIN HISTORY DUE TO: HPI:	
chief complaint: fever cough congested fuzzy pulling ears non-feeding less active vomiting diarrhea rash ingestion <u>FELL ON HEAD</u>	
onset/duration: min / hrs / days ago <u>2 WKS AGO AND</u> <u>2 DAYS AGO</u> complaints of: <u>worse / persistent since</u>	constant sudden-onset intermittent episodes <u>taking</u> context: sick contacts home school other <u>recent travel outside US</u> <u>RECENTLY OCCURRED</u> <u>COMMITTEE</u>
severity: fever to <u>°F / °C</u> oral rectal axillary TM not measured - subjective none noted	
associated symptoms: acting differently <u>fussy crying more not sleeping less active inconsolable</u> drinking / eating less <u>not drinking fast feeding / liquids</u> <u>decreased urination fast urinated</u> sleeping more	
Similar symptoms previously: <u>RECENTLY</u>	
Recently seen / treated by doctor / hospitalized: <u>TRAVEL SYM</u>	

ADAMS, NEVAEH
 ACT# : 0006446847
 ADM: 7/21/19
 MED# : 138580
 DOB: 7/21/2015
 FC: E
 SEX: F AGE: 4 yr
 SFR - FRM DR - FRM S. JAVIN

ROS	
ENT	CVS
Pulling at ears (R/L)	palpitations
runny nose	NEURO
sore throat / mouth	seizure
EYES	MS
red eyes / discharge	extremity pain / swelling (R/L)
RESPIRATORY	SKIN
cough	raugh
trouble breathing	facial trunk extremities diffuse
G	petechiae
vomiting / diarrhea	diaper rash
abdominal distention	LYMPH
bloody in stools	swollen glands
GU	>
painful / swollen genital area	PSYCH
problems urinating	anxiety / depression
LUMP	<input checked="" type="checkbox"/> preg <input type="checkbox"/> premenstrual <input type="checkbox"/> all systems neg except as marked

• CONST components also addressed in HPI

PAST HX

Birth HX	birth wt.	ear infection (R/L)
complications at birth		febrile seizure
problems in-utero		lung disease asthma
premature birth	wks	pharyngitis
perinatal exposure		pneumonia
bronchitis / bronchiolitis		seizure disorder
cardio problems		sickle cell disease
congenital heart disease		urinary tract infection
development delay		
diabetes Type I insulin		

old records reviewed / summary

Surgeries / Procedures none

VP shunt

Immunization UTD

Medications none see nurses note Allergies NKDA
 ASA ibuprofen acetaminophen see nurses note

SOCIAL HX friends: daycare / school

caregiver / foster care

2nd hand smoke exposure / smoker ppd / never / past / quit ago

ETOH / substance abuse

FAMILY HX reviewed, not relevant adopted

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<input type="checkbox"/> Nursing Assessment Reviewed <input checked="" type="checkbox"/> Initial Vital Signs Reviewed <i>7/2/19 101</i>	
BP: <u>91/65</u> HR: <u>101</u> RR: <u>24</u> Temp: <u>98.7</u> Pulse Ox: <u>95%</u> O ₂ : <u>Interp</u> mmHg: <u>hypoxic</u>	
PHYSICAL EXAM	
EXAM LIMITED BY: General Appearance <input checked="" type="checkbox"/> appears well <u>mild / moderate / severe distress</u> <input checked="" type="checkbox"/> active / playful / smiles <u>tussy / crying / cries on exam / irritable</u> <input checked="" type="checkbox"/> tachypnea mmHg <u>tachypneic / weak cry</u> <input checked="" type="checkbox"/> good eye contact <input checked="" type="checkbox"/> sleeping/easily aroused	
INFANTS <input checked="" type="checkbox"/> mmHl consolability <u>poor consolability / poor intake suck</u> <input checked="" type="checkbox"/> mmHl feeding / suck <u>poor muscle tone</u> <input checked="" type="checkbox"/> flat ant. fontanel <u>closed / bulging / sunken ant. fontanel</u>	
HEENT <input checked="" type="checkbox"/> head atraumatic <u>normocephalic / swelling</u> <input checked="" type="checkbox"/> conjunc. & lids mmHl <u>conjunctival icterus / injected conjunctiva</u> PERRL <input checked="" type="checkbox"/> EOM palsy (R/L) / anisocoria <input checked="" type="checkbox"/> conjunctival exudate (R/L) <input checked="" type="checkbox"/> sunken eyes / photophobia	
<input checked="" type="checkbox"/> ears mmHl <u>TM erythema / dullness (R/L)</u> <u>loss of TM landmarks (R/L)</u> <u>TM obscured by wax (R/L)</u> CERUM <i>(Injections R/L)</i>	
<input checked="" type="checkbox"/> nose mmHl <input checked="" type="checkbox"/> pharynx mmHl <input checked="" type="checkbox"/> moist mucous membranes <u>rhinorrhea / purulent nasal drainage</u> <u>pharyngeal erythema / tonsilar exudate</u> <u>ulcerations / vesicles</u> <u>drooling / trismus / max.</u> <u>dry mucous membranes</u>	
NECK <input checked="" type="checkbox"/> supple <input checked="" type="checkbox"/> no masses <u>meningismus / Brudzinski / Kernig's</u> <u>lymphadenopathy</u>	
RESPIRATORY <input checked="" type="checkbox"/> no resp. distress <input checked="" type="checkbox"/> breath sounds mmHl <u>respiratory distress</u> <u>wheezes / rales / rhonchi (R/L)</u> <u>retractions / accessory muscle use</u> <u>prolonged expiration</u> <u>decreased air movement</u> <u>grunting (infants)</u> <u>stridor</u>	
CVS <input checked="" type="checkbox"/> br. rate & rhythm <u>murmur grade / sys / dias</u> <input checked="" type="checkbox"/> heart sounds mmHl <u>peripheral pulses weak / thready</u> <input checked="" type="checkbox"/> strong periph pulses <u>slow capillary refill sec</u> <input checked="" type="checkbox"/> mmHl capillary refill	
ABDOMEN / GI <input checked="" type="checkbox"/> non-tender <input checked="" type="checkbox"/> no distension <input checked="" type="checkbox"/> no organomegaly <u>tenderness / guarding / rebound</u> <u>generalized RUQ LUQ RLQ LLQ</u> <u>hepatomegaly / splenomegaly / mass</u> <u>abnm bowel sounds</u>	
GENITALIA <input checked="" type="checkbox"/> mmHl inspection <u>discharge / erythema / swelling / tenderness</u> <input checked="" type="checkbox"/> circumcised (male) <u>testes descended</u> <input checked="" type="checkbox"/> uncircumcised (male) <u>hernia (R/L)</u>	
EXTREMITIES <input checked="" type="checkbox"/> non-tender <input checked="" type="checkbox"/> mmHl ROM <u>tenderness (R/L)</u>	
SKIN <input checked="" type="checkbox"/> normal color <input checked="" type="checkbox"/> warm, dry <input checked="" type="checkbox"/> no rash / lesions <input checked="" type="checkbox"/> no petechiae <u>cyanosis / diaphoresis / pallor / icterus</u> <u>poor skin turgor</u> <u>diaper rash / skin rash</u> <u>urticular exanthematosus impigmentous vesiculiform</u> <u>scutuliform monofil erythematous vesicular crusted skin lesions</u>	
NEURO <input checked="" type="checkbox"/> motor mmHl <input checked="" type="checkbox"/> sensation mmHl <input checked="" type="checkbox"/> CN's mmHl (2-12) <input checked="" type="checkbox"/> neuro at baseline <u>sensory loss / weakness</u> <u>facial asymmetry</u>	
PROCEDURES <u>removal of cerumen from ear (R/L) with ear curette / irrigation</u>	
PROGRESS <input type="checkbox"/> see additional template # 94 51a Time: _____ unchanged Improved re-examined	

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<p>XRAYS / CT</p> <p>head chest abdomen pelvis _____ <input type="checkbox"/> Interpreted by ED provider unless noted otherwise _____ mm/NAD no infiltrates mm heart size mm mediastinum abmt _____</p> <p>_____ mm/NAD _____ <input type="checkbox"/> Interpreted by ED provider unless noted otherwise _____ mm/NAD abmt _____</p> <p>_____ mm/NAD abmt _____</p> <p>LABS *Normal lab value ranges are included on the original lab report</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <th>CBC</th> <th>Chemistries</th> <th>UA</th> </tr> <tr> <td>normal except</td> <td>normal except</td> <td>CRP _____ normal except</td> </tr> <tr> <td>WBC</td> <td>Gluc _____ ASV _____</td> <td>UVA _____</td> </tr> <tr> <td>Hgb</td> <td>BUN _____ Rotavirus _____</td> <td>UVA _____</td> </tr> <tr> <td>Hct</td> <td>Creat _____ Flu Screen _____</td> <td>UVA _____</td> </tr> <tr> <td>Platelets</td> <td>Na _____ Strep Screen _____</td> <td>Cultures sent _____</td> </tr> <tr> <td>sgot</td> <td>K _____ Mono Spot _____</td> <td>blood x _____</td> </tr> <tr> <td>bands</td> <td>_____</td> <td>urine _____</td> </tr> <tr> <td>lymph</td> <td>_____</td> <td>other _____</td> </tr> </table> <p>Pulse Ox % on RA / LO, Intact mm/hypoxic Tanc</p> <p>PROCEDURES</p> <p>LP discussed risks, benefits, options; patient / parent / guardian consents Time: open press= _____ sitting/lying (R/L) fluid color RBC monos _____ sterile technique glucose WBC lymphs _____ L3-4 L4-5 protein polyg gm/stn _____</p> <p>PROGRESS - Continued</p> <p><input type="checkbox"/> see additional template # 94 51e Time: unchanged improved re-examined CMV 6 wbl 6.9 Hgb 11.9</p> <p>CT scan opm 6</p> <p>able to take food / fluid in emergency department EGDT for sepsis considered + Persistent Asthma - 2-5y / long term control med / alternative med + Pharyngitis - 2y-18y / strep A test / antibiotic + URI - 3m-18y / No antibiotic measure exclusions: refused / not indicated / indicated / contraindicated / not available / dispensed <input type="checkbox"/> patient ambulating / monitoring at pre-ovent baseline Discharge VS: BP _____ HR _____ RR _____ Temp _____</p>	CBC	Chemistries	UA	normal except	normal except	CRP _____ normal except	WBC	Gluc _____ ASV _____	UVA _____	Hgb	BUN _____ Rotavirus _____	UVA _____	Hct	Creat _____ Flu Screen _____	UVA _____	Platelets	Na _____ Strep Screen _____	Cultures sent _____	sgot	K _____ Mono Spot _____	blood x _____	bands	_____	urine _____	lymph	_____	other _____	<p>ADAMS, NEVAEH ADM: 7/21/18 ACT# : 0008446847 MED# : 138580 DOB: 7/21/2015 FC: E SEX: F AGE: 4 yr SFR: FRM DR: FF11R DAVID</p> <p>Discussed with Dr. _____ Time: _____ will see patient in ED / hospital / office Counselor patient / family regarding: Additional history from: lab / rad results diagnosis need for follow-up family caretaker paramedics prior records ordered holding orders written <input type="checkbox"/> Rx given</p> <p>CRITICAL CARE (excluding time for other separate services) TIME <input type="checkbox"/> 30-74 min <input type="checkbox"/> 75-104 min min</p> <p>Initial visit unless marked: <input type="checkbox"/> subsequent <input type="checkbox"/> sequelae</p> <p>CLINICAL IMPRESSION</p> <p>Respiratory • Asthma / Reactive airway dz : acute exacerbation status asthmaticus : tx ap mild / mod / severe dz : intermittent persistent Bronchospasm, acute Bronchitis: acute RSV chronic simple mucopurulent Bronchiolitis: acute RSV Cold (Nasopharyngitis) Croup Epiglottitis: acute w/ obstruction Influenza: H1N1 A/B _____</p> <p>Otitis media: R/L : acute recurrent chronic : serous suppurative w/ TM perf central marginal</p> <p>• Pharyngitis: acute Strep Paroxysmal: interstitial atypical bronchopneumonia lobar aspiration viral: RSV influenza: A/B bacterial:</p> <p>Sinusitis: acute recurrent chronic : maxillary frontal ethmoid</p> <p>• URI</p> <p>Other Dehydration Gastroenteritis infectious viral Kawasaki's dz Meningitis: viral bacterial H Infl Pneum Strep Staph Mononucleosis: EBV CMV w/ splenomegaly hepatomegaly Neonatal jaundice Poisoning, accidental (substance): Pyelonephritis: acute chronic w/ obstruction SIRS / Septic, severe w/ shock Skin rash: impetigo: nonbullous diaper rash varicella roseola fifth dz: pharyngitis rosea hand, foot, mouth dz Tick borne dz: Rocky Mt spotted fever Lyme disease Tick paralysis UTI: cystitis acute chronic w/ hematuria Viral syndrome</p> <p>Signs / Symptoms Abd pain: RUQ LUQ RLQ LLQ generalized acute abd w/ rebound tenderness Nausea / Vomiting / Diarrhea Fever Headache Hypoxemia</p> <p>Disposition Time 7/21/19 DISPOSITION: <input type="checkbox"/> home <input type="checkbox"/> admitted <input type="checkbox"/> OBS <input type="checkbox"/> AMA (see AMA template #73) <input type="checkbox"/> transferred CONDITION: <input type="checkbox"/> unchanged <input type="checkbox"/> improved <input type="checkbox"/> stable Care transferred to: MD / DO / MLP Time: 2019 <input type="checkbox"/> I have reviewed the chart and agree with the documentation as recorded by the MLP, including the assessment, treatment plan, and disposition. <input type="checkbox"/> I personally evaluated and examined the patient in conjunction with the MLP and agree with the management and disposition of the patient.</p> <p>FNP (Date/Time) 7/21/19 4:48 PM <input type="checkbox"/> Template Complete <input type="checkbox"/> See Addendum (Dated / Template #) 7/21/19 General Pediatric Illness - 14 Pg 3 of 4 Rev. 08/15 • Reportable Measure</p>
CBC	Chemistries	UA																										
normal except	normal except	CRP _____ normal except																										
WBC	Gluc _____ ASV _____	UVA _____																										
Hgb	BUN _____ Rotavirus _____	UVA _____																										
Hct	Creat _____ Flu Screen _____	UVA _____																										
Platelets	Na _____ Strep Screen _____	Cultures sent _____																										
sgot	K _____ Mono Spot _____	blood x _____																										
bands	_____	urine _____																										
lymph	_____	other _____																										

**EXHIBIT NO. B15F
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Name : ADAMS, NEVAEH H MRN: WEL000138580
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39
ATTENDING:

----- MEDICATION RECONCILIATION (SCANNED) -----
DATE OF NOTE: JUL 21, 2019@10:24 ENTRY DATE: JUL 23, 2019@10:25:02
AUTHOR: SCOTT, LATISHA EXP COSTIGNER:
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ LATISHA COLLINS
OFFICE ASSISTANT
Signed: 07/23/2019 10:27

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Name : ADAMS, NEVAEH H
DOB/SEX: JUL 21, 2015, FEMALE
HOSP : WELCH COMMUNITY HOSPITAL
ATTENDING:

MRN: WEL000138580
ACT: WEL006446847
ADM: Jul 21, 2019 16:39

ADAMS, NEVADA
ADM : 7/21/19

Name: Nicole Octomos

**WELCH COMMUNITY HOSPITAL
MEDICATION RECONCILIATION FORM**

LIST BELOW ALL OF THE PATIENT'S MEDICATION PRIOR TO ADMISSION (INCLUDING OVER-THE-COUNTER AND HERBAL MEADS)

Name: NOVACATH Detomas	Age: 50	Gender: M	SER. # 0000000000000000	DR. DR. ELLIS, DAVID				
Allergies:								
<input type="checkbox"/> Patient is on no medications at this time								
LIST BELOW ALL OF THE PATIENT'S MEDICATION PRIOR TO ADMISSION (INCLUDING OVER-THE-COUNTER AND HERBAL MEADS)								
Name of Medication/Dose	Amount	Route	Frequency	Last Dose	Reason for Medication	Continue on Admission	Continue after Surgery or Transfer	Continue on Discharge
1. Nicrolitracin 10mg 15ml	15ml	by mouth / topical Inject / Inhale	1 times a day as needed			Y N	Y N	V N
2.		by mouth / topical Inject / Inhale	1 times a day as needed			Y N	Y N	Y N
3.		Inject / Inhale	1 times a day as needed			Y N	Y N	Y N
4.		Inject / Inhale	1 times a day as needed			Y N	Y N	Y N
5.		by mouth / topical Inject / Inhale	1 times a day as needed			Y N	Y N	Y N
6.		by mouth / topical Inject / Inhale	1 times a day as needed			Y N	Y N	Y N
7.		by mouth / topical Inject / Inhale	1 times a day as needed			Y N	Y N	Y N
8.		by mouth / topical Inject / Inhale	1 times a day as needed			Y N	Y N	Y N
9.		by mouth / topical Inject / Inhale	1 times a day as needed			Y N	Y N	Y N
10.		by mouth / topical Inject / Inhale	1 times a day as needed			Y N	Y N	Y N

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- ```

graph TD
 A[Source of Medication List] --> B[Patient Medication List
Patient/Family Recall]
 B --> C[Pharmacy: _____]
 C --> D[Primary Care Physician List]
 D --> E[Previous Discharge Paperwork]
 E --> F[Reconciliation Prescriber NID/BODI]
 F --> G[Medication bottles]

```

Physician \_\_\_\_\_ Date \_\_\_\_\_

Revised 7/13

1

Revised 3/13

1

**EXHIBIT NO. B15F  
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Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006446847  
ADM: Jul 21,2019 16:39

\*\*\* END \*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
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Name : ADAMS, NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006446847  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21,2019 16:39  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

Order Date: St: Requestor: Start Date: Stop Date:  
 Nature of Order: Signature:  
 Item Ordered:  
 -----

07/21/19 20:21 a EELLS,DAVID 07/21/19 20:21  
 ELECTRONICALLY ENTERED ELECTRONIC  
 Treating Specialty:  
 Ordering Location: ER  

- Activity:
- 07/21/2019 20:21 New Order entered by EELLS,DAVID (PHYSICIAN)
- Order Text: Discharge Patient
- Discharge: Home
- Diagnosis:
- Headache
- Prescriptions:
- none
- Provide written discharge instructions for diagnosis.
- Specific discharge instructions:
- tylenol for pain
- Return to Emergency Department for any increase or worsening of signs or symptoms.
- Follow up:
- Pediatrics Clinic in 2 days for

 Nature of Order: ELECTRONICALLY ENTERED  
 Elec Signature: EELLS,DAVID (PHYSICIAN) on 07/21/2019 20:21  
 -----

07/21/19 19:44 c EELLS,DAVID 07/21/19  
 ELECTRONICALLY ENTERED ELECTRONIC  
 Treating Specialty:  
 Ordering Location: ER  
 History and Reason for Exam:  

- Activity:
- 07/21/2019 19:44 New Order entered by EELLS,DAVID (PHYSICIAN)
- Order Text: CT HEAD W/O CONTRAST
- Nature of Order: ELECTRONICALLY ENTERED
- Elec Signature: EELLS,DAVID (PHYSICIAN) on 07/21/2019 19:44

 -----

07/21/19 17:34 p EELLS,DAVID 07/21/19 17:35  
 ELECTRONICALLY ENTERED ELECTRONIC  
 Treating Specialty:  
 Ordering Location: ER  

- Activity:
- 07/21/2019 17:34 New Order entered by EELLS,DAVID (PHYSICIAN)
- Order Text: URINE CULTURE ROUTINE, PANEL LABCORP URINE, CLEAN CATCH STAT I ONCE
- Nature of Order: ELECTRONICALLY ENTERED
- Elec Signature: EELLS,DAVID (PHYSICIAN) on 07/21/2019 17:35

 -----

**EXHIBIT NO. B15F  
PAGE: 167 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006446847  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21,2019 16:39  
 ATTENDING:

---

07/21/19 17:34:24 p EELLS,DAVID 07/21/19 17:35  
 ELECTRONICALLY ENTERED ELECTRONIC  
 Treating Specialty:  
 Ordering Location: ER  
 - Activity:  
 - 07/21/2019 17:34 New Order entered by EELLS,DAVID (PHYSICIAN)  
 - Order Text: MICROSCOPIC URINE-WEL URINE, RANDOM STAT I ONCE  
 - Nature of Order: ELECTRONICALLY ENTERED  
 - Elec Signature: EELLS, DAVID (PHYSICIAN) on 07/21/2019 17:35  
 -

07/21/19 17:34:24 p EELLS,DAVID 07/21/19 17:35  
 ELECTRONICALLY ENTERED ELECTRONIC  
 Treating Specialty:  
 Ordering Location: ER  
 - Activity:  
 - 07/21/2019 17:34 New Order entered by EELLS,DAVID (PHYSICIAN)  
 - Order Text: URINALYSIS COMPLETE-WEL URINE, RANDOM STAT WC ONCE  
 - Nature of Order: ELECTRONICALLY ENTERED  
 - Elec Signature: EELLS, DAVID (PHYSICIAN) on 07/21/2019 17:35  
 -

07/21/19 17:34:24 c EELLS,DAVID 07/21/19 18:02 07/21/19 18:20  
 ELECTRONICALLY ENTERED ELECTRONIC  
 Treating Specialty:  
 Ordering Location: ER  
 - Activity:  
 - 07/21/2019 17:34 New Order entered by EELLS,DAVID (PHYSICIAN)  
 - Order Text: COMPREHENSIVE METABOLIC PROFILE-WEL PLASMA-GRNL  
 STAT I ONCE  
 - Nature of Order: ELECTRONICALLY ENTERED  
 - Elec Signature: EELLS, DAVID (PHYSICIAN) on 07/21/2019 17:35  
 -

07/21/19 17:34:24 c EELLS,DAVID 07/21/19 18:02 07/21/19 17:55  
 ELECTRONICALLY ENTERED ELECTRONIC  
 Treating Specialty:  
 Ordering Location: ER  
 - Activity:  
 - 07/21/2019 17:34 New Order entered by EELLS,DAVID (PHYSICIAN)  
 - Order Text: CBC-WEL BLOOD-LAV STAT I ONCE  
 - Nature of Order: ELECTRONICALLY ENTERED  
 - Elec Signature: EELLS, DAVID (PHYSICIAN) on 07/21/2019 17:35  
 -

\*\*\* END \*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
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Name : ADAMS, NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

Report Released Date/Time: Jul 21, 2019@18:20

Provider: EELLS, DAVID

Specimen: PLASMA. WCHEM 0721 23

Specimen Collection Date: Jul 21, 2019@18:02

| Test name      | Result | Flg | units  | Ref.  | range   | Site | Result         | Dt/Time |
|----------------|--------|-----|--------|-------|---------|------|----------------|---------|
| ALBUMIN-WEL    | 3.6    |     | g/dL   | 3.4   | - 5.0   | [68] | 07/21/19 18:20 |         |
| AST-WEL        | 30     |     | U/L    | 15    | - 37    | [68] | 07/21/19 18:20 |         |
| TBIL W         | 0.20   |     | mg/dl  | 0.20  | - 1.00  | [68] | 07/21/19 18:20 |         |
| CALCIUM-WEL    | 9.2    |     | mg/dL  | 8.5   | - 10.1  | [68] | 07/21/19 18:20 |         |
| CREATININE-WEL | 0.58   |     | mg/dL  | 0.40  | - 1.00  | [68] | 07/21/19 18:20 |         |
| TPRT W         | 6.7    |     | g/dL   | 6.4   | - 8.2   | [68] | 07/21/19 18:20 |         |
| BUN W          | 13     |     | mg/dl  | 7     | - 18    | [68] | 07/21/19 18:20 |         |
| A/G RATIO-WEL  | 1.2    | L   |        | 1.5   | - 2.2   | [68] | 07/21/19 18:20 |         |
| B/C R W        | 22.40  | H   |        | 12.00 | - 20.00 | [68] | 07/21/19 18:20 |         |
| ALTI-WEL       | 20     |     | U/L    | 12    | - 78    | [68] | 07/21/19 18:20 |         |
| GLUCOSE-WEL    | 115    | H   | mg/dl  | 74    | - 106   | [68] | 07/21/19 18:20 |         |
| SODIUM-WEL     | 145    |     | mmol/L | 135   | - 145   | [68] | 07/21/19 18:20 |         |
| POTASSIUM-WEL  | 4.0    |     | mmol/L | 3.4   | - 5.4   | [68] | 07/21/19 18:20 |         |
| CHLORIDE-WEL   | 109    | H   | mmol/L | 98    | - 107   | [68] | 07/21/19 18:20 |         |
| CO2 W          | 24.4   |     | mmol/L | 21.0  | - 32.0  | [68] | 07/21/19 18:20 |         |
| ALPI WEL       | 173    | H   | U/L    | 46    | - 116   | [68] | 07/21/19 18:20 |         |

Comment: Collected by TLS at 1802

Released by rc at 1820

Performing Lab Sites

[68] WEL

454 McDOWELL STREET WELCH, WV 24801

----- END -----

Report Released Date/Time: Jul 21, 2019@17:55

Provider: EELLS, DAVID

Specimen: BLOOD. WHEM 0721 52

Specimen Collection Date: Jul 21, 2019@18:02

| Test name      | Result | Flg | units    | Ref. | range  | Site | Result         | Dt/Time |
|----------------|--------|-----|----------|------|--------|------|----------------|---------|
| WBC-WEL        | 6.9    |     | x10 3/uL | 4.8  | - 10.8 | [68] | 07/21/19 17:55 |         |
| NEU%-WEL       | 61.2   |     | %        | 42.2 | - 75.2 | [68] | 07/21/19 17:55 |         |
| LYM%-WEL       | 32.6   |     | %        | 20.5 | - 51.5 | [68] | 07/21/19 17:55 |         |
| MON%-WEL       | 1.3    | L   | %        | 5.5  | - 11.7 | [68] | 07/21/19 17:55 |         |
| EOS%-WEL       | 4.5    | H   | %        | 0.9  | - 2.9  | [68] | 07/21/19 17:55 |         |
| BAS%-WEL       | 0.4    |     | %        | 0.2  | - 1.0  | [68] | 07/21/19 17:55 |         |
| NEU#-WEL       | 4.2    |     | #        | 1.4  | - 6.5  | [68] | 07/21/19 17:55 |         |
| LYMPH #-WEL    | 2.3    |     | #        | 1.2  | - 3.4  | [68] | 07/21/19 17:55 |         |
| MON#-WEL       | 0.1    | L   | #        | 0.3  | - 0.8  | [68] | 07/21/19 17:55 |         |
| EOS#-WEL       | 0.3    | H   | #        | 0.0  | - 0.2  | [68] | 07/21/19 17:55 |         |
| BAS#-WEL       | 0.0    |     | #        | 0.0  | - 0.1  | [68] | 07/21/19 17:55 |         |
| RBC-WEL        | 4.20   |     | x10 6/uL | 4.20 | - 5.40 | [68] | 07/21/19 17:55 |         |
| HEMOGLOBIN-WEL | 11.9   | L   | g/dL     | 12.0 | - 16.0 | [68] | 07/21/19 17:55 |         |
| HEMATOCRIT-WEL | 35.4   | L   | %        | 37.0 | - 47.0 | [68] | 07/21/19 17:55 |         |
| MCV-WEL        | 84.1   |     | fL       | 81.0 | - 99.0 | [68] | 07/21/19 17:55 |         |
| MCH-WEL        | 28.3   |     | pg       | 27.0 | - 31.0 | [68] | 07/21/19 17:55 |         |
| MCHC-WEL       | 33.7   |     | g/dL     | 33.0 | - 37.0 | [68] | 07/21/19 17:55 |         |

**EXHIBIT NO. B15F  
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Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006446847  
ADM: Jul 21,2019 16:39

-----  
RDW-WEL 11.2 L % 11.5 - 14.5 [68] 07/21/19 17:55  
PLATELETS-WEL 295 x10 3/uL 130 - 400 [68] 07/21/19 17:55  
MPV-WEL 7.1 L fL 7.4 - 10.4 [68] 07/21/19 17:55  
Comment: TECH-FSF  
DRAWN BY TLS @ 1802  
RELEASED @ 1755

Performing Lab Sites  
[68] WEL  
454 McDOWELL STREET WELCH, WV 24801  
----- END -----

\*\*\* END \*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 170 OF 233**

|                                 |                        |
|---------------------------------|------------------------|
| Name : ADAMS, NEVAEH H          | MRN: WEL000138580      |
| DOB/SEX: JUL 21,2015, FEMALE    | ACT: WEL006446847      |
| HOSP : WELCH COMMUNITY HOSPITAL | ADM: Jul 21,2019 16:39 |
| ATTENDING:                      |                        |

---

\*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

----- CT HEAD W/O CONTRAST -----

|                             |                         |
|-----------------------------|-------------------------|
| Exm Date: JUL 21,2019@19:49 | Pat Loc: ER (Req'g Loc) |
| Req Phys: EELLS,DAVID       | Img Loc: WEL CT         |
|                             | Service: Unknown        |

(Case 38 COMPLETE) CT HEAD W/O CONTRAST (CT Detailed) CPT:70450  
Reason for Study: head trauma

Clinical History:

|                         |                            |
|-------------------------|----------------------------|
| Report Status: Verified | Date Reported: JUL 22,2019 |
|                         | Date Verified: JUL 22,2019 |

Verifier E-Sig:

Report:  
EXAMINATION: CT HEAD W/O CONTRAST 7/22/2019 8:15 AM

HISTORY: Headache, 2 falls

COMPARISON: None

In order to have a CT radiation dose as low as reasonably achievable, Automated Exposure Control was utilized for adjustment of the mA and/or KV according to patient size.

TECHNIQUE: Serial axial tomographic images of the brain were obtained without the use of intravenous contrast.

FINDINGS:

Motion artifact limits this examination at multiple levels. No large intracranial hemorrhage. No mass effect. No midline shift.

Visualized gray-white matter differentiation is grossly preserved. The structures of the posterior fossa are unremarkable.

The included orbits and their contents are unremarkable. There is opacification of the maxillary, frontal, and ethmoid sinuses. The visualized osseous structures and overlying soft tissues of the skull and face are unremarkable.

Impression:

1. Limited examination due to patient motion artifact. No definite evidence of an acute intracranial hemorrhage. If there is high clinical concern, repeat imaging should be obtained.

A preliminary report was provided by Alta Vista Radiology.

**EXHIBIT NO. B15F  
PAGE: 171 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006446847  
ADM: Jul 21,2019 16:39

-----  
Electronically signed by: Joseph A Lambert II, MD on: 7/22/2019

8:18 AM

Primary Diagnostic Code:

Primary Interpreting Staff:  
JOSEPH ALAN LAMBERT II, M, Staff Physician  
Verified by JOSEPH ALAN LAMBERT II, M  
/JAL

\*\*\* END \*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 172 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006446847  
ADM: Jul 21,2019 16:39

\*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 173 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 174 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006446847  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jul 21, 2019 16:39  
ATTENDING:  
-----

ADRs: No ADRs on file.

Allergies: PENICILLIN  
=====

\*\*\*\*NO MEDICATIONS FOUND\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

{{{ END }}} Patient Encounter(s) History Report Dec 19, 2019@13:42

**EXHIBIT NO. B15F  
PAGE: 175 OF 233**

Patient Encounter(s) History Report Dec 19, 2019@13:43

(From: 08/20/19 --- Thru: 08/21/19)

Name : ADAMS, NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

Insomnia |  
 SNOMED-CT: Insomnia  
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Turner syndrome |  
 SNOMED-CT: Turner syndrome  
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Anorexia symptom |  
 SNOMED-CT: Anorexia symptom  
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B15F  
PAGE: 176 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

-----

MRN: WEL000138580  
ACT: WEL006449584  
ADM: Aug 20,2019 10:38

Updated: 6/5/17

==== END ===

Hallucinations |  
SNOMED-CT: Hallucinations  
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:  
Status: ACTIVE  
SC Cond: UNKNOWN  
Exposure: None

Provider:  
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
Updated: 6/5/17

==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 177 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

Causative agent: PENICILLIN  
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS  
PENICILLIN-G RELATED PENICILLINS  
PENICILLINS, AMINO DERIVATIVES  
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (LICENSED PRACTICAL NURSE)  
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J

Observed/Historical: Historical

==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 178 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006449584  
ADM: Aug 20,2019 10:38

\*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F**  
**PAGE: 179 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

----- VACCINE RECORD -----  
 DATE OF NOTE: AUG 20, 2019@11:29 ENTRY DATE: AUG 20, 2019@11:29:25  
 AUTHOR: BEASLEY, TARA EXP COSIGNER:  
 URGENCY: STATUS: COMPLETED

Welch Community Hospital  
 VACCINE ADMINISTRATION RECORD

Name: ADAMS, NEVAEH H DOB: JUL 21, 2015 Age: 4 Sex: FEMALE  
 Address:  
 Phone:  
 Parent/Guardian:  
 Physician:  
 Mother's Maiden Name:

Vaccine (select one): Kinrix 1  
 VFC Elig. Code:  
 Vaccine Administered Date: 20-Aug-2019  
 Site Given: LVL = Left Vastus Lateralis  
 Manufacturer: GSK  
 Lot #: 4R7NR  
 Expiration Date: 11/07/2020  
 Date Published: 11/05/2015  
 Date Provided: 08/20/2019  
 Vaccine Administrator Initials: TB  
 Parent/Guardian Initials: KA  
 Contraindications:  
 NONE NOTED

Comments:  
 NO REACTIONS NOTED.

WVIP-VAR-6/03

Vaccine (select one): MMR 2  
 VFC Elig. Code:  
 Vaccine Administered Date: 20-Aug-2019  
 Site Given: RVL = Right Vastus Lateralis  
 Manufacturer: MERCK  
 Lot #: N025894  
 Expiration Date: 09/19/2019  
 Date Published: 02/12/2018  
 Date Provided: 08/20/2019  
 Vaccine Administrator Initials: TB  
 Parent/Guardian Initials: KA  
 Contraindications:  
 NONE NOTED

Comments:

**EXHIBIT NO. B15F  
PAGE: 180 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
-----

NO REACTONS NOTED.

---

/es/ TARA BEASLEY, LPN

Signed: 08/20/2019 11:32

----- PRESENTING SHEET (SCANNED) -----  
DATE OF NOTE: AUG 20, 2019@10:51 ENTRY DATE: AUG 20, 2019@10:51:11  
AUTHOR: MATNEY, MCKENNA M EXP COSTIGNER:  
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ MCKENNA M MATNEY  
OFFICE ASSISTANT  
Signed: 08/20/2019 10:52

**EXHIBIT NO. B15F  
PAGE: 181 OF 233**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21,2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006449584  
 ADM: Aug 20,2019 10:38

**RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION FORM** *shots*

**PLEASE FILL OUT TOP PORTION ONLY**

|                           |                              |                          |
|---------------------------|------------------------------|--------------------------|
| NAME: <u>Nevaeh Adams</u> | TODAY'S DATE: <u>8-20-19</u> |                          |
| TIME: <u>10:19</u>        | AGE: <u>4</u>                | BIRTHDAY: <u>7-21-15</u> |

\*\*\*TO BE FILLED OUT BY HOSPITAL STAFF\*\*\*

|                                                                                                                                                                             |                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| DISPOSITION: <input checked="" type="checkbox"/> WIC <input type="checkbox"/> PEDS <input type="checkbox"/> IM <input type="checkbox"/> SURG <input type="checkbox"/> OBGYN | ACT #: <u>006449584</u> |
| Registration Complaint: <u>Immunizations</u>                                                                                                                                | ICU: <u>1</u>           |
| NURSE: <u>M</u>                                                                                                                                                             | MRN: <u>138580</u>      |
|                                                                                                                                                                             | SC: <u>1</u>            |
|                                                                                                                                                                             | MR: <u>4.W</u>          |

**EXHIBIT NO. B15F  
PAGE: 182 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
-----

----- INSURANCE CARD -----  
DATE OF NOTE: AUG 20, 2019@10:51 ENTRY DATE: AUG 20, 2019@10:51:31  
AUTHOR: MATNEY, MCKENNA M EXP COSTIGNER:  
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.  
INSURANCE CARD BACK (SCANNED):

/es/ MCKENNA M MATNEY  
OFFICE ASSISTANT  
Signed: 08/20/2019 10:52

**EXHIBIT NO. B15F  
PAGE: 183 OF 233**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006449584  
 ADM: Aug 20, 2019 10:38

2487854901

Elig Inquiry Date:

**Eligibility Report**

Elig Check: 08/20/2019

Print Date: 08/20/2019 10:42:56 AM

**Patient**

The patient is the subscriber or contract holder for the insurance plan.

**Primary**

Insured Number: 00405164305  
 Name: ADAMS, NEVAEH H  
 Address: PO BOX 46  
 City, State Zip: BIG SANDY, WV 24816  
 Date of Birth: 07/21/2015  
 Gender: Female  
 Insured Status: Active  
 Effective Date: 08/20/2019  
 Expire Date: 08/20/2019

**Insurance**

For Member Eligibility Verification and Claim Status inquiries, please contact the payer using the number on the back of the member's card.

Provider Number: 1134158809

**Additional Payer Information**

Payer Information Contacts  
 8426 - DAVIS VISION / FASHION FOCUS

Name: TPL  
 Identifier: PLAN SPONSOR  
 Insurance Type: C1 - Commercial  
 Dates:  
 ELIGIBILITY 08/20/2019 - 08/20/2019  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: 235376313  
 PLAN BEGIN 08/01/2019  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: 235376313

**Benefits**

| Benefit                                                                           | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type | Coverage Level        | Date        | Date Qualifier |
|-----------------------------------------------------------------------------------|--------|---------|--------|----------|-----------|------------|----------------|-----------------------|-------------|----------------|
| <b>HEALTH BENEFIT PLAN COVERAGE - 30</b>                                          |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 08/20/2019-08/20/2019 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES . Phone: (888)483-0793 |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 08/20/2019-08/20/2019 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES . Phone: (888)483-0797 |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 08/20/2019-08/20/2019 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                       |             |                |

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PAGE: 184 OF 233**

2467854901

Elg Inquiry Date:

**Eligibility Report**

Elg Check: 08/20/2019

Print Date: 08/20/2019 10:42:57 AM

| Benefit                                                                                | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type                      | Coverage Level | Date                  | Date Qualifier        |
|----------------------------------------------------------------------------------------|--------|---------|--------|----------|-----------|------------|-------------------------------------|----------------|-----------------------|-----------------------|
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/20/2019-08/20/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/20/2019-08/20/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/20/2019-08/20/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                             |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/01/2018            | PLAN BEGIN            |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                             |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/01/2018            | PLAN BEGIN            |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/01/2018            | PLAN BEGIN            |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/01/2018            | PLAN BEGIN            |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                             |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/01/2018            | PLAN BEGIN            |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793      |        |         |        |          |           |            |                                     |                |                       |                       |
| CO-PAYMENT                                                                             | 0.00   |         |        |          |           |            | Medicaid                            |                | 08/20/2019-08/20/2019 | ELIGIBILITY           |
| MANAGED CARE COORDINATOR                                                               |        |         |        |          |           |            | Health Maintenance Organization (H) |                | 08/20/2019-08/20/2019 | PRIMARY CARE PROVIDER |
| Entity: PLAN SPONSOR, Name: UNICARE HEALTHPLAN OF WEST VIRGINIA , Phone: (800)782-0095 |        |         |        |          |           |            |                                     |                |                       |                       |
| <hr/>                                                                                  |        |         |        |          |           |            |                                     |                |                       |                       |
| MEDICAL CARE - 1                                                                       |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/20/2019-08/20/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                             |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/20/2019-08/20/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/20/2019-08/20/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/20/2019-08/20/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                             |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 08/20/2019-08/20/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793      |        |         |        |          |           |            |                                     |                |                       |                       |

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**EXHIBIT NO. B15F  
PAGE: 185 OF 233**

2467054901

Elg Inquiry Date:

**Eligibility Report**

Elg Check: 08/20/2019

Print Date: 08/20/2019 10:42:57 AM

| Benefit                                                                           | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type | Coverage Level | Date                  | Date Qualifier |
|-----------------------------------------------------------------------------------|--------|---------|--------|----------|-----------|------------|----------------|----------------|-----------------------|----------------|
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/20/2019-08/20/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |
| CHIROPRACTIC -33                                                                  |        |         |        |          |           |            | Medicaid       |                | 08/20/2019-08/20/2019 | ELIGIBILITY    |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            |                |                |                       |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/20/2019-08/29/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/20/2019-08/29/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/20/2019-08/20/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/20/2019-08/20/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 08/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |

Page 3

**EXHIBIT NO. B15F  
PAGE: 186 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
-----

----- PRIVACY NOTICE (SCANNED) -----  
DATE OF NOTE: AUG 20, 2019@10:51 ENTRY DATE: AUG 20, 2019@10:51:47  
AUTHOR: MATNEY, MCKENNA M EXP COSTIGNER:  
URGENCY: STATUS: COMPLETED

Privacy notice attached as scanned document.

/es/ MCKENNA M MATNEY  
OFFICE ASSISTANT  
Signed: 08/20/2019 10:52

**EXHIBIT NO. B15F  
PAGE: 187 OF 233**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006449584  
 ADM: Aug 20, 2019 10:38

**Bureau for Behavioral Health and Health Facilities (BBHHF)/  
WELCH COMMUNITY HOSPITAL**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE  
AND DISCLOSE FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS PURPOSES**

**PATIENT/RESIDENT**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ ID Number: \_\_\_\_\_

ADAMS, NEVAEH  
 ADM: 8/20/19 ACT: 8/20/19  
 DOB: 7/21/2015 MED: 108580  
 SEX: F IC: F  
 SSN: PTC DR: KORRAH MAYOR  
 AGE: 4 yr

I hereby consent for the BBHHF/Welch Community Hospital to use and disclose my protected health information for treatment, payment and health care operations purposes. These purposes are described, and examples of each purpose are given, in the BBHHF/Welch Community Hospital's attached Notice of Privacy Rights. This also acknowledges that I have received a copy of the BBHHF/Welch Community Hospital Notice of Privacy Practices. This consent does not apply to protected health information for psychotherapy notes and marketing purposes, where an authorization is required under 45 CFR § 164.508. I retain the right to request restrictions on how and to whom the protected health information may be released, although the BBHHF/Welch Community Hospital does not have to accept my restrictions.

A person or organization that receives my information because of this consent may have the legal right to disclose this information to other people or organizations without my knowledge or consent.

The Welch Community Hospital values your privacy of information. However, in the unlikely incidence that a breach or inappropriate access or use of your information occurs, we wish to contact you most expeditiously based on your preferred method of contact.

- US Mail
- By Telephone
- By Email

If this authorization is signed by someone who is not the patient/resident listed at the top of this form, provide a description of the signer's authority to act for the patient.

Type of Authority: \_\_\_\_\_

Documentation Provided: \_\_\_\_\_ Yes \_\_\_\_\_ No

Signature: X Karen M. Adcox Date: 8/20/19

Witness: \_\_\_\_\_ Witness: M. Hernandez

**EXHIBIT NO. B15F  
PAGE: 188 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
-----

----- IDENTIFICATION CARD/DRIVERS LICENCE -----  
DATE OF NOTE: AUG 20, 2019@10:51 ENTRY DATE: AUG 20, 2019@10:52:07  
AUTHOR: MATNEY, MCKENNA M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

no id

/es/ MCKENNA M MATNEY  
OFFICE ASSISTANT  
Signed: 08/20/2019 10:52

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----  
DATE OF NOTE: AUG 20, 2019@10:50 ENTRY DATE: AUG 20, 2019@10:50:53  
AUTHOR: MATNEY, MCKENNA M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ MCKENNA M MATNEY  
OFFICE ASSISTANT  
Signed: 08/20/2019 10:52

**EXHIBIT NO. B15F  
PAGE: 189 OF 233**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21,2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006449584  
 ADM: Aug 20,2019 10:38



|           |                     |                 |                   |
|-----------|---------------------|-----------------|-------------------|
| Place     |                     | ADAMS, NEVAEH   | ACT# : 0006449584 |
|           |                     | ADM : 8/20/19   | MED# : 138580     |
|           |                     | DOB : 7/21/2015 | FC : E            |
|           |                     | SEX : F         | AGE : 4 yr        |
| SER : POC | DR : KOBBAH, PIAYON |                 |                   |

**WELCH COMMUNITY HOSPITAL  
 454 McDOWELL STREET  
 WELCH, WV 24802**

**CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY**

*Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.*

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

**EXHIBIT NO. B15F  
PAGE: 190 OF 233**

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.
7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood. I understand my blood, as well as the employees blood will be tested for possibly above mentioned diseases. The test results of both employee and patient will be confidential as provided by law.

ADAMS, NEVAEH  
ADM : 8/28/19 ACT# : 0008449584  
MED# : 138580  
DOB : 7/21/2015 FC : E  
SEX : F AGE : 4 yr  
SER : PDC DR : KOBBAH, PIAYON

**EXHIBIT NO. B15F**  
**PAGE: 191 OF 233**

If you would like to opt out of HIV testing, please initial the line below. There may be some instances where patients are not allowed to opt out. For further information, please refer to the information sheet given to you upon registration.

Initials of patient/patient representative: XLMWA

- B. RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: XKMD

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

- 9. NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

- 10. PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

I object to having my name, location and general condition ADAMS, NEVAEH  
directory.

|                    |                   |
|--------------------|-------------------|
| ADM : 012019       | ACT# : 0006419684 |
| DRG : 721/2015     | MED# : 139580     |
| SEX : F            | FC : E            |
| SER : PDC          | AGE : 4 yr        |
| NR : KOBBAH, MAYON |                   |

**EXHIBIT NO. B15F  
PAGE: 192 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
-----

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----  
DATE OF NOTE: AUG 20, 2019@10:22 ENTRY DATE: AUG 21, 2019@10:22:27  
AUTHOR: HALE, DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 08/21/2019 10:23

**EXHIBIT NO. B15F  
PAGE: 193 OF 233**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006449584  
 ADM: Aug 20, 2019 10:38

**ADAMS, NEVAEH**  
 ADM: 8/20/19 ACT# : 0006449584  
 MED# : 138580  
 DOB : 7/21/2015 FC : E  
 SEX : F AGE : 4 yr  
 SEL: POC DR: KOBBAH, PIAYON

Name: Nevaeh Adams Age: 4 DOB: 7/21/15

Date of Arrival: \_\_\_\_\_ Time: 1020

Reason for Visit: School Physical. Needing Immunization

ALLERGIES:  NKDA  Iodine  Latex  IV Contrast  Sulfa  PCN / Amoxicillin

Other \_\_\_\_\_

BP \_\_\_\_\_ HR 120 Temp 95.5 F<sup>°</sup> RR 24 Pulse Ox 99 % Ht 38 Wt 35  
 Pain (0-10) \_\_\_\_\_ Location \_\_\_\_\_ LMP \_\_\_\_\_  PREGNANT \_\_\_\_\_ months/weeks

Medical History:  No chronic medical conditions

HTN  Hyperlipidemia  Diabetes  Heart Disease (A-fib MI CHF)  CVA / TIA  
 Seizures  Migraines  Gout  GERD  Chronic Pain \_\_\_\_\_  
 COPD  Asthma  Thyroid  Psych (Anxiety / Depression)  Cancer \_\_\_\_\_

Other: Turner Syndrome Walking Amb.

Surgical History:  No Surgeries

Appendix  Gallbladder  Cardiac (Stent / Bypass)  Hysterectomy  BTx  C-section  Hernia  
 Tonsils/Adenoids  Dental  Ear Tubes  Ortho (B) Hip Surgery

Other \_\_\_\_\_

Social History:  Denies tobacco/alcohol/drug use

Cigarettes \_\_\_\_\_ PPD / Quit  Smokeless Tobacco  Vape  Alcohol  Drugs  IVDU (current/former)

Primary Care Provider: Kibbali  No PCP

Nurse Signature: M. Hillman, LPN

\*\*\*\* PATIENT REQUIRES HIGHER LEVEL OF CARE \*\*\*\*

Focused assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**EXHIBIT NO. B15F  
PAGE: 194 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
-----

----- MEDICATION RECONCILIATION (SCANNED) -----  
DATE OF NOTE: AUG 20, 2019@10:22 ENTRY DATE: AUG 21, 2019@10:22:46  
AUTHOR: HALE, DIANNE M EXP COSTIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 08/21/2019 10:23

**EXHIBIT NO. B15F  
PAGE: 195 OF 233**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006449584  
 ADM: Aug 20, 2019 10:38

**WELCH COMMUNITY HOSPITAL  
MEDICATION RECONCILIATION FORM**

**ADAMS, NEVAEH**  
 ADM: 8/20/19 ACT#: 0006449584  
 DOB: 7/21/2015 MED#: 138580  
 SEX: F FC: E  
 AGE: 4 yr  
 SER: POC DR: KOBBAI, PIAYON

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Allergies/Describe Reaction:**

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER-THE-COUNTER AND HERBAL MEDS

| Name of Medication/Dose | Route/<br>Frequency | Last<br>Dose | Reason for Medication | Continue<br>on<br>Admission | Continue<br>on<br>Transfer | Continue<br>After<br>Surgery | Conti<br>n<br>on<br>Dischar |
|-------------------------|---------------------|--------------|-----------------------|-----------------------------|----------------------------|------------------------------|-----------------------------|
| 1. Growth Hormone       |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 2.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 3.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 4.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 5.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 6.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 7.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 8.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 9.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 10.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 11.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 12.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 13.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 14.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 15.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 16.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 17.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 18.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 19.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 20.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 21.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 22.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 23.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |
| 24.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                         |

**New Medications Added**

| Date | Name of Medication/Dose | Route/Frequency/Duration | Reason | Provider Name |
|------|-------------------------|--------------------------|--------|---------------|
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |

**Source of Medication List**

- Patient Medication List
- Patient/Family Recall
- Pharmacy: \_\_\_\_\_
- Primary Care Physician List
- Previous Discharge Paperwork
- Reconciling Prescriber (MD/DO)

**Medication List Recorded/Reviewed by RN/MD/DO/PA/NP/LENT/RPH**

By: \_\_\_\_\_ Date: 8-20-19  
 By: \_\_\_\_\_ Date: \_\_\_\_\_  
 By: \_\_\_\_\_ Date: \_\_\_\_\_  
 By: \_\_\_\_\_ Date: \_\_\_\_\_  
 By: \_\_\_\_\_ Date: \_\_\_\_\_

Physician

Date

Physician

Date

**EXHIBIT NO. B15F  
PAGE: 196 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
-----

----- CLINIC NOTE (SCANNED) -----  
DATE OF NOTE: AUG 20, 2019@10:21 ENTRY DATE: AUG 21, 2019@10:22:06  
AUTHOR: HALE, DIANNE M EXP COSTIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Clinic Note(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 08/21/2019 10:23

**EXHIBIT NO. B15F**  
**PAGE: 197 OF 233**

Name : ADAMS, NEVAEH H  
 DOB / SEX : JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN : WEL000138580  
 ACT: WEL006449584  
 ADM: AUG 20, 2019 10:38

|                                       |                                                               |                                                                                                                                                                       |                                        |                                              |                                                   |     |                                         |                                                                  |
|---------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------|---------------------------------------------------|-----|-----------------------------------------|------------------------------------------------------------------|
| Screen Date                           | 8/20/15                                                       | West Virginia Department of Health and Human Resources<br>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen |                                        |                                              |                                                   |     |                                         | 4 Year Form                                                      |
| Name                                  | Nevaeh Adams                                                  |                                                                                                                                                                       | DOB                                    | 7/21/15                                      | Age                                               | 4   | Sex                                     | M <input checked="" type="checkbox"/> F <input type="checkbox"/> |
| Weight                                | 28                                                            | Height                                                                                                                                                                | 38 1/2 in.                             | BM                                           | Pulse                                             | 126 | BP                                      | ~                                                                |
| Allergies                             | <input type="checkbox"/> NKDA                                 |                                                                                                                                                                       | Amoxicillin   PCN                      |                                              | Resp                                              | 34  | Temp                                    | 98.4                                                             |
| Current meds                          | <input type="checkbox"/> None                                 |                                                                                                                                                                       | Cervarith hormone                      |                                              |                                                   |     | Pulse Ox (optional)                     | 99%                                                              |
| <input type="checkbox"/> Foster Child | <input type="checkbox"/> Child with special health care needs |                                                                                                                                                                       | Turmeric Syndrome                      |                                              | <input type="checkbox"/> IEP/section 504 in place |     | (+) <input checked="" type="checkbox"/> |                                                                  |
| Accompanied by                        | <input checked="" type="checkbox"/> Parent                    | <input type="checkbox"/> Grandparent                                                                                                                                  | <input type="checkbox"/> Foster parent | <input type="checkbox"/> Foster organization | <input type="checkbox"/> Other                    |     |                                         |                                                                  |

Oral Health  
 Date of last dental visit 4 months ago.  
 Current oral health problems 2 teeth dm X2.  
 Water source  Public  Well  Bottled  
 Fluoride supplementation  Yes  No  
 Fluoride varnish applied (apply every 3 to 6 months)  
 Yes  No

Vision Acuity Screen:  
 R \_\_\_\_\_ L \_\_\_\_\_  UTO (refuse in 6 months)  
 Wears glasses?  Yes  No (+) wear glasses.

Hearing Screen  
 20 dB@  UTO (refuse in 6 months)  
 R ear 500HZ R ear 1000HZ 2000HZ 4000HZ  
 L ear 500HZ L ear 1000HZ 2000HZ 4000HZ  
 Wears hearing aids?  Yes  No

**Developmental**  
 Developmental Surveillance ( Check those that apply)  
 Child can enter bathroom and have a bowel movement by himself/herself  Child can brush his/her teeth  Child can dress and undress without much help  Child can engage in well-developed imaginative play  Child can answer simple questions  Child can speak in words that are 100% understandable to strangers  Child can draw pictures that you recognize  Child can follow simple rules when playing games  Child can tell you a story from a book  Child can skip on 1 foot  Child can climb stairs, alternating feet, without support  Child can draw a person with at least 3 body parts  Child can draw a simple cross  Child can button/buttom and button/medium size buttons  Child can grasp pencil with thumb and fingers instead of fist  
 Concerns about child's behavior, speech, learning, social or motor skills

Immunizations: Attach current immunization record  
 UTD  Given, see Immunization record  Entered into WVSIS  
 Referrals:  Developmental  
 Mental/behavioral health/trauma - HelpWV.com/1-844-438-7453  
 Dental  Vision  Hearing  
 Other  
 Children with Special Health Care Needs (CSHCN) 1-800-442-4704  
 Women, Infants and Children (WIC) 1-304-588-0039

WELCH PEDIATRICS  
 Please Print Name of Facility or Clinician  
Katherine M.  
 Signature of Clinician/Title

**School Entry Requirements**


The information above this line is intended to be refused to meet school entry requirements

Child care/after school care home

How much stress are you and your family under now?

None  Slight  Moderate  Severe

What kind of stress? ( Check those that apply)

Relationships (partner, family and/or friends)  School/work  
 Child care  Drugs  Alcohol  Violence/abuse (physical, emotional and/or sexual)  Family member incarcerated  Lack of support/help  Financial/money  Emotional loss  Health insurance  Other N/A

Risk Indicators ( Check those that apply)  None

Child exposed to  Cigarettes  E-Cigarettes  Alcohol  
 Drugs (prescription or otherwise)  Access to firearm(s)/weapon(s)  Has a firearm(s)/weapon(s)  
 Are the firearm(s)/weapon(s) secured?  Yes  No  NA  
 Witnessed violence/abuse  Threatened with violence/abuse  
 Scary experience that your child cannot forget

Do you utilize a carbooster seat for your child?  Yes  No  
 Excessive television/video game/screen/cell phone use

**General Health**

Growth plotted on growth chart

BMI calculated and plotted on BMI chart

ADAMS, NEVAEH

ADM : 8/20/19 ACT# : 0008449594

MED# : 136580

DOB : 7/21/2015 FC : E

SEX : F AGE : 4 yr

SER : POC DR : KOBBAH, PAYTON



**Medical History**  
 Initial Screen  Periodic Screen  
 Recent injuries, surgeries, illnesses, visits to other providers and/or counselors and/or hospitalizations: N/A  
 Family health history reviewed N/A  
 Concerns and/or questions: N/A

**Social/Psychosocial History**  
 What is your family living situation: mine / dad  
 Family relationships  Good  Okay  Poor  
 Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)?  Yes  No  
 Are you and/or your partner working outside home?  Yes  No

**EXHIBIT NO. B15F  
PAGE: 198 OF 233**

Date 8/20/14 Name Nevaeh Adams DOB 7/21/15 Age 4 Sex  M  F

4 Year Form, Page 2

Nutrition/Physical Activity/Sleep  
 Normal eating habits?  Yes  No  
 Fruits/vegetables/lean protein per day WNL  
 Vitamins Flinstones  
 Normal elimination (+)  
 Physical activity/exercise on hour most days  
 Type of physical activity/exercise Outside play  
 Normal sleeping pattern?  Yes  No 10-12  
 Hours of sleep each night?

\*See Portofolio Schedule for Risk Factors

\*Anemia Risk (Hemoglobin/Hematocrit)  
 Low risk  High risk

\*Lead Risk  
 Low risk  High risk

\*Tuberculosis Risk  
 Low risk  High risk

\*Dyslipidemia Risk  
 Low risk  High risk

**Physical Examination (N=Normal, Abn=Abnormal)**

General Appearance  N  Abn \_\_\_\_\_  
 Skin  N  Abn \_\_\_\_\_  
 Neurological  N  Abn \_\_\_\_\_  
 Reflexes  N  Abn \_\_\_\_\_  
 Head  N  Abn \_\_\_\_\_  
 Neck  N  Abn \_\_\_\_\_  
 Eyes  N  Abn \_\_\_\_\_  
 Red Reflex  N  Abn \_\_\_\_\_  
 Ocular Alignment  N  Abn \_\_\_\_\_  
 Ears  N  Abn \_\_\_\_\_  
 Nose  N  Abn \_\_\_\_\_  
 Oral Cavity/Throat  N  Abn \_\_\_\_\_  
 Lung  N  Abn \_\_\_\_\_  
 Heart  N  Abn \_\_\_\_\_  
 Pulses  N  Abn \_\_\_\_\_  
 Abdomen  N  Abn \_\_\_\_\_  
 Genitalia  N  Abn \_\_\_\_\_  
 Back  N  Abn \_\_\_\_\_  
 Hips  N  Abn \_\_\_\_\_  
 Extremities  N  Abn \_\_\_\_\_

Possible Signs of Abuse  Yes  No

Concerns and/or questions \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Anticipatory Guidance**

(Consult Bright Futures, Fourth Edition for further information  
<http://brightfutures.aap.org>)

**Social Determinants of Health**

- Living situation and food security
- Tobacco, alcohol, and drugs
- Intimate partner violence
- Safety in the community
- Engagement in the community

**School Readiness**

- Language understanding and fluency
- Feelings

- Opportunities to socialize with other children
- Readiness for structured learning experiences
- Early childhood programs and preschool

**Developing Healthy Nutrition and Personal Habits**

- Milk, water, and juice
- Nutritious foods
- Daily routines that promote health

**Media Use**

- Limits on use
- Promoting physical activity and safe play

**Safety**

- Belt-positioning car booster seats
- Outdoor safety
- Water safety
- Sun protection
- Pets
- Breastmilk safety

**Other**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Plan of Care**  
 Assessment  Well Child  Other Diagnosis 14/

**Labs**  
 Hemoglobin/hematocrit ( high risk)  
 Blood lead (if not completed at 12 and/or 24 months or high risk)  
 (enter into WVSSS)  
 TB skin test ( high risk)  
 Lipid profile ( high risk)  
 Other \_\_\_\_\_

**Referrals**  
 See page 1, school requirements

**Prior Authorizations**  
 For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-842-9704 or dhhr.wv.gov/healthcheck

**Follow Up/Next Visit**  5 years of age  
 Other \_\_\_\_\_

Screen has been reviewed and is complete

See page 1, school requirements for required signature

**ADAMS, NEVAEH**

ADM: 8/20/14 ACT# : 0006449584

MED# : 138580

DOB : 7/21/2015 FC : E

SEX : F AGE : 4 yr

SER : PDC DR : KOBDAII, PIAYUN

www.wvhcrspvhmcfhnic.org/2018



**EXHIBIT NO. B15F  
PAGE: 199 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21, 2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

\*\*\* END \*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F**  
**PAGE: 200 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:

\*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

Order Date:      St: Requestor:      Start Date:      Stop Date:  
Nature of Order:      Signature:  
Item Ordered:

\*\*\* END \*\*\*\* \* CONFIDENTIAL ORDERS SUMMARY \*

**EXHIBIT NO. B15F  
PAGE: 201 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 202 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 203 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006449584  
ADM: Aug 20,2019 10:38

\*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 204 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSp : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 205 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006449584  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Aug 20, 2019 10:38  
ATTENDING:  
=====

ADRs: No ADRs on file.

Allergies: PENICILLIN  
=====

\*\*\*\*NO MEDICATIONS FOUND\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

{{{ END }}} Patient Encounter(s) History Report Dec 19, 2019@13:43

**EXHIBIT NO. B15F  
PAGE: 206 OF 233**

Patient Encounter(s) History Report Dec 19, 2019@13:44

(From: 12/03/19 --- Thru: 12/04/19)

Name : ADAMS, NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006458686  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 03, 2019 13:26  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

Insomnia |  
 SNOMED-CT: Insomnia  
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Turner syndrome |  
 SNOMED-CT: Turner syndrome  
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Anorexia symptom |  
 SNOMED-CT: Anorexia symptom  
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON, CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON, CHARLOTTE G

**EXHIBIT NO. B15F  
PAGE: 207 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006458686  
ADM: Dec 03,2019 13:26

-----  
Updated: 6/5/17

==== END ===

Hallucinations |  
SNOMED-CT: Hallucinations  
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:  
Status: ACTIVE  
SC Cond: UNKNOWN  
Exposure: None

Provider:  
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
Updated: 6/5/17

==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 208 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006458686  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 03, 2019 13:26  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

Causative agent: PENICILLIN  
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS  
PENICILLIN-G RELATED PENICILLINS  
PENICILLINS, AMINO DERIVATIVES  
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN, MELISSA J (LICENSED PRACTICAL NURSE)  
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN, MELISSA J

Observed/Historical: Historical

==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 209 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006458686  
ADM: Dec 03,2019 13:26

\*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 210 OF 233**

|                                 |                        |
|---------------------------------|------------------------|
| Name : ADAMS, NEVAEH H          | MRN: WEL000138580      |
| DOB/SEX: JUL 21,2015, FEMALE    | ACT: WEL006458686      |
| HOSP : WELCH COMMUNITY HOSPITAL | ADM: Dec 03,2019 13:26 |
| ATTENDING:                      |                        |

---

\*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

----- CLINIC NOTE (FREE TEXT) -----  
 DATE OF NOTE: DEC 3,2019@14:01 ENTRY DATE: DEC 3,2019@14:01:18  
 AUTHOR: KOBBAH,PIAYON E EXP COSIGNER:  
 URGENCY: STATUS: COMPLETED

Dr. kobbah dictating a clinic note on Navaeh Adams.

Chief complaint left ear ache cough fever.

History of present illness this is a 4-year-old female since last night is complaining of left ear a cough and running a low-grade fever. She is eating and drinking well. Mom says she is having greenish nasal discharge with the intermittent mild cough. She denied headache sore throat.

Past medical history Turner's syndrome and congenital hip dislocation.

Past surgical history she's had surgery on both hips.

Social history lives at home with her parents

PCP Dr. kobbah

Family history noncontributory

Medications she takes home therapy.

Allergies no known drug allergies.

Review of systems 12 systems were reviewed and were negative except as indicated in the history of present illness.

Physical exam temperature 97.9 pulse 112 respiration 18 blood pressure 92/58 oxygen saturation 99% on room air weight 52 pounds.

The patient is awake alert active in no acute distress.

Head atraumatic normocephalic

Neck is supple without meningismus

Throat is clear

Both TMs are obscured by cerumen the right TM is partially visible and is clear.

Pupils equal reactive to light sclera conjunctiva clear

Chest clear to auscultation no rales rhonchi wheezing or retraction

Heart no murmurs

Skin Bluefield sandpaperlike rash that blanches with pressure.

Capillary refill less than 2 seconds. She is nontoxic appearing.

Assessment viral exanthem.

**EXHIBIT NO. B15F  
PAGE: 211 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006458686  
ADM: Dec 03,2019 13:26

Plan amoxicillin 500 mg twice daily for 10 days.

Loratadine 1 teaspoon daily.

Cerumenex 5 drops are both ears twice daily for 4 days.

Return to the pediatric clinic in one week for follow-up.

Return immediately if condition worsens.

/es/ PIAYON E KOBBAH, MD

Signed: 12/03/2019 14:11

----- PRESENTING SHEET (SCANNED) -----  
DATE OF NOTE: DEC 3,2019@13:52 ENTRY DATE: DEC 3,2019@13:52:14  
AUTHOR: MORRIS,MARY BETH EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ MARY BETH MORRIS  
OFFICE ASSISTANT  
Signed: 12/03/2019 13:52

**EXHIBIT NO. B15F  
PAGE: 212 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006458686  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 03, 2019 13:26  
 ATTENDING:

| RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION FORM |               |                          |                              |                   |  |
|--------------------------------------------------------|---------------|--------------------------|------------------------------|-------------------|--|
| PLEASE FILL OUT TOP PORTION ONLY                       |               |                          |                              |                   |  |
| NAME: <u>Danah Adams</u>                               |               |                          | TODAY'S DATE: <u>12-3-19</u> |                   |  |
| TIME: <u>12:55</u>                                     | AGE: <u>4</u> | BIRTHDAY: <u>7-21-15</u> |                              |                   |  |
| ***TO BE FILLED OUT BY HOSPITAL STA                    |               |                          | ADAMS, NEVAEH                |                   |  |
| DISPOSITION: WIC / PEDS / IM / SURG                    |               |                          | ADM: 1200319                 | ACT# : 0206458686 |  |
| Registration Complaint: <u>Emoche</u>                  |               |                          | DOB: 7/21/2015               | MED# : 738680     |  |
|                                                        |               |                          | SEX: F                       | FC: E             |  |
|                                                        |               |                          | SFA: PDC                     | AGE: 004Y         |  |
|                                                        |               |                          | DA: KOBRAH, PIAYON           |                   |  |
| NURSE: <u>L. Chevalier</u>                             |               |                          | TIME: <u>13:30</u>           |                   |  |

**EXHIBIT NO. B15F  
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Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006458686  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 03, 2019 13:26  
ATTENDING:  
-----

----- IDENTIFICATION CARD/DRIVERS LICENCE -----  
DATE OF NOTE: DEC 3, 2019@13:52 ENTRY DATE: DEC 3, 2019@13:52:47  
AUTHOR: MORRIS,MARY BETH EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

ID Card /Drivers License attached as scanned image.  
none

/es/ MARY BETH MORRIS  
OFFICE ASSISTANT  
Signed: 12/03/2019 13:52

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----  
DATE OF NOTE: DEC 3, 2019@13:51 ENTRY DATE: DEC 3, 2019@13:51:14  
AUTHOR: MORRIS,MARY BETH EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ MARY BETH MORRIS  
OFFICE ASSISTANT  
Signed: 12/03/2019 13:52

**EXHIBIT NO. B15F  
PAGE: 214 OF 233**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006458686  
 ADM: Dec 03, 2019 13:26



**ADAMS, NEVAEH**  
 ADM: 12/03/19

ACT#: 0006458686  
 MED#: 138580  
 DOB: 7/21/2015  
 FC: E  
 SEX: F  
 AGE: 004 YR  
 SER: POC  
 DR: KOBBAH, PIAYON

**WELCH COMMUNITY HOSPITAL**  
 454 McDOWELL STREET  
 WELCH, WV 24801

**CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY**

*Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.*

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

**EXHIBIT NO. B15F  
PAGE: 215 OF 233**

ADAMS, NEVAEH  
 ADM : 12/03/19 ACT# : 0006458686  
 DOB : 7/21/2015 MED# : 138580  
 SEX : F FC : E  
 SER : PDC AGE : 004Yr  
 DR : KOBBAH, PIAYON

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.
7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

**EXHIBIT NO. B15F**  
**PAGE: 216 OF 233**

|                 |                    |
|-----------------|--------------------|
| ADAMS, NEVAEH   | AC# : 0006458865   |
| ADM : 12/03/19  | MED# : 138580      |
| DOB : 7/21/2015 | FC : E             |
| SEX : F         | AGE : 00AY W       |
| SER : PDC       | DR : KOBRAI, PIYON |

If you would like to opt out of receiving information from other healthcare providers, please initial the line below. There may be some instances where patients are not allowed to opt out. For further information, please refer to the information sheet given to you upon registration.

Initials of patient/patient representative: KNA

8. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: KNA

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

9. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

10. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

I object to having my name, location and general condition listed in the facility directory.

**EXHIBIT NO. B15F  
PAGE: 217 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006458686  
ADM: Dec 03,2019 13:26

----- INSURANCE CARD -----  
DATE OF NOTE: DEC 3,2019@13:50 ENTRY DATE: DEC 3,2019@13:50:41  
AUTHOR: MORRIS,MARY BETH EXP COSTIGNER:  
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.  
INSURANCE CARD BACK (SCANNED):

/es/ MARY BETH MORRIS  
OFFICE ASSISTANT  
Signed: 12/03/2019 13:52

**EXHIBIT NO. B15F  
PAGE: 218 OF 233**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006458686  
 ADM: Dec 03, 2019 13:26

2550946522

Elig Inquiry Date: 12/03/2019

**Eligibility Report**

Elig Check: 12/03/2019

Print Date: 12/03/2019 01:31:19 PM

**Patient**

The patient is the subscriber or contract holder for the insurance plan.

**Primary**

Insured Number: 00405164305  
 Name: ADAMS, NEVAEH H  
 Address: PO BOX 46  
 City, State Zip: BIG SANDY, WV 24816  
 Date of Birth: 07/21/2015  
 Gender: Female  
 Insured Status: Active  
 Effective Date: 12/03/2019  
 Expire Date: 12/03/2019

**Insurance**

For Member Eligibility Verification and Claim Status inquiries, please contact the payer using the number on the back of the member's card.

Provider Number: 1134158909

**Additional Payer Information**

Payer Information Contacts  
 8426 - DAVIS VISION / FASHION FOCUS

Name: TPL  
 Identifier: PLAN SPONSOR  
 Insurance Type: C1 - Commercial  
 Dates:  
 ELIGIBILITY 12/03/2019 - 12/03/2019  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: 235376313  
 PLAN BEGIN 01/01/2019  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: 235376313

**Benefits**

| Benefit                                                                           | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type | Coverage Level | Date                  | Date Qualifier |
|-----------------------------------------------------------------------------------|--------|---------|--------|----------|-----------|------------|----------------|----------------|-----------------------|----------------|
| <b>HEALTH BENEFIT PLAN COVERAGE - 30</b>                                          |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                |                | 12/03/2019-12/03/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES . Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                |                | 12/03/2019-12/03/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES . Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                |                | 12/03/2019-12/03/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                |                       |                |

Page 1

**EXHIBIT NO. B15F  
PAGE: 219 OF 233**

2859946522

Elg Inquiry Date: 12/03/2019

**Eligibility Report**

Elg Check: 12/03/2019

Print Date: 12/03/2019 01:31:20 PM

| Benefit                                                                                | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type                      | Coverage Level | Date                  | Date Qualifier        |
|----------------------------------------------------------------------------------------|--------|---------|--------|----------|-----------|------------|-------------------------------------|----------------|-----------------------|-----------------------|
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 12/03/2019-12/03/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 12/03/2019-12/03/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                             |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 12/03/2019-12/03/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 06/01/2018            | PLAN BEGIN            |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                             |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 06/01/2018            | PLAN BEGIN            |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 06/01/2018            | PLAN BEGIN            |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 06/01/2018            | PLAN BEGIN            |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 06/01/2018            | PLAN BEGIN            |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793      |        |         |        |          |           |            |                                     |                |                       |                       |
| CO-PAYMENT                                                                             | 0.00   |         |        |          |           |            | Medicaid                            |                | 12/03/2019-12/03/2019 | ELIGIBILITY           |
| MANAGED CARE COORDINATOR                                                               |        |         |        |          |           |            | Health Maintenance Organization (H) |                | 12/03/2019-12/03/2019 | PRIMARY CARE PROVIDER |
| Entity: PLAN SPONSOR, Name: UNICARE HEALTHPLAN OF WEST VIRGINIA , Phone: (800)702-0095 |        |         |        |          |           |            |                                     |                |                       |                       |
| <hr/>                                                                                  |        |         |        |          |           |            |                                     |                |                       |                       |
| MEDICAL CARE - 1                                                                       |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 12/03/2019-12/03/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                             |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 12/03/2019-12/03/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 12/03/2019-12/03/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY                  |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 12/03/2019-12/03/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793      |        |         |        |          |           |            |                                     |                |                       |                       |
| ACTIVE COVERAGE                                                                        |        |         |        |          |           |            | Medicaid                            |                | 12/03/2019-12/03/2019 | ELIGIBILITY           |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY                   |        |         |        |          |           |            |                                     |                |                       |                       |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793      |        |         |        |          |           |            |                                     |                |                       |                       |

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**EXHIBIT NO. B15F**  
**PAGE: 220 OF 233**

2859946522

Elg Inquiry Date: 12/03/2019

**Eligibility Report**

Elg Check: 12/03/2019

Print Date: 12/03/2019 01:31:21 PM

| Benefit                                                                           | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type | Coverage Level | Date                  | Date Qualifier |
|-----------------------------------------------------------------------------------|--------|---------|--------|----------|-----------|------------|----------------|----------------|-----------------------|----------------|
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 12/03/2019-12/03/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                |                       |                |
| <b>CHIROPRACTIC - 33</b>                                                          |        |         |        |          |           |            | Medicaid       |                | 12/03/2019-12/03/2019 | ELIGIBILITY    |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            |                |                |                       |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 12/03/2019-12/03/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 12/03/2019-12/03/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 12/03/2019-12/03/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 12/03/2019-12/03/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 12/03/2019-12/03/2019 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR: Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |

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**EXHIBIT NO. B15F  
PAGE: 221 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006458686  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 03, 2019 13:26  
ATTENDING:  
-----

----- PRESCRIPTION COPY (SCANNED) -----  
DATE OF NOTE: DEC 3, 2019@09:54 ENTRY DATE: DEC 4, 2019@09:54:30  
AUTHOR: HALE, DIANNE M EXP COSTIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned copy of Prescription(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 12/04/2019 09:54

**EXHIBIT NO. B15F**  
**PAGE: 222 OF 233**

**8771**

**WELCH COMMUNITY HOSPITAL**  
**PIAVON E. KOBBAH, M.D.**

WV, Lic#14821  
 454 McDowell St.

(304) 436-8461

DEAM BK3857246  
 Welch, WV 24801

Name Nevaeh Adams

Address

Date 14/3/19

Raw Printing: Welch, WV (304-436-8461) Welch, WV

This prescription may be filled with a generically equivalent drug product unless the words "BRAND NECESSARY OR THE WORDS "BRAND NECESSARY" ARE WRITTEN IN THE PRESCRIPTION." (AS NOTED ON THE PRESCRIPTION FORM)

THIS IS A SECURITY RX

Dubrox 6.5%Drip 1 vial

As 5 stgs to both ears bid

X4 daysRefill # 0000000000

- 1-24
- 25-49
- 50-74
- 75-100
- 101-150
- 151 and over

Prescription is valid if more than one (1) prescription is written per blank.

**8772**

**WELCH COMMUNITY HOSPITAL**  
**PIAVON E. KOBBAH, M.D.**

WV, Lic#14921  
 454 McDowell St.

(304) 436-8461

DEAM BK3857246  
 Welch, WV 24801

Name Nevaeh Adams

Address

Date 14/3/19

Raw Printing: Welch, WV (304-436-8461) Welch, WV

This prescription may be filled with a generically equivalent drug product unless the words "BRAND NECESSARY OR THE WORDS "BRAND NECESSARY" ARE WRITTEN IN THE PRESCRIPTION." (AS NOTED ON THE PRESCRIPTION FORM)

THIS IS A SECURITY RX

Ambrox 400mg/5ccDsp 100 ccSis + tdp po bid x 10gRefill # 0000000000

- 1-24
- 25-49
- 50-74
- 75-100
- 101-150
- 151 and over

Prescription is valid if more than one (1) prescription is written per blank.

ADAMS, NEVAEH  
 ADM: 12/03/19  
 DOB: 7/2/2015  
 SEX: F  
 SCR: POC  
 ACT#: 0005468886  
 MED#: 136580  
 FC: E  
 AGE: 004 YR  
 DR. KOBBAH PIAVON

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

**EXHIBIT NO. B15F  
PAGE: 223 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006458686  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 03, 2019 13:26  
ATTENDING:  
-----

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----  
DATE OF NOTE: DEC 3, 2019@09:53 ENTRY DATE: DEC 4, 2019@09:53:42  
AUTHOR: HALE, DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 12/04/2019 09:54

**EXHIBIT NO. B15F  
PAGE: 224 OF 233**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006458686  
 ADM: Dec 03, 2019 13:26

**ADAMS, NEVAEH**  
 ADM: 12/03/19 ACT#: 0006458686  
 MED#: 138580  
 DOB: 7/21/2015 FC: E  
 SEX: F AGE: 004Y yr  
 SER: POC DR: KOBBAH, PIAYON

**RURAL HEALTH CLINIC**

Name: Nevaeh Adams Age: 4 DOB: 7-21-15  
 Date of Arrival: 12-3-19 Time: 1316

Reason for Visit:  
Cough, fever, since last night

ALLERGIES:  NKDA  Iodine  Latex  IV Contrast  Sulfa  PCN / Amoxicillin

Other \_\_\_\_\_

BP 87/59 HR 117 Temp 97.9 RR 18 Pulse Ox 98% HI \_\_\_\_\_ WT 33  
 Pain (0-10) \_\_\_\_\_ Location \_\_\_\_\_ LMP \_\_\_\_\_ PREGNANT \_\_\_\_\_ months/weeks

Medical History:  No chronic medical conditions

HTN  Hyperlipidemia  Diabetes  Heart Disease (A-fib MI CHF)  CVA / TIA  
 Seizures  Migraines  Gout  GERD  Chronic Pain \_\_\_\_\_  
 COPD  Asthma  Thyroid  Psych (Anxiety / Depression)  Cancer \_\_\_\_\_

Other: Juvenile lymphoma

Surgical History:  No Surgeries

Appendix  Gallbladder  Cardiac (Stent / Bypass)  Hysterectomy  Bnl.  Cesarean  Hernia  
 Tonsil/Adenoids  Dental  Ear Tubes  Ortho \_\_\_\_\_

Other: BOTH HIPS

Social History:  Denies tobacco/alcohol/drug use

Cigarettes PPD / Quit  Smokeless Tobacco  Vape  Alcohol  Drugs  IVDU (current/former)

Primary Care Provider: Kobbah  No PCP

Nurse Signature: Carmelina Owen LPN

**\*\*\*\* PATIENT REQUIRES HIGHER LEVEL OF CARE \*\*\*\***

Focused assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**EXHIBIT NO. B15F  
PAGE: 225 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006458686  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 03, 2019 13:26  
ATTENDING:  
-----

----- MEDICATION RECONCILIATION (SCANNED) -----  
DATE OF NOTE: DEC 3, 2019@09:53 ENTRY DATE: DEC 4, 2019@09:54:03  
AUTHOR: HALE, DIANNE M EXP COSTIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 12/04/2019 09:54



**EXHIBIT NO. B15F  
PAGE: 227 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006458686  
ADM: Dec 03,2019 13:26

\*\*\* END \*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 228 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----  
MRN: WEL000138580  
ACT: WEL006458686  
ADM: Dec 03,2019 13:26

\*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

Order Date: St: Requestor: Start Date: Stop Date:  
Nature of Order: Signature:  
Item Ordered:  
=====

\*\*\* END \*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 229 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006458686  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 03, 2019 13:26  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 230 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006458686  
ADM: Dec 03,2019 13:26

\*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 231 OF 233**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006458686  
ADM: Dec 03,2019 13:26

\*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 232 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006458686  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Dec 03, 2019 13:26  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

**EXHIBIT NO. B15F  
PAGE: 233 OF 233**

Name : ADAMS, NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21, 2015, FEMALE ACT: WEL006458686  
HOSPT : WELCH COMMUNITY HOSPITAL ADM: Dec 03, 2019 13:26  
ATTENDING:  
=====

ADRs: No ADRs on file.

Allergies: PENICILLIN  
=====

\*\*\*\*NO MEDICATIONS FOUND\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

{{{ END }}} Patient Encounter(s) History Report Dec 19, 2019@13:44

EXHIBIT NO. B16F  
PAGE: 1 OF 3



As required under 20 CFR §404.1512(a) and/or 20 CFR §416.912(a), we are obligated to submit non-redacted and complete copies of all documents we receive that relate to our client's claim.

Accordingly, please make the enclosed medical record a part of the record in this claim.

Please note that if the medical provider returned to us the copies of form SSA-1696, our client's medical release and our cover letter requesting records, we are not enclosing copies of those documents as they do not relate to the issue of our client's disability. We do have those pages available and will submit them upon your request.

Finally, please also make this letter a part of the record in this matter.

**EXHIBIT NO. B16F  
PAGE: 2 OF 3**

**Looney Enterprises LLC**  
**794 Virginia Ave.**  
**Welch, WV 24801-0000**  
**304-436-8435 FAX: 304-436-8436**

October 01, 2020

**RE: Adams, Mr. Nevaeh**  
**Exam Date: 10/10/2017**  
**Patient's Date of Birth: July 21, 2015**

Dear :

This report will provide you with a summary of pertinent clinical findings and observations from my examination. It is a pleasure to have the opportunity to share in the care of this patient.

**EXAMINATION:** Click on EXAMINATION to Document, Pediatric eye health and vision examination.

**EXAM TECHNICIAN:** Looney, Denetta

**PRIMARY CARE PHYSICIAN:** Dr. Musafar

**COMANAGING DOCTOR:** Template

**CHIEF COMPLAINT:** RT: Mother reports patient was diagnosed with Turner Syndrome and has lazy eye (RT)

Timeline: October 2015., Doctor recommended follow up from previous examination, Mother reports needs to be close to television.

**HPI NORMS:** No complaints reported of physical ocular symptoms. Not experiencing routine headaches or double vision. No reports of visual floaters or light flashes.

**VISION COMPLAINT:** Mother reports needs to be close to tv

**PATIENT HISTORY NORMS:** No systemic medications reported. No ocular medications. No history of ocular surgery. No history of trauma or ocular injuries. Ocular family history is unremarkable. Patient is currently a non-smoker. No out-of-the-ordinary social history is reported. Past medical history, unremarkable.

**SYSTEMIC MEDICATIONS:** No systemic medications are currently used except: Unknown Hormonal medication (Growth hormone shot weekly), No known systemic medication allergies.

**SPECTACLE Rx STATUS:** No current Rx.

**SYSTEM NORMS:** No reported disorders or current medical treatment of: Allergy, Cardiovascular, Constitutional, Cranial / Facial, Endocrine, Gastrointestinal, Genitourinary, Hematologic / Lymphatic, Immunologic, Integumentary / Skin, Musculoskeletal, Neurologic, Psychiatric, Respiratory

**COLOR DISCRIMINATION:** Color vision was found to be normal.

**EYE MOVEMENT SKILLS:** Saccades 4+, smooth and accurate. Pursuits 4+, smooth and accurate.

**PAM (Potential Acuity):** Click here to document or right click on the heading to remove

**GLARE ACUITY:** Click here to document or right click on the heading to remove

**CUP/DISC RATIO:**

RT: Horz NR Vert NR

LT: Horz NR Vert NR

**TONOMETRY:** RT: Soft mmHg LT: Soft mmHg Test: Digital Time: 13:45 Category: Examination

**EXTERNAL EXAM:** Confrontation fields are full in all quadrants. Facial symmetry exists. Ocular adnexa and nodes normal. Eyelids and lashes clean, healthy and free of defects. Extraocular muscle motilities and versions full. Cover test testing ortho @ primary gaze, distance and near. Pupils are equal, round and fully reactive to light.

**EXTRAOCULAR MUSCLES:** Right Eye: Testing reveals convergent misalignment. Hirshburg testing shows misalignment temporally of light reflex OD.

**SLIT-LAMP EXAM:** Tears demonstrate normal surface qualities and chemistry. Corneal epithelium, stroma and endothelium clear and healthy. Bulbar and palpebral conjunctiva are healthy and white. Chambers are deep and free of cells and flare. Iris appears healthy, normal anatomy and convexity. Lens, both capsules, cortex, and nucleus are normal for age.

**POSTERIOR SEGMENT:** Vitreous body clear for age and fully attached. Nerve head well perfused, with good rim tissue. Healthy macula with no edema or degenerative pigmentation. Healthy peripheral retinal structures and vasculature. No drusen, exudate, hemorrhages or evidence of retinopathy. Unless otherwise noted below, Bilateral: Unable to observe posterior segment or fundus. Red Reflex present OU.

**DISPOSITION:** This patient's mood is pleasant and sociable.

**ORIENTATION:** Patient is fully alert to time, place, and person. Recent and remote memory is fully intact.

**COMPUTERIZED SCREENING FIELDS:** Bilateral: Fields were found to be full in all quadrants.

**IMPRESSION(S):**

Right Eye: Esotropia. Unspecified esotropia

This fax was received by GFI FaxMaker fax server. For more information, visit <http://www.gfi.com>

Patient: Adams, Mr. Nevaeh - Page: 2

**EXHIBIT NO. B16F  
PAGE: 3 OF 3**

**UNABLE TO EXAMINE PATIENT**

**PATIENT UNCOOPERATIVE WITH TESTING**

Explained to patient's mother that child needs sedated exam to determine diagnosis and management

**TREATMENT EXTRAOCULAR MUSCLES:** Right Eye: Refer patient to ophthalmologist specializing in ocular motilities or binocularly. Pediatric Ophthal. Roanoke Vistar Eye Group

**ORDERS:**

Schedule on or about 10/10/2018: Examination: Eye Health and Vision Exam long Ordered by: Looney, Brian D. Entered by: Admin, Admin. [Active] on 10/10/2017 By Admin, Admin.

**ELECTRONIC SIGNATURE:** Electronically Signed By: Brian D Looney on 10/10/2017 02:26 PM.

**FOLLOW-UP:** Recall on or about : Eye Health and Vision Exam

**DIAGNOSIS:**

H50.021 Monocular esotropia with A pattern, right eye

**PROCEDURE:**

92002 Exam - Intermediate New

**Finalized Exam:** \_\_\_\_\_ Date: 10/10/2017  
Brian D. Looney OD

Respectfully submitted,

Brian D. Looney OD

Note: The information contained in this report is confidential. Unauthorized disclosure may result in civil/criminal action as provided by HIPAA (1996) regulations.

EXHIBIT NO. B17F  
PAGE: 1 OF 152



As required under 20 CFR §404.1512(a) and/or 20 CFR §416.912(a), we are obligated to submit non-redacted and complete copies of all documents we receive that relate to our client's claim.

Accordingly, please make the enclosed medical record a part of the record in this claim.

Please note that if the medical provider returned to us the copies of form SSA-1696, our client's medical release and our cover letter requesting records, we are not enclosing copies of those documents as they do not relate to the issue of our client's disability. We do have those pages available and will submit them upon your request.

Finally, please also make this letter a part of the record in this matter.

**EXHIBIT NO. B17F  
PAGE: 2 OF 152**

Patient Encounter(s) History Report Sep 30, 2020@09:11

(From: 01/09/20 --- Thru: 01/10/20)

Name : ADAMS,NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006461889  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 09,2020 13:19  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

Insomnia |  
 SNOMED-CT: Insomnia  
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Turner syndrome |  
 SNOMED-CT: Turner syndrome  
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]  
 Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Anorexia symptom |  
 SNOMED-CT: Anorexia symptom  
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G

**EXHIBIT NO. B17F  
PAGE: 3 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006461889  
ADM: Jan 09,2020 13:19

-----  
Updated: 6/5/17

==== END ===

Hallucinations |  
SNOMED-CT: Hallucinations  
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:  
Status: ACTIVE  
SC Cond: UNKNOWN  
Exposure: None

Provider:  
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
Updated: 6/5/17

==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 4 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006461889  
ADM: Jan 09,2020 13:19

\*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

Causative agent: PENICILLIN  
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS  
PENICILLIN-G RELATED PENICILLINS  
PENICILLINS,AMINO DERIVATIVES  
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN,MELISSA J (LICENSED PRACTICAL NURSE)  
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN,MELISSA J  
Observed/Historical: Historical  
==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 5 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006461889  
ADM: Jan 09,2020 13:19

\*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

EXHIBIT NO. B17F  
PAGE: 6 OF 152

Name : ADAMS,NEVAEH H  
 DOB/SEX: JUL 21,2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

---

MRN: WEL000138580  
 ACT: WEL006461889  
 ADM: Jan 09,2020 13:19

\*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

----- CLINIC NOTE (FREE TEXT) -----  
 DATE OF NOTE: JAN 9,2020@13:49 ENTRY DATE: JAN 9,2020@13:50:04  
 AUTHOR: KOBBAH,PIAYON E EXP COSIGNER:  
 URGENCY: STATUS: COMPLETED

Dr. kobbah dictating a clinic note on Nevaeh Adams.

Chief complaint cough running nose and fever.

History of present illness this is a 4-year-old female who presents with a 2 day history of cough running nose and a fever. There is eating and drinking well and urinating adequately. She's had a clear runny nose.

Past medical history Turner's syndrome.

Past surgical history bilateral hip surgery.

Social history she lives at home with her parents she does attend preschool.

Family history noncontributory. No one else is ill at home.

Medications she takes no home medications regularly.

Allergies no known drug allergies

Immunizations up-to-date

PCP Dr. kobbah

Review of systems 12 systems were reviewed and were negative except as indicated in the history present illness.

Physical exam temperature 101.6 pulse 130 respiration 24 oxygen saturation 96% on room air weight 39 pounds.

Patient is awake alert active in no acute distress.

Head is normocephalic atraumatic.

Neck is supple without meningismus

Throat is clear

TMs are clear

Pupils equal reactive to light sclera conjunctiva clear

Chest clear to auscultation no rales rhonchi or wheezing or retraction

Heart no murmurs

Abdomen flat soft nontender active bowel sounds no masses

Skin no rash good turgor moist mucous membranes she appears well hydrated well-perfused nontoxic appearing.

**EXHIBIT NO. B17F  
PAGE: 7 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006461889  
ADM: Jan 09,2020 13:19

-----  
Assessment viral syndrome.

Plan rest of the half a teaspoon daily.

Alternate ibuprofen and Tylenol for fever

Encourage fluids

Return to the pediatric clinic if condition worsens

Otherwise return

Throat is clear

/es/ PIAYON E KOBBAH, MD

Signed: 01/09/2020 13:58

----- PRESENTING SHEET (SCANNED) -----  
DATE OF NOTE: JAN 9,2020@13:35 ENTRY DATE: JAN 9,2020@13:35:36  
AUTHOR: MORRIS,MARY BETH EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

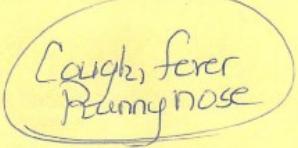
See attached Presenting Sheet document(s).

/es/ MARY BETH MORRIS  
OFFICE ASSISTANT  
Signed: 01/09/2020 13:36

**EXHIBIT NO. B17F  
PAGE: 8 OF 152**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006461889  
 ADM: Jan 09, 2020 13:19

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |               |                               |  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------|-------------------------------|--|--|
| <b>RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION FORM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |               |                               |  |  |
| PLEASE FILL OUT TOP PORTION ONLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |               |                               |  |  |
| NAME: <u>Nevaeh Adams</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |               | TODAY'S DATE: <u>1-9-2020</u> |  |  |
| TIME: <u>107pm</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | AGE: <u>4</u> | BIRTHDAY: _____               |  |  |
| <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="flex: 1;"> <p><b>ADAMS, NEVAEH</b></p> <p>ADM : 1/09/20      ACT# : 0006461889<br/>                           MED# : 138580</p> <p>DOB : 7/21/2015      FC : E<br/>                           SEX : F      AGE : 004Yr</p> <p>SER : PDC      DR : KOBBAH, PIAYON</p> </div> <div style="flex: 1; text-align: center;"> <p>***TO BE FILLED OUT BY HOSPITAL STAFF***</p> <p>DISPOSITION: <input checked="" type="checkbox"/> WIC <input checked="" type="checkbox"/> PEDS <input checked="" type="checkbox"/> IM <input checked="" type="checkbox"/> SURG <input checked="" type="checkbox"/> OBGYN</p> </div> <div style="flex: 1; text-align: right; margin-top: 20px;">  </div> </div> |  |               |                               |  |  |
| <p>NURSE: <u>Sherry RH/ST LPN</u>      TIME: <u>107pm</u></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |               |                               |  |  |

**EXHIBIT NO. B17F  
PAGE: 9 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006461889  
ADM: Jan 09,2020 13:19

----- IDENTIFICATION CARD/DRIVERS LICENCE -----  
DATE OF NOTE: JAN 9,2020@13:35 ENTRY DATE: JAN 9,2020@13:36:02  
AUTHOR: MORRIS,MARY BETH EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

ID Card /Drivers License attached as scanned image.  
none

/es/ MARY BETH MORRIS  
OFFICE ASSISTANT  
Signed: 01/09/2020 13:36

----- INSURANCE CARD -----  
DATE OF NOTE: JAN 9,2020@13:33 ENTRY DATE: JAN 9,2020@13:33:15  
AUTHOR: MORRIS,MARY BETH EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.  
INSURANCE CARD BACK (SCANNED):

/es/ MARY BETH MORRIS  
OFFICE ASSISTANT  
Signed: 01/09/2020 13:36

**EXHIBIT NO. B17F  
PAGE: 10 OF 152**

Name : ADAMS,NEVAEH H  
 DOB/SEX: JUL 21,2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006461889  
 ADM: Jan 09,2020 13:19

---

2583219621

Elig Inquiry Date: 01/09/2020

**Eligibility Report**

Elig Check: 01/09/2020

Print Date: 01/09/2020 01:28:27 PM

**Patient**

The patient is the subscriber or contract holder for the insurance plan.

**Primary**

Insured Number: 00405164305  
 Name: ADAMS, NEVAEH H  
 Address: PO BOX 46  
 City, State Zip: BIG SANDY, WV 24816  
 Date of Birth: 07/21/2015  
 Gender: Female  
 Insured Status: Active  
 Effective Date: 01/09/2020  
 Expire Date: 01/09/2020

**Insurance**

For Member Eligibility Verification and Claim Status inquiries, please contact the payer using the number on the back of the member's card.

Provider Number: 1134158900

**Additional Payer Information**

|                 |                              |
|-----------------|------------------------------|
| Name:           | TPL                          |
| Identifier:     | PLAN SPONSOR                 |
| Insurance Type: | C1 - Commercial              |
| Dates:          |                              |
| ELIGIBILITY     | 01/09/2020 - 01/09/2020      |
| ID Qualifier:   | MEMBER IDENTIFICATION NUMBER |
| ID:             | 235376313                    |
| PLAN BEGIN      | 01/01/2019                   |
| ID Qualifier:   | MEMBER IDENTIFICATION NUMBER |
| ID:             | 235376313                    |

**Benefits**

| Benefit                                                                           | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type | Coverage Level | Date                  | Date Qualifier |
|-----------------------------------------------------------------------------------|--------|---------|--------|----------|-----------|------------|----------------|----------------|-----------------------|----------------|
| <b>HEALTH BENEFIT PLAN COVERAGE - 30</b>                                          |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 01/09/2020-01/09/2020 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 01/09/2020-01/09/2020 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           |            | Medicaid       |                | 01/09/2020-01/09/2020 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                |                       |                |

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**EXHIBIT NO. B17F  
PAGE: 11 OF 152**

2583219621

Elig Inquiry Date: 01/09/2020

**Eligibility Report**

Elig Check: 01/09/2020

Print Date: 01/09/2020 01:28:27 PM

| Benefit                  | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type                                                                                                                                             | Coverage Level | Date                  | Date Qualifier        |
|--------------------------|--------|---------|--------|----------|-----------|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------|-----------------------|
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 01/09/2020-01/09/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793  |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 01/09/2020-01/09/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                         |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 01/09/2020-01/09/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 06/01/2018            | PLAN BEGIN            |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 06/01/2018            | PLAN BEGIN            |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 06/01/2018            | PLAN BEGIN            |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797  |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 06/01/2018            | PLAN BEGIN            |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793  |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 06/01/2018            | PLAN BEGIN            |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797  |                |                       |                       |
| CO-PAYMENT               | 0.00   |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 01/09/2020-01/09/2020 | ELIGIBILITY           |
| MANAGED CARE COORDINATOR |        |         |        |          |           |            | Health Maintenance Organization (H)                                                                                                                        |                | 01/09/2020-01/09/2020 | PRIMARY CARE PROVIDER |
|                          |        |         |        |          |           |            | Entity: PLAN SPONSOR, Name: UNICARE HEALTHPLAN OF WEST VIRGINIA , Phone: (800)782-0095                                                                     |                |                       |                       |
| <b>MEDICAL CARE - 1</b>  |        |         |        |          |           |            |                                                                                                                                                            |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 01/09/2020-01/09/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 01/09/2020-01/09/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 01/09/2020-01/09/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 01/09/2020-01/09/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797  |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 01/09/2020-01/09/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793  |                |                       |                       |

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**EXHIBIT NO. B17F**  
**PAGE: 12 OF 152**

2583219621

Elig Inquiry Date: 01/09/2020

**Eligibility Report**

Elig Check: 01/09/2020

Print Date: 01/09/2020 01:28:28 PM

| Benefit                  | Amount                                                                            | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type | Coverage Level | Date                  | Date Qualifier |
|--------------------------|-----------------------------------------------------------------------------------|---------|--------|----------|-----------|------------|----------------|----------------|-----------------------|----------------|
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 01/09/2020-01/09/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |         |        |          |           |            |                |                |                       |                |
| <b>CHIROPRACTIC - 33</b> |                                                                                   |         |        |          |           |            | Medicaid       |                | 01/09/2020-01/09/2020 | ELIGIBILITY    |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            |                |                |                       |                |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 01/09/2020-01/09/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 01/09/2020-01/09/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 01/09/2020-01/09/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 01/09/2020-01/09/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 01/09/2020-01/09/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |         |        |          |           |            |                |                |                       |                |

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**EXHIBIT NO. B17F  
PAGE: 13 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006461889  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 09,2020 13:19  
ATTENDING:  
-----

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----  
DATE OF NOTE: JAN 9,2020@13:33 ENTRY DATE: JAN 9,2020@13:33:35  
AUTHOR: MORRIS,MARY BETH EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ MARY BETH MORRIS  
OFFICE ASSISTANT  
Signed: 01/09/2020 13:36

**EXHIBIT NO. B17F  
PAGE: 14 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006461889  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 09,2020 13:19  
ATTENDING:  
-----

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----  
DATE OF NOTE: JAN 9,2020@12:33 ENTRY DATE: JAN 10,2020@12:33:14  
AUTHOR: PRUITT,STANLEY EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ STANLEY PRUITT  
OFFICE ASSISTANT  
Signed: 01/10/2020 12:33

EXHIBIT NO. B17F  
PAGE: 15 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006461889  
 ADM: Jan 09, 2020 13:19

ADAMS, NEVAEH  
 ADM: 1/09/20 ACT#: 0006461889  
 MED#: 138580  
 DOB: 7/21/2015 FC: E . HEALTH CLINIC  
 SEX: F AGE: 004Y yr  
 SFB: POC DR: KORAH PLAYON Name: 4 DOB: 7/21/15  
 Date of Arrival: 1-9-2020 Time: 107 pm

Reason for Visit: Cough & runny nose, fever

ALLERGIES:  NKDA  Iodine  Latex  IV Contrast  Sulfa  PCN / Amoxicillin

Other \_\_\_\_\_

BP \_\_\_\_\_ HR 134 Temp 101.6 RR 24 Pulse Ox 94% Ht \_\_\_\_\_ Wt 39  
 Pain (0-10) \_\_\_\_\_ Location \_\_\_\_\_ LMP \_\_\_\_\_  PREGNANT months/weeks

Medical History:  No chronic medical conditions

HTN  Hyperlipidemia  Diabetes  Heart Disease (A-fib MI CHF)  CVA / TIA  
 Seizures  Migraines  Gout  GERD  Chronic Pain \_\_\_\_\_  
 COPD  Asthma  Thyroid  Psych (Anxiety / Depression)  Cancer \_\_\_\_\_

Other: Turners.

Surgical History:  No Surgeries

Appendix  Gallbladder  Cardiac (Stent / Bypass)  Hysterectomy  BTL  C-section  Hernia  
 Tonsils/Adenoids  Dental  Ear Tubes  Ortho \_\_\_\_\_

Other: Both hips.

Social History:  Denies tobacco/alcohol/drug use

Cigarettes PPD / Quit  Smokeless Tobacco  Vape  Alcohol  Drugs  IVDU (current/former)

Primary Care Provider: \_\_\_\_\_  No PCP

Nurse Signature: Sherry R Welch APR 1-9-2020

\*\*\*\* PATIENT REQUIRES HIGHER LEVEL OF CARE \*\*\*\*

Focused assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**EXHIBIT NO. B17F  
PAGE: 16 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006461889  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 09,2020 13:19  
ATTENDING:  
-----

----- MEDICATION RECONCILIATION (SCANNED) -----  
DATE OF NOTE: JAN 9,2020@12:33 ENTRY DATE: JAN 10,2020@12:33:57  
AUTHOR: PRUITT,STANLEY EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ STANLEY PRUITT  
OFFICE ASSISTANT  
Signed: 01/10/2020 12:34

EXHIBIT NO. B17F  
PAGE: 17 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006461889  
 ADM: Jan 09, 2020 13:19

WELCH COMMUNITY HOSPITAL  
MEDICATION RECONCILIATION FORM

ADAMS, NEVAEH  
 ADM : 1/09/20 ACT# : 0006461889  
 DOB : 7/21/2015 MED# : 138580  
 SEX : F FC : E  
 SER : PDC AGE : 004Y yr  
 DR : KOBBAH.PIAYON

|                              |      |
|------------------------------|------|
| Name:                        | DOB: |
| Allergies/Describe Reaction: |      |

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER-THE-COUNTER AND HERBAL MEDS

| Name of Medication/Dose | Route/<br>Frequency | Last<br>Dose | Reason for Medication | Continue<br>on<br>Admission | Continue<br>on<br>Transfer | Continue<br>After<br>Surgery | Contin<br>on<br>Dischar |
|-------------------------|---------------------|--------------|-----------------------|-----------------------------|----------------------------|------------------------------|-------------------------|
| 1. <i>Benedryl</i>      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 2.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 3.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 4.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 5.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 6.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 7.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 8.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 9.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 10.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 11.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 12.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 13.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 14.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 15.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 16.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 17.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 18.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 19.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 20.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 21.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 22.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 23.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |
| 24.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y N                     |

## New Medications Added

| Date | Name of Medication/Dose | Route/Frequency/Duration | Reason | Provider Name |
|------|-------------------------|--------------------------|--------|---------------|
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |

## Source of Medication List

- Patient Medication List
- Patient/Family Recall
- Pharmacy:
- Primary Care Physician List
- Previous Discharge Paperwork

Reconciling Prescriber (MD/DO)

## Medication List Recorded/Reviewed by RN/MD/DO/PAT/LPN/RPH

By: *Sherry L. R. P.* Date: *1-4-2020*  
 By: \_\_\_\_\_ Date: \_\_\_\_\_  
 By: \_\_\_\_\_ Date: \_\_\_\_\_  
 By: \_\_\_\_\_ Date: \_\_\_\_\_  
 By: \_\_\_\_\_ Date: \_\_\_\_\_

Physician

Date

Physician

Date

**EXHIBIT NO. B17F  
PAGE: 18 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006461889  
ADM: Jan 09,2020 13:19

\*\*\* END \*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 19 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006461889  
ADM: Jan 09,2020 13:19

\*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

Order Date: St: Requestor: Start Date: Stop Date:  
Nature of Order: Signature:  
Item Ordered:  
=====

\*\*\* END \*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 20 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006461889  
ADM: Jan 09,2020 13:19

\*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 21 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006461889  
ADM: Jan 09,2020 13:19

\*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 22 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006461889  
ADM: Jan 09,2020 13:19

\*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*  
No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 23 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 24 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006461889  
HOSPT : WELCH COMMUNITY HOSPITAL ADM: Jan 09, 2020 13:19  
ATTENDING:  
-----

ADRs: No ADRs on file.

Allergies: PENICILLIN  
=====

\*\*\*\*NO MEDICATIONS FOUND\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

[ [ [ END ] ] ] Patient Encounter(s) History Report Sep 30, 2020@09:11

**EXHIBIT NO. B17F  
PAGE: 25 OF 152**

Patient Encounter(s) History Report Sep 30, 2020@09:13

(From: 01/22/20 --- Thru: 01/23/20)

Name : ADAMS,NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006463075  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 22,2020 12:09  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

Insomnia |  
 SNOMED-CT: Insomnia  
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Turner syndrome |  
 SNOMED-CT: Turner syndrome  
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]  
 Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Anorexia symptom |  
 SNOMED-CT: Anorexia symptom  
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G

**EXHIBIT NO. B17F  
PAGE: 26 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22,2020 12:09

-----  
Updated: 6/5/17

==== END ===

Hallucinations |  
SNOMED-CT: Hallucinations  
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:  
Status: ACTIVE  
SC Cond: UNKNOWN  
Exposure: None

Provider:  
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
Updated: 6/5/17

==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 27 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22,2020 12:09

\*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

Causative agent: PENICILLIN  
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS  
PENICILLIN-G RELATED PENICILLINS  
PENICILLINS,AMINO DERIVATIVES  
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN,MELISSA J (LICENSED PRACTICAL NURSE)  
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN,MELISSA J  
Observed/Historical: Historical  
==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 28 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22,2020 12:09

\*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 29 OF 152**

Name : ADAMS,NEVAEH H  
 DOB/SEX: JUL 21,2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006463075  
 ADM: Jan 22, 2020 12:09

\*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

----- CLINIC NOTE (FREE TEXT) -----  
 DATE OF NOTE: JAN 22,2020@13:46 ENTRY DATE: JAN 22,2020@13:46:21  
 AUTHOR: KOBBAH,PIAYON E EXP COSIGNER:  
 URGENCY: STATUS: COMPLETED

Dr. kobbah dictating a clinic note on Navaeh Adams.

Chief complaint drainage from both eyes cough and congestion.

History of present illness this is a 4-year-old female who since Sunday has had nasal and chest congestion with nonproductive cough and drainage and having the eyelids. She's had no fever. She eating and drinking well. Activity level has been normal. She has been receiving allergy medicine that includes Allegra and Benadryl with no resolution.

Past medical history Turner's syndrome.

Past surgical history she's had repair of fall white dictation of the aorta. She's also had bilateral hip surgeries.

Social history she attends preschool lives with her parents

Immunizations up-to-date.

Family history no one else is ill at home.

Medications Allegra growth hormone and Benadryl.

Allergies penicillin.

PCP Dr. kobbah

Review of systems 12 systems were reviewed and were negative except as indicated in the history of present illness.

The patient is awake alert active in no acute distress.

Physical exam temperature 97.1 pulse 112 respiration 14 blood pressure 86/61 oxygen saturation 99% on room air weight 40 pounds.

The patient is awake alert active in no acute distress.

Head atraumatic normocephalic

Neck is supple without meningismus

Throat is clear

TMs are both clear

Pupils are equal reactive to light there is crusting to both eyes legs. We'll sclera conjunctiva clear.

Chest clear to auscultation no rales no rhonchi no wheezing no retractions

**EXHIBIT NO. B17F  
PAGE: 30 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22,2020 12:09

-----  
Heart normal S1 without murmurs.

Abdomen flat soft nontender active bowel sounds no masses

Skin no rash good skin turgor moist mucous membrane she appears well hydrated well-perfused nontoxic appearing.

Assessment allergic rhinitis.

Plan saline nose drops.

Warm compresses to eyelids.

Continue Allegra.

Discontinue Benadryl.

Massage tear ducts.

Return to the pediatric clinic immediately if condition worsens.

Otherwise return for follow-up on Monday, January 30

/es/ PIAYON E KOBBAH, MD

Signed: 01/22/2020 14:01

----- PRESENTING SHEET (SCANNED) -----  
DATE OF NOTE: JAN 22,2020@12:22 ENTRY DATE: JAN 22,2020@12:22:09  
AUTHOR: COWANS,MYESHA B EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ MYESHA B COWANS  
OFFICE ASSISTANT  
Signed: 01/22/2020 12:22

**EXHIBIT NO. B17F  
PAGE: 31 OF 152**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006463075  
 ADM: Jan 22, 2020 12:09

|                                                                                                                                                             |                              |                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------|--|
| <b>RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION FORM</b>                                                                                               |                              |                          |  |
| <b>PLEASE FILL OUT TOP PORTION ONLY</b>                                                                                                                     |                              |                          |  |
| NAME: <u>Nevaeh Adams</u>                                                                                                                                   | TODAY'S DATE: <u>1/22/20</u> |                          |  |
| TIME: <u>11:48 AM</u>                                                                                                                                       | AGE: <u>4</u>                | BIRTHDAY: <u>7/21/15</u> |  |
| <b>***TO BE FILLED OUT BY HOSPITAL STAFF***</b>                                                                                                             |                              |                          |  |
| DISPOSITION: <u>WIC PEDS IM SURG OBGYN</u>                                                                                                                  |                              |                          |  |
| Registration Complaint: <u>(B) Eye Discharge</u>                                                                                                            |                              |                          |  |
| NURSE: <u>M</u>                                                                                                                                             | TIME: <u>1209</u>            |                          |  |
| <b>ADAMS, NEVAEH</b><br>ADM : 1/22/20 ACT# : 0006463075<br>MED# : 138580<br>DOB : 7/21/2015 FC : E<br>SEX : F AGE : 004 YR<br>SER : PDC DR : KOBBAH, PIAYON |                              |                          |  |

**EXHIBIT NO. B17F  
PAGE: 32 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22,2020 12:09

----- INSURANCE CARD -----  
DATE OF NOTE: JAN 22,2020@12:22 ENTRY DATE: JAN 22,2020@12:22:23  
AUTHOR: COWANS,MYESHA B EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.  
INSURANCE CARD BACK (SCANNED):

/es/ MYESHA B COWANS  
OFFICE ASSISTANT  
Signed: 01/22/2020 12:22

**EXHIBIT NO. B17F  
PAGE: 33 OF 152**

Name : ADAMS,NEVAEH H  
 DOB/SEX: JUL 21,2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

---

MRN: WEL000138580  
 ACT: WEL006463075  
 ADM: Jan 22,2020 12:09

**Eligibility Receipt**

Page 1 of 2

**Eligibility Receipt**

Eligibility Inquiry verifies whether a member was eligible for a covered program on the date(s) of service submitted in the request. This information does not guarantee eligibility or payment for the service rendered.

**Member**

|                      |                       |             |
|----------------------|-----------------------|-------------|
| Name                 | Date of Birth         | Member ID   |
| ADAMS, NEVAEH        | 7/21/2015             | 00405164305 |
| Tracking Number      | 20022W000007810       |             |
| Date of Inquiry      | 1/22/2020 12:13:44 PM |             |
| From Date of Service | 1/22/2020             |             |
| To Date of Service   | 1/22/2020             |             |
| Procedure Codes      |                       |             |
| HIPAA Category Code  |                       |             |

**Enrollments**

| Program/Benefit Name                    | Coverage Status     | Coverage Level | Plan Type | Effective Date   | Termination Date | Member ID   |
|-----------------------------------------|---------------------|----------------|-----------|------------------|------------------|-------------|
| - WV Mountain Health Trust Benefit Plan | Active              | Secondary      | Medical   | 06/01/2018       |                  | 00405164305 |
| Rate Code                               | Coverage            | Effective Date |           | Termination Date |                  |             |
| FCMGKF                                  | Categorically Needy | 06/01/2018     |           |                  |                  |             |
| FCMGKF                                  | Tier 1 Copay        | 07/01/2019     |           |                  |                  |             |

**Other Insurance**

| Plan       | Plan Type | Policy Type | Policy # | Group # | Status                              | Carrier Name | Coverage Status | Effective Date | Terminating Date |
|------------|-----------|-------------|----------|---------|-------------------------------------|--------------|-----------------|----------------|------------------|
| COB Vision | Vision    | NOPOLICY    |          | Primary | 8426 - DAVIS VISION / FASHION FOCUS | Active       |                 | 01/01/2019     |                  |

**Copay**

It is the member's responsibility to pay the copay to the provider at the time of the service. Copays are at the benefit level (individual service codes).

Beginning for claims with a Date of Service on or after January 22, 2020, copays for this member are:

| Service | Copay Amount | Effective Date | Termination Date | Tier             |
|---------|--------------|----------------|------------------|------------------|
| N/A     | \$0          | 01/22/2020     | 01/22/2020       | Member is exempt |

**PCP / Medical Home**

| Effective Date          | Termination Date                                   |
|-------------------------|----------------------------------------------------|
| PCP / Medical Home Name | UNICARE HEALTHPLAN OF WEST VIRGINIA, INC.          |
| Address                 | PO Box 91, Attn: Claims, Charleston, WV 25321-0091 |
| Office Number           | 800-782-0095                                       |
|                         | Coverage Status Active                             |

**Lock-In**

No Lock-In information found for DOS range requested.

**Spend Down**

No Spend Down information found at this time.

[CLOSE WINDOW](#) [PRINT](#)

**ADAMS, NEVAEH**  
 ACT# : 0006463075  
 ADM : 1/22/20  
 DOB : 7/21/2015  
 SEX : F  
 SER : POC  
 MED# : 138580  
 FC : E  
 AGE : 004Y YR  
 DR : KOBBAH, PIAYON

**EXHIBIT NO. B17F  
PAGE: 34 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006463075  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 22, 2020 12:09  
ATTENDING:  
-----

----- IDENTIFICATION CARD/DRIVERS LICENCE -----  
DATE OF NOTE: JAN 22,2020@12:22 ENTRY DATE: JAN 22,2020@12:22:39  
AUTHOR: COWANS,MYESHA B EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

No ID to obtain for this visit

/es/ MYESHA B COWANS  
OFFICE ASSISTANT  
Signed: 01/22/2020 12:22

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----  
DATE OF NOTE: JAN 22,2020@12:21 ENTRY DATE: JAN 22,2020@12:21:45  
AUTHOR: COWANS,MYESHA B EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ MYESHA B COWANS  
OFFICE ASSISTANT  
Signed: 01/22/2020 12:23

EXHIBIT NO. B17F  
PAGE: 35 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006463075  
 ADM: Jan 22, 2020 12:09



|                 |                     |
|-----------------|---------------------|
| ADAMS, NEVAEH   | ACT# : 0006463075   |
| ADM : 1/22/20   | MED# : 138580       |
| DOB : 7/21/2015 | FC : E              |
| SEX : F         | AGE : 004Y yr       |
| SER : PDC       | DR : KOBBAH, PIAYON |

WELCH COMMUNITY HOSPITAL  
 454 McDOWELL STREET  
 WELCH, WV 24801

## CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

*Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.*

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

**EXHIBIT NO. B17F  
PAGE: 36 OF 152**

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.
7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

|                 |                     |
|-----------------|---------------------|
| ADAMS, NEVAEH   | ACT# : 0008463075   |
| ADM : 1/22/20   | MED# : 138580       |
| DOB : 7/21/2015 | FC : E              |
| SEX : F         | AGE : 004Y yr       |
| SER : PDC       | DR : KOBBAH, PIAYON |

**EXHIBIT NO. B17F  
PAGE: 37 OF 152**

If you would like to opt out of HIV testing, please initial the line below. There may be some instances where patients are not allowed to opt out. For further information, please refer to the information sheet given to you upon registration.

Initials of patient/patient representative: JCA

8. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: KFA

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

9. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

10. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

I object to having my name, location and general condition listed in the facility directory.

|                      |                   |
|----------------------|-------------------|
| <b>ADAMS, NEVAEH</b> |                   |
| ADM : 1/22/20        | ACT# : 0006463075 |
| DOB : 7/21/2015      | MED# : 138580     |
| SEX : F              | FC : E            |
| SER : PDC            | AGE : 004Y yr     |
| DR : KOBBAH, PIAYON  |                   |

**EXHIBIT NO. B17F  
PAGE: 38 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006463075  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 22,2020 12:09  
ATTENDING:  
-----

----- MEDICATION RECONCILIATION (SCANNED) -----  
DATE OF NOTE: JAN 22,2020@11:42 ENTRY DATE: JAN 23,2020@11:42:10  
AUTHOR: HALE,DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 01/23/2020 11:42

**EXHIBIT NO. B17F**  
**PAGE: 39 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22, 2020 12:09

**WELCH COMMUNITY HOSPITAL  
MEDICATION RECONCILIATION FORM**

**ADAMS, NEVAEH**  
ADM : 1/22/20 ACT# : 0006463075  
DOB : 7/21/2015 MED# : 138580  
SEX : F FC : E  
SER : EDC AGE : 604Y yr  
DR : KOBRAH, PIAYON

| Name:                        | DOB:                | MAYO                                                                                                      |                       |                             |                            |                              |                       |  |
|------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|-----------------------|-----------------------------|----------------------------|------------------------------|-----------------------|--|
| Allergies/Describe Reaction: |                     | LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER-THE-COUNTER AND HERBAL MEDS |                       |                             |                            |                              |                       |  |
| Name of Medication/Dose      | Route/<br>Frequency | Last<br>Dose                                                                                              | Reason for Medication | Continue<br>on<br>Admission | Continue<br>on<br>Transfer | Continue<br>After<br>Surgery | Conti<br>on<br>Discha |  |
| 1. Growth Hormone            |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 2.                           |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 3.                           |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 4.                           |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 5.                           |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 6.                           |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 7.                           |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 8.                           |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 9.                           |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 10.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 11.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 12.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 13.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 14.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 15.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 16.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 17.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 18.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 19.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 20.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 21.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 22.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 23.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |
| 24.                          |                     |                                                                                                           |                       | Y N                         | Y N                        | Y N                          | Y                     |  |

- Source of Medication List**
- Patient Medication List**
- Patient/Family Recall**
- Pharmacy:**
- Primary Care Physician List**
- Previous Discharge Paperwork**
- Reconciling Prescriber (MD/DO)**

**Medication List Recorded/Reviewed by RN/MD/DO/PA/NP/LPN/RPh**

By: \_\_\_\_\_ Date: \_\_\_\_\_  
By: \_\_\_\_\_ Date: \_\_\_\_\_

**Physician** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician** \_\_\_\_\_ **Date** \_\_\_\_\_

**EXHIBIT NO. B17F  
PAGE: 40 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22,2020 12:09

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----  
DATE OF NOTE: JAN 22,2020@11:41 ENTRY DATE: JAN 23,2020@11:41:56  
AUTHOR: HALE,DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 01/23/2020 11:42

EXHIBIT NO. B17F  
PAGE: 41 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006463075  
 ADM: Jan 22, 2020 12:09

ADAMS, NEVAEH

ADM : 1/22/20 ACT# : 0006463075  
 DOB : 7/21/2015 MED# : 139580  
 SEX : F FC : E  
 SER : PDC DR : KOBBAH, PIAYON AGE : 004Y yr

RURAL HEALTH CLINIC

Name: Nevaeh Adams Age: 4 DOB: 7-21-15

Date of Arrival: \_\_\_\_\_ Time: 1201

Reason for Visit: (B) Eye discharge Matting X 4 days Sunday  
 Cough - Chest Congestion -  
 Mother has been giving bronchial Tx Allergy Meds. Not  
 Working - Cough - Nasal drainage -

ALLERGIES:  NKDA  Iodine  Latex  IV Contrast  Sulfa  PCN  Amoxicillin

Other

BP 86/60 HR 112 Temp 97.1 RR 14 Pulse Ox 99 % Ht 41 Wt 40  
 Pain (0-10) \_\_\_\_\_ Location \_\_\_\_\_ LMP \_\_\_\_\_  PREGNANT months/weeks

Medical History:  No chronic medical conditions

HTN  Hyperlipidemia  Diabetes  Heart Disease (A-fib MI CHF)  CVA / TIA  
 Seizures  Migraines  Gout  GERD  Chronic Pain \_\_\_\_\_

COPD  Asthma  Thyroid  Psych (Anxiety / Depression)  Cancer \_\_\_\_\_

Other: Turner Syndrome  Hip

Surgical History:  No Surgeries

Appendix  Gallbladder  Cardiac (Stent / Bypass)  Hysterectomy  BTx  C-section  Hernia  
 Tonsils/Adenoids  Dental  Ear Tubes  Ortho  Hip

Other: Leaking Aorta

Social History:  Denies tobacco/alcohol/drug use

Cigarettes PPD / Quit  Smokeless Tobacco  Vape  Alcohol  Drugs  IVDU (current/former)

Primary Care Provider: Kubba  No PCP

Nurse Signature: M. Willman LPN

## \*\*\*\* PATIENT REQUIRES HIGHER LEVEL OF CARE \*\*\*\*

Focused assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

\_\_\_\_\_  
 Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**EXHIBIT NO. B17F  
PAGE: 42 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22,2020 12:09

\*\*\* END \*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 43 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22,2020 12:09

\*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

Order Date: St: Requestor: Start Date: Stop Date:  
Nature of Order: Signature:  
Item Ordered:  
=====

\*\*\* END \*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 44 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22,2020 12:09

\*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 45 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22,2020 12:09

\*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 46 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006463075  
ADM: Jan 22,2020 12:09

\*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 47 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 48 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006463075  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Jan 22, 2020 12:09  
ATTENDING:  
-----

ADRs: No ADRs on file.

Allergies: PENICILLIN

=====

\*\*\*\*NO MEDICATIONS FOUND\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

[ [ [ END ] ] ] Patient Encounter(s) History Report Sep 30, 2020@09:13

**EXHIBIT NO. B17F  
PAGE: 49 OF 152**

Patient Encounter(s) History Report Sep 30, 2020@09:14

(From: 02/17/20 --- Thru: 02/18/20)

Name : ADAMS,NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006465368  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Feb 17,2020 10:40  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

Insomnia |  
 SNOMED-CT: Insomnia  
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Turner syndrome |  
 SNOMED-CT: Turner syndrome  
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]  
 Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Anorexia symptom |  
 SNOMED-CT: Anorexia symptom  
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G

**EXHIBIT NO. B17F  
PAGE: 50 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006465368  
ADM: Feb 17,2020 10:40

-----  
Updated: 6/5/17

==== END ===

Hallucinations |  
SNOMED-CT: Hallucinations  
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:  
Status: ACTIVE  
SC Cond: UNKNOWN  
Exposure: None

Provider:  
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
Updated: 6/5/17

==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 51 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006465368  
ADM: Feb 17,2020 10:40

\*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

Causative agent: PENICILLIN  
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS  
PENICILLIN-G RELATED PENICILLINS  
PENICILLINS,AMINO DERIVATIVES  
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN,MELISSA J (LICENSED PRACTICAL NURSE)  
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN,MELISSA J  
Observed/Historical: Historical  
==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 52 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006465368  
ADM: Feb 17,2020 10:40

\*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 53 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006465368  
ADM: Feb 17,2020 10:40

\*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

----- IDENTIFICATION CARD/DRIVERS LICENCE -----  
DATE OF NOTE: FEB 17,2020@12:44 ENTRY DATE: FEB 17,2020@12:44:30  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

ID Card /Drivers License attached as scanned image.  
none

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 02/17/2020 12:45

----- INSURANCE CARD -----  
DATE OF NOTE: FEB 17,2020@12:44 ENTRY DATE: FEB 17,2020@12:44:38  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.  
INSURANCE CARD BACK (SCANNED):

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 02/17/2020 12:45

**EXHIBIT NO. B17F  
PAGE: 54 OF 152**

Name : ADAMS,NEVAEH H  
 DOB/SEX: JUL 21,2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006465368  
 ADM: Feb 17, 2020 10:40

---

2608139263

Elig Inquiry Date: 02/17/2020

**Eligibility Report**

Elig Check: 02/17/2020

Print Date: 02/17/2020 12:43:16 PM

**Patient**

The patient is the subscriber or contract holder for the insurance plan.

**Primary**

Insured Number: 00405164305  
 Name: ADAMS, NEVAEH H  
 Address: PO BOX 46  
 City, State Zip: BIG SANDY, WV 24816  
 Date of Birth: 07/21/2015  
 Gender: Female  
 Insured Status: Active  
 Effective Date: 02/17/2020  
 Expire Date: 02/17/2020

**Insurance**

For Member Eligibility Verification and Claim Status inquiries, please contact the payer using the number on the back of the member's card.

Provider Number: 1134158900

**Additional Payer Information**

|                 |                              |
|-----------------|------------------------------|
| Name:           | TPL                          |
| Identifier:     | PLAN SPONSOR                 |
| Insurance Type: | C1 - Commercial              |
| Dates:          | 02/17/2020 - 02/17/2020      |
| ID Qualifier:   | MEMBER IDENTIFICATION NUMBER |
| ID:             | 235376313                    |
| PLAN BEGIN      | 01/01/2019                   |
| ID Qualifier:   | MEMBER IDENTIFICATION NUMBER |
| ID:             | 235376313                    |

**Benefits**

| Benefit                                                                          | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type | Coverage Level | Date                  | Date Qualifier |
|----------------------------------------------------------------------------------|--------|---------|--------|----------|-----------|------------|----------------|----------------|-----------------------|----------------|
| <b>HEALTH BENEFIT PLAN COVERAGE - 30</b>                                         |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                  |        |         |        |          |           |            | Medicaid       |                | 02/17/2020-02/17/2020 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY            |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                       |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                  |        |         |        |          |           |            | Medicaid       |                | 02/17/2020-02/17/2020 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY            |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES, Phone: (888)483-0793 |        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE                                                                  |        |         |        |          |           |            | Medicaid       |                | 02/17/2020-02/17/2020 | ELIGIBILITY    |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY            |        |         |        |          |           |            |                |                |                       |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES, Phone: (888)483-0797 |        |         |        |          |           |            |                |                |                       |                |

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**EXHIBIT NO. B17F  
PAGE: 55 OF 152**

2608139263

Elig Inquiry Date: 02/17/2020

**Eligibility Report**

Elig Check: 02/17/2020

Print Date: 02/17/2020 12:43:17 PM

| Benefit                  | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type                                                                                                                                             | Coverage Level | Date                  | Date Qualifier        |
|--------------------------|--------|---------|--------|----------|-----------|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------|-----------------------|
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 02/17/2020-02/17/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797  |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 02/17/2020-02/17/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793  |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 02/17/2020-02/17/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 06/01/2018            | PLAN BEGIN            |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 06/01/2018            | PLAN BEGIN            |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 06/01/2018            | PLAN BEGIN            |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793  |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 06/01/2018            | PLAN BEGIN            |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793  |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 06/01/2018            | PLAN BEGIN            |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793  |                |                       |                       |
| CO-PAYMENT               | 0.00   |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 02/17/2020-02/17/2020 | ELIGIBILITY           |
| MANAGED CARE COORDINATOR |        |         |        |          |           |            | Health Maintenance Organization (H)                                                                                                                        |                | 02/17/2020-02/17/2020 | PRIMARY CARE PROVIDER |
|                          |        |         |        |          |           |            | Entity: PLAN SPONSOR, Name: UNICARE HEALTHPLAN OF WEST VIRGINIA , Phone: (800)782-0095                                                                     |                |                       |                       |
| <b>MEDICAL CARE - 1</b>  |        |         |        |          |           |            |                                                                                                                                                            |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 02/17/2020-02/17/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 02/17/2020-02/17/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 02/17/2020-02/17/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 02/17/2020-02/17/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797  |                |                       |                       |
| ACTIVE COVERAGE          |        |         |        |          |           |            | Medicaid                                                                                                                                                   |                | 02/17/2020-02/17/2020 | ELIGIBILITY           |
|                          |        |         |        |          |           |            | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY<br>Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793  |                |                       |                       |

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**EXHIBIT NO. B17F  
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2608139263

Elig Inquiry Date: 02/17/2020

**Eligibility Report**

Elig Check: 02/17/2020

Print Date: 02/17/2020 12:43:17 PM

| Benefit                  | Amount                                                                            | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type | Coverage Level | Date                  | Date Qualifier |
|--------------------------|-----------------------------------------------------------------------------------|---------|--------|----------|-----------|------------|----------------|----------------|-----------------------|----------------|
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 02/17/2020-02/17/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |         |        |          |           |            |                |                |                       |                |
| <b>CHIROPRACTIC - 33</b> |                                                                                   |         |        |          |           |            | Medicaid       |                | 02/17/2020-02/17/2020 | ELIGIBILITY    |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            |                |                |                       |                |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 02/17/2020-02/17/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 02/17/2020-02/17/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 02/17/2020-02/17/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 02/17/2020-02/17/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 02/17/2020-02/17/2020 | ELIGIBILITY    |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |         |        |          |           |            |                |                |                       |                |
| ACTIVE COVERAGE          |                                                                                   |         |        |          |           |            | Medicaid       |                | 06/01/2018            | PLAN BEGIN     |
|                          | Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |         |        |          |           |            |                |                |                       |                |
|                          | Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |         |        |          |           |            |                |                |                       |                |

Page 3

**EXHIBIT NO. B17F  
PAGE: 57 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006465368  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Feb 17,2020 10:40  
ATTENDING:  
-----

----- PRESENTING SHEET (SCANNED) -----  
DATE OF NOTE: FEB 17,2020@12:44 ENTRY DATE: FEB 17,2020@12:44:50  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 02/17/2020 12:45

**EXHIBIT NO. B17F  
PAGE: 58 OF 152**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006465368  
 ADM: Feb 17, 2020 10:40

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|                                                                                                                                                   |                              |                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------------------|--|
| <b>RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION FORM</b>                                                                                     |                              |                           |  |
| <b>PLEASE FILL OUT TOP PORTION ONLY</b>                                                                                                           |                              |                           |  |
| NAME: <u>Nevaeh Adams</u>                                                                                                                         | TODAY'S DATE: <u>2-17-20</u> |                           |  |
| TIME: <u>10:33</u>                                                                                                                                | AGE: <u>4</u>                | BIRTHDAY: <u>07 21 15</u> |  |
| ***TO BE FILLED OUT BY HOSPITAL STAFF***                                                                                                          |                              |                           |  |
| DISPOSITION: WIC <input checked="" type="checkbox"/> PEDS <input type="checkbox"/> IM <input type="checkbox"/> SURG <input type="checkbox"/> OBGY |                              |                           |  |
| Registration Complaint: <u>Page limitation</u>                                                                                                    |                              |                           |  |
| NURSE: <u>S. Moya LPN</u>                                                                                                                         | TIME: <u>1042</u>            |                           |  |

ADAMS, NEVAEH  
 ADM: 211720  
 ACT #: 0006465368  
 MED#: 138580  
 DOB: 7/21/2015  
 FC: E  
 SEX: F  
 AGE: 004Y yr  
 SER: PDC DR: KOBBAH, PIAYON

**EXHIBIT NO. B17F  
PAGE: 59 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006465368  
ADM: Feb 17,2020 10:40

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----  
DATE OF NOTE: FEB 17,2020@12:44 ENTRY DATE: FEB 17,2020@12:45:02  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 02/17/2020 12:45

**EXHIBIT NO. B17F  
PAGE: 60 OF 152**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSPT : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006465368  
 ADM: Feb 17, 2020 10:40



|                     |                   |
|---------------------|-------------------|
| ADAMS, NEVAEH       |                   |
| ADM : 2/17/20       | ACT# : 0006465368 |
| DOB : 7/21/2015     | MED# : 138580     |
| SEX : F             | FC : E            |
| SER : PDC           | AGE : 004Y yr     |
| DR : KOBBAH, PIAYON |                   |

WELCH COMMUNITY HOSPITAL  
 454 McDOWELL STREET  
 WELCH, WV 24801

#### CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

*Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.*

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

**EXHIBIT NO. B17F  
PAGE: 61 OF 152**

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.
7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

|                 |                     |
|-----------------|---------------------|
| ADAMS, NEVAEH   | ACT# : 0006465368   |
| ADM : 2/17/20   | MED# : 139590       |
| DOB : 7/21/2015 | FC : E              |
| SEX : F         | AGE : 004Y yr       |
| SER : PDC       | DR : KOBBAH, PIAYON |

**EXHIBIT NO. B17F  
PAGE: 62 OF 152**

If you would like to opt out of HIV testing, please initial the line below. There may be some instances where patients are not allowed to opt out. For further information, please refer to the information sheet given to you upon registration.

Initials of patient/patient representative: VRA

- 8. RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: VRA

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

- 9. NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

- 10. PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

I object to having my name, location and general directory.

|                 |                     |
|-----------------|---------------------|
| ADAMS, NEVAEH   | ACT# : 0008465368   |
| ADM : 2/17/20   | MED# : 138580       |
| DOB : 2/21/2015 | FC : E              |
| SEX : F         | AGE : 004Y yr       |
| SER : PDC       | DR : KOBBAH, PIAYON |

**EXHIBIT NO. B17F  
PAGE: 63 OF 152**

Name : ADAMS,NEVAEH H  
 DOB/SEX: JUL 21,2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006465368  
 ADM: Feb 17,2020 10:40

----- CLINIC NOTE (FREE TEXT) -----  
 DATE OF NOTE: FEB 17,2020@11:31 ENTRY DATE: FEB 17,2020@11:31:23  
 AUTHOR: KOBBAH,PIAYON E EXP COSIGNER:  
 URGENCY: STATUS: COMPLETED

Dr. Kober dictating a clinic note on Naveah Adams.

Chief complaint left eye irritation.

History of present illness this is a 4-year-old female who started complaining last night of pain in her left eye. According to the parents the patient has been rubbing at left eye persistently for several weeks. I saw the patient 2 weeks ago for similar symptoms. She was placed on Claritin. She is also tearing from that eye but it doesn't appear to be photosensitive. She's had no fever. Has been no trauma. Neck is no redness to the sclera. There is no purulent drainage from the eye. She has excessive tearing from that eye.

Past medical history Turner's syndrome.

Past surgical history cardiac procedure for Coarctation of the aorta and bilateral hip surgeries.

Social history she attends preschool and lives at home with her parents

Family history no one has similar symptoms at home.

Immunizations up-to-date.

Medications she takes growth hormone monthly injections. Loratadine.

Allergies she has a sensitivity to penicillin.

PCP Dr. Kobbah

Review of systems 12 systems were reviewed and were negative except as indicated in the history of present illness.

Physical exam temperature 97.3 pulse 110 respirations 18 oxygen saturation 97% on room air weight 42 pounds

The patient is awake alert active in no acute distress.

Head atraumatic normocephalic

Neck is supple without meningismus.

Throat is clear

TMs are clear

Pupils equal reactive to light sclera and conjunctiva clear the patient does have allergic shiners with excessive tearing from the left eye. She does have bilateral red reflexes

THROAT is clear

**EXHIBIT NO. B17F  
PAGE: 64 OF 152**

Name : ADAMS,NEVAEH H  
 DOB/SEX: JUL 21,2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006465368  
 ADM: Feb 17,2020 10:40

Nasal passages edematous with clear nasal discharge

Chest clear to auscultation then no rales no rhonchi no wheezing or actions

Heart no murmurs

Skin no rash good turgor moist mucous membrane she appears well hydrated well-perfused she is nontoxic appearing.

We irrigated the patient's left eye with sterile eye solution and installed tetracaine drops to the eye. We then stained the eye with fluorescein and viewed it under Woods lamp. There was no stain uptake. The patient tolerated the procedure well. The eye was also examined on the magnification using an otoscope. There is no foreign body found.

Assessment allergic conjunctivitis.

Plan loratadine half a teaspoon daily.

Singulair 4 mg chewable tablet at bedtime.

Olopatadine 0.2% drops. Apply 1 drop to the left eye twice daily.

Return to the pediatric clinic immediately if condition worsens.

Otherwise return as needed.

/es/ PIAYON E KOBBAH, MD

Signed: 02/17/2020 11:55

----- PRESCRIPTION COPY (SCANNED) -----  
 DATE OF NOTE: FEB 17,2020@10:07 ENTRY DATE: FEB 19,2020@10:07:32  
 AUTHOR: HALE,DIANNE M EXP COSIGNER:  
 URGENCY: STATUS: COMPLETED

See attached scanned copy of Prescription(s).

/es/ DIANNE M HALE  
 OFFICE ASSISTANT  
 Signed: 02/19/2020 10:07

EXHIBIT NO. B17F  
PAGE: 65 OF 152

Name : ADAMS, NEVAEH H  
DOB / SEX : JUL 21, 2015, FEMALE  
HO SP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN : WEL000138580  
ACT: WEL006465358  
ADM: Feb 17, 2020 10:40

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>9029</b><br><b>WELCH COMMUNITY HOSPITAL</b><br><b>PIAYON E. KOBBAH, M.D.</b><br>WV, Lic#14921<br>454 McDowell St.<br>(304) 436-8461<br>DEAF BK3857248<br>Welch, WV 24801                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |
| Name <u>Nevaeh Adams</u><br>Address _____<br><small>THIS PRESCRIPTION MAY BE FILLED WITH A GENERICALLY EQUIVALENT DRUG PRODUCT UNLESS THE WORDS "BRAND NECESSARY" OR THE WORDS "BRAND MEDICALLY NECESSARY" ARE WRITTEN IN THE PRACTITIONER'S OWN HANDWRITING ON THIS PRESCRIPTION FORM.</small><br><small>PAW Printed, Welch, WV 438-8111 WCH D11</small><br>Date <u>2/17/2020</u><br><small>THIS IS A SECURITY RX</small><br>RxP <u>12345</u><br>Dose <u>1 tab</u><br>Sig <u>1 tab OS bid</u><br>Refill <u>12345</u><br><small>JULY</small><br><small>1-24    <input type="checkbox"/><br/>           25-49    <input type="checkbox"/><br/>           50-74    <input type="checkbox"/><br/>           75-100    <input type="checkbox"/><br/>           101-150    <input type="checkbox"/><br/>           151 and over    <input type="checkbox"/></small><br><small>Prescription is void if more than one (1) prescription is written per blank</small>         |  |
| <b>9028</b><br><b>WELCH COMMUNITY HOSPITAL</b><br><b>PIAYON E. KOBBAH, M.D.</b><br>WV, Lic#14921<br>454 McDowell St.<br>(304) 436-8461<br>DEAF BK3857248<br>Welch, WV 24801                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |
| Name <u>Nevaeh Adams</u><br>Address _____<br><small>THIS PRESCRIPTION MAY BE FILLED WITH A GENERICALLY EQUIVALENT DRUG PRODUCT UNLESS THE WORDS "BRAND NECESSARY" OR THE WORDS "BRAND MEDICALLY NECESSARY" ARE WRITTEN IN THE PRACTITIONER'S OWN HANDWRITING ON THIS PRESCRIPTION FORM.</small><br><small>PAW Printed, Welch, WV 438-8111 WCH D11</small><br>Date <u>2/17/2020</u><br><small>THIS IS A SECURITY RX</small><br>RxP <u>12345</u><br>Dose <u>30</u><br>Sig <u>1 tab PO qhs</u><br>Refill <u>12345</u><br><small>JULY</small><br><small>1-24    <input checked="" type="checkbox"/><br/>           25-49    <input type="checkbox"/><br/>           50-74    <input type="checkbox"/><br/>           75-100    <input type="checkbox"/><br/>           101-150    <input type="checkbox"/><br/>           151 and over    <input type="checkbox"/></small><br><small>Prescription is void if more than one (1) prescription is written per blank</small> |  |

ADAMS, NEVAEH  
 ADM : 2/17/20  
 DOB : 7/21/2015  
 SEX : F  
 SER : PDC      DR : KOBBAH, PIAYON  
 ACT# : 0006465368  
 MED# : 138580  
 FC : E  
 AGE : 004Y YI

Prescription is void if more than one (1) prescription is written per blank

**EXHIBIT NO. B17F  
PAGE: 66 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006465368  
ADM: Feb 17,2020 10:40

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----  
DATE OF NOTE: FEB 17,2020@10:06 ENTRY DATE: FEB 19,2020@10:06:30  
AUTHOR: HALE,DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 02/19/2020 10:07

EXHIBIT NO. B17F  
PAGE: 67 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006465368  
 ADM: Feb 17, 2020 10:40

## RURAL HEALTH CLINIC

**ADAMS, NEVAEH**  
 ADM: 2/17/20 ACT#: 0008465368  
 MED#: 138580  
 DOB: 7/21/2015 FC: E  
 SEX: F AGE: 004Y yr  
 SER: POC DR: KOBBAH, PIAYON

Name: Nevaeh Adams Age: 4 DOB: 7-21-15

Date of Arrival: 2-17-2020 Time: 1039

## Reason for Visit:

Eye irritation - Started last night

ALLERGIES:  NKDA  Iodine  Latex  IV Contrast  Sulfa  PCN / Amoxicillin

## Other

BP \_\_\_\_\_ HR 110 Temp 97.3 RR 18 Pulse Ox 97% Ht \_\_\_\_\_ Wt Y2lb  
 Pain (0-10) \_\_\_\_\_ Location \_\_\_\_\_ LMP \_\_\_\_\_  PREGNANT \_\_\_\_\_ months/weeks

Medical History:  No chronic medical conditions

HTN  Hyperlipidemia  Diabetes  Heart Disease (A-fib MI CHF)  CVA / TIA  
 Seizures  Migraines  Gout  GERD  Chronic Pain \_\_\_\_\_  
 COPD  Asthma  Thyroid  Psych (Anxiety / Depression)  Cancer \_\_\_\_\_

Other: Turner Syndrome

Surgical History:  No Surgeries

Appendix  Gallbladder  Cardiac (Stent / Bypass)  Hysterectomy  BTL  C-section  Hernia  
 Tonsils/Adenoids  Dental  Ear Tubes  Ortho

Other: hil hips | Medic procedure - Constipation of rectum

Social History:  Denies tobacco/alcohol/drug use

Cigarettes \_\_\_\_\_ PPD / Quit  Smokeless Tobacco  Vape  Alcohol  Drugs  IVDU (current/former)

Primary Care Provider: Kobbaah  No PCP

Nurse Signature: b. Morgan Lew

## \*\*\*\* PATIENT REQUIRES HIGHER LEVEL OF CARE \*\*\*\*

Focused assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

\_\_\_\_\_

\_\_\_\_\_

Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**EXHIBIT NO. B17F  
PAGE: 68 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006465368  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Feb 17,2020 10:40  
ATTENDING:  
-----

----- MEDICATION RECONCILIATION (SCANNED) -----  
DATE OF NOTE: FEB 17,2020@10:06 ENTRY DATE: FEB 19,2020@10:06:45  
AUTHOR: HALE,DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 02/19/2020 10:07

**EXHIBIT NO. B17F  
PAGE: 69 OF 152**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006465368  
 ADM: Feb 17, 2020 10:40

**WELCH COMMUNITY HOSPITAL  
MEDICATION RECONCILIATION FORM**

**ADAMS, NEVAEH**  
 ADM: 2/17/20 ACT#: 0006465368  
 MED#: 138580  
 DOB: 7/21/2015 FC: E  
 SEX: F AGE: 004Y yr  
 SER: PDC DR: KOBBAH, PIAYON

|       |      |
|-------|------|
| Name: | DOB: |
|-------|------|

**Allergies/Describe Reaction:**

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER-THE-COUNTER AND HERBAL MEDS

| Name of Medication/Dose | Route/<br>Frequency | Last<br>Dose | Reason for Medication | Continue<br>on<br>Admission | Continue<br>on<br>Transfer | Continue<br>After<br>Surgery | Contin<br>on<br>Dischar |
|-------------------------|---------------------|--------------|-----------------------|-----------------------------|----------------------------|------------------------------|-------------------------|
| 1. Allegra OTC          |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 2. Benadryl OTC         |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 3.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 4. Cenacitin Hormone    |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 5.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 6.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 7.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 8.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 9.                      |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 10.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 11.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 12.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 13.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 14.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 15.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 16.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 17.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 18.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 19.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 20.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 21.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 22.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 23.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |
| 24.                     |                     |              |                       | Y N                         | Y N                        | Y N                          | Y P                     |

## New Medications Added

| Date | Name of Medication/Dose | Route/Frequency/Duration | Reason | Provider Name |
|------|-------------------------|--------------------------|--------|---------------|
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |

## Source of Medication List

- Patient Medication List
- Patient/Family Recall
- Pharmacy: \_\_\_\_\_
- Primary Care Physician List
- Previous Discharge Paperwork
- Reconciling Prescriber (MD/DO)

## Medication List Recorded/Reviewed by RN/MD/DO/PA/NP/LPN/RPh

- |           |             |
|-----------|-------------|
| By: _____ | Date: _____ |

Physician

Date

Physician

Date

**EXHIBIT NO. B17F  
PAGE: 70 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006465368  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Feb 17,2020 10:40  
ATTENDING:  
-----

----- SCHOOL AND WORK EXCUSE (SCANNED) -----  
DATE OF NOTE: FEB 17,2020@10:06 ENTRY DATE: FEB 19,2020@10:07:04  
AUTHOR: HALE,DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 02/19/2020 10:07

EXHIBIT NO. B17F  
PAGE: 71 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006465368  
 ADM: Feb 17, 2020 10:40

**ADAMS, NEVAEH**  
 ADM: 2/17/20 ACT#: 0006465368 Human Resources  
 MED#: 138580 HOSPITAL  
 DOB: 7/21/2015 FC: E at or Work  
 SEX: F AGE: 004Y yr  
 SER: POC DR: KOBBAH, PIAYON

has been under

my care from 2/17/2020 to 2/23/2020

and is able to return to school or work on 2/24/2020

Limitations/Remarks:

**ORIGINAL**  
 4/2006

DrdKobbah JObesley Un.

Address 1004

Phone 434-5821 Date 2/17/2020

ADAMS, NEVAEH  
 ADM: 2/17/20 ACT#: 0006465368  
 DOB: 7/21/2015 MED#: 138580  
 SEX: F FC: E  
 SER: POC AGE: 004Y yr  
 DR: KOBBAH PIAYON

**EXHIBIT NO. B17F  
PAGE: 72 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006465368  
ADM: Feb 17,2020 10:40

\*\*\* END \*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 73 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006465368  
ADM: Feb 17,2020 10:40

\*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

Order Date: St: Requestor: Start Date: Stop Date:  
Nature of Order: Signature:  
Item Ordered:  
=====

\*\*\* END \*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 74 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006465368  
ADM: Feb 17,2020 10:40

\*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 75 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006465368  
ADM: Feb 17,2020 10:40

\*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 76 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006465368  
ADM: Feb 17,2020 10:40

\*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 77 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 78 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006465368  
HOSPT : WELCH COMMUNITY HOSPITAL ADM: Feb 17, 2020 10:40  
ATTENDING:  
-----

ADRs: No ADRs on file.

Allergies: PENICILLIN  
=====

\*\*\*\*NO MEDICATIONS FOUND\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

[ [ [ END ] ] ] Patient Encounter(s) History Report Sep 30, 2020@09:14

**EXHIBIT NO. B17F  
PAGE: 79 OF 152**

Patient Encounter(s) History Report Sep 30, 2020@09:15

(From: 09/20/20 --- Thru: 09/21/20)

Name : ADAMS,NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477503  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 20,2020 11:17  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

Insomnia |  
 SNOMED-CT: Insomnia  
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Turner syndrome |  
 SNOMED-CT: Turner syndrome  
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]  
 Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Anorexia symptom |  
 SNOMED-CT: Anorexia symptom  
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G

**EXHIBIT NO. B17F  
PAGE: 80 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006477503  
ADM: Sep 20,2020 11:17

-----  
Updated: 6/5/17

==== END ===

Hallucinations |  
SNOMED-CT: Hallucinations  
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:  
Status: ACTIVE  
SC Cond: UNKNOWN  
Exposure: None

Provider:  
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
Updated: 6/5/17

==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 81 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006477503  
ADM: Sep 20,2020 11:17

\*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

Causative agent: PENICILLIN  
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS  
PENICILLIN-G RELATED PENICILLINS  
PENICILLINS,AMINO DERIVATIVES  
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN,MELISSA J (LICENSED PRACTICAL NURSE)  
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN,MELISSA J  
Observed/Historical: Historical  
==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 82 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006477503  
ADM: Sep 20,2020 11:17

\*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 83 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006477503  
ADM: Sep 20,2020 11:17

\*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

----- CORONAVIRUS (2019-NCOV QUESTIONNAIRE (SCANNED) -----  
DATE OF NOTE: SEP 20,2020@14:04 ENTRY DATE: SEP 21,2020@14:04:12  
AUTHOR: HALE,DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Coronavirus (2019-nCoV) Questionnaire document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 09/21/2020 14:04

EXHIBIT NO. B17F  
PAGE: 84 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSPT : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477503  
 ADM: Sep 20, 2020 11:17

**Patient**  
**Novel Coronavirus Disease 2019 (COVID-19)**

**ADAMS, NEVAEH H**  
 ADM : 9/20/20 ACT #: 0006477503  
 MED# : 138580  
 DOB : 7/21/2015 FC : C  
 SEX : F AGE : 005Y yr  
 SER : WIC DR : COWANS, RODNEY

|                                              |                                |
|----------------------------------------------|--------------------------------|
| Patient Name: Nevaeh Adams                   | Patient Phone: 281-589-9295    |
| DOB: 7/21/15                                 | Date of Symptom Onset: 7/19/20 |
| Person Screening: M - Symptomatic<br>9/20/20 | County of Residence: McDowell  |

**Screening Questions****Does the individual have any signs and symptoms in the past 14 days?**

given Motrin/Tylenol

- fever  shortness of breath  a new or worsening cough  sore throat  headache  nausea  vomiting  
 diarrhea  abdominal pain  muscle aches  fatigue  runny nose  loss of taste

Other: \_\_\_\_\_

none

**AND have you traveled:**

- Out of the country in the last 14 days?  
 Out of state greater than 75 miles within the last 14 days?  
 Or to any beach or any other destination that is considered a High Alert Area by the CDC or the State of West Virginia within the last 14 days?

**OR is the individual at highest risk of poor health outcomes including any of the following? (check all that apply):**

- Over the age of 60  
 Serious underlying medical conditions\* or immunocompromised+  
 Pregnant  
 Hospitalized with severe lower respiratory illness

NX Turners Syndrome  
 Hip Dysplasia  
 Leaking Aortic Valve

**OR has the individual been in close contact with a sick person with confirmed COVID-19? (Check all that apply):**

- Living in the same household as a sick person with COVID-19  
 Caring for a sick person with COVID-19  
 Being within 6 feet of a sick person with COVID-19 for about 10 minutes  
 Being in direct contact with secretions from a sick person with COVID-19 (being coughed on, kissing, sharing utensils, etc.).

none

**OR does the individual live or work in any of the following situations? (check all that apply):**

- Any setting where healthcare services are being delivered (hospital, behavioral health facilities, long-term care facilities, corrections, etc.).  
 Public safety occupation (law enforcement, firefighter, EMS, etc.).  
 Critical infrastructure occupation (grocery stores, pharmacist, restaurants, gas stations, public utilities, etc.).

fall River Glen  
 Pre K

**Testing is recommended for anyone who is symptomatic AND is at highest risk for poor health outcomes OR is a close contact of confirmed COVID-19 OR lived or works in a high-risk situation.**Temperature 96.4  
Less than 100.0

Date collected: \_\_\_\_\_  
 Specimen type: \_\_\_\_\_  
 Lab type:  State  Commercial  Hospital

\*Underlying medical conditions include chronic lung disease, moderate to severe asthma, and serious heart conditions. People of any age with severe obesity (BMI >40) or other certain medical conditions particularly if not well controlled, such as diabetes, renal failure, or liver disease may be at risk for severe illness.

+Many conditions can cause a person to be immunocompromised, including cancer treatment, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications.

6/25/2020

**EXHIBIT NO. B17F  
PAGE: 85 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006477503  
ADM: Sep 20,2020 11:17

----- TB & CONTAGIOUS RESP ILLNESS ASSESSMENT (SCANNED) -----  
DATE OF NOTE: SEP 20,2020@14:04 ENTRY DATE: SEP 21,2020@14:04:31  
AUTHOR: HALE,DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Tuberculosis and Contagious Respiratory Illness Assessment document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 09/21/2020 14:04

**EXHIBIT NO. B17F  
PAGE: 86 OF 152**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21, 2015, FEMALE  
HOSPT : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006477503  
ADM: Sep 20, 2020 11:17

### **Tuberculosis and Contagious Respiratory Illness Assessment**

**1. Do you have any prior history of Tuberculosis (TB) or a positive TB skin test?**

Yes  No

**2. Have you had any close contact with a person(s) who has TB?**

Yes  No

**3. Have you had any close contact with a person(s) with an influenza-like illness, within the last 14 days? (Fever > 100°F and a cough or sore throat).**

Yes  No

**4. Are you experiencing or have experienced in the last 14 days, any of the following symptoms?**

Fever (> 100°F) and/or chills

Body aches

Coughing

Sore throat

None of the above

ADAMS, NEVAEH H  
ADM : 9120120 ACT# : 0006477503  
DOB : 7/21/2015 MED# : 138580  
SEX : F FC : C  
SFR : WIC DR : COWANS, RONNIE YR : 005Y

If the patient answered yes to either question #1 or #2, they are considered "positive" for symptoms suggestive of tuberculosis (TB), ensure a mask has been placed on the patient. Contact the appropriate healthcare provider for a CXR if a recent one is not available. Remove patient from other patients/visitors as much as possible. Notify the receiving department the patient is positive for suggestive TB. If the patient is to be admitted, ensure the patient is placed in Airborne Precautions. \_\_\_\_\_ Initials

If the patient answered yes to question #3, they are considered "positive" for symptoms suggestive of contagious respiratory infection, ensure a mask has been placed on the patient and notify the receiving department. Remove the patient from other patients/visitors as much as possible. If the patient is to be admitted, ensure the patient is placed in Droplet Precautions. \_\_\_\_\_ Initials

*MVP-BC* 9/20/2020

date/time:

**EXHIBIT NO. B17F  
PAGE: 87 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477503  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 20,2020 11:17  
ATTENDING:  
-----

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----  
DATE OF NOTE: SEP 20,2020@14:03 ENTRY DATE: SEP 21,2020@14:03:17  
AUTHOR: HALE,DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 09/21/2020 14:04

EXHIBIT NO. B17F  
PAGE: 88 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477503  
 ADM: Sep 20, 2020 11:17

## RURAL HEALTH CLINI

ADAMS, NEVAEH H  
 ADM: 9/20/20 ACT#: 0006477503  
 DOB: 7/21/2015 MED#: 139580  
 SEX: F FC: C  
 SER: WIC AGE: 005Yr  
 DR: COWANS, RODNEY

Name: Nevaeh Adams Age: 5  
 Date of Arrival: 9/20/2020 Time: 1145

Reason for Visit:  
Started @ 3nm sore throat w/ belly hurt  
Fever 101.5 @ home green tinge  
vomited after 4hrs melatonin  
LAST night Motrin 45 mins PTA

ALLERGIES:  NKDA  Iodine  Latex  IV Contrast  Sulfa  PCN / Amoxicillin

Other

BP 96/47 HR 125 Temp 96.4 RR 24 Pulse Ox 98 % Ht \_\_\_\_\_ Wt 47  
 Pain (0-10) \_\_\_\_\_ Location \_\_\_\_\_ LMP \_\_\_\_\_  PREGNANT months/weeks  
 LAST PPD \_\_\_\_\_ LAST TETANUS 4TP

Medical History:  No chronic medical conditions

HTN  Hyperlipidemia  Diabetes  Heart Disease (A-fib MI CHF)  CVA / TIA  
 Seizures  Migraines  Gout  GERD  Chronic Pain \_\_\_\_\_  
 COPD  Asthma  Thyroid  Psych (Anxiety / Depression)  Cancer \_\_\_\_\_

Other: Turner syndrome, Hip Dysplasia, Aortic Valve,

Surgical History:  No Surgeries

Appendix  Gallbladder  Cardiac (Stent / Bypass)  Hysterectomy  BTx  C-section  Hernia  
 Tonsils/Adenoids  Dental  Ear Tubes  Ortho \_\_\_\_\_

Other: HIPs

Social History:  Denies tobacco/alcohol/drug use

Cigarettes PPD / Quit  Smokeless Tobacco  Vape  Alcohol  Drugs  IVDU (current/former)

Primary Care Provider: Kobbs L  No PCP

Nurse Signature: An FND-BL

## \*\*\*\* PATIENT REQUIRES HIGHER LEVEL OF CARE \*\*\*\*

Focused assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

\_\_\_\_\_  
 Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**EXHIBIT NO. B17F  
PAGE: 89 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477503  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 20,2020 11:17  
ATTENDING:  
-----

----- MEDICATION RECONCILIATION (SCANNED) -----  
DATE OF NOTE: SEP 20,2020@14:03 ENTRY DATE: SEP 21,2020@14:03:38  
AUTHOR: HALE,DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 09/21/2020 14:04

EXHIBIT NO. B17F  
PAGE: 90 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477503  
 ADM: Sep 20, 2020 11:17

WELCH COMMUNITY HOSPITAL  
MEDICATION RECONCILIATION FORM

ADAMS, NEVAEH H  
 ADM: 9/20/2020  
 ACT# : 0006477503  
 MED# : 138580  
 DOB: 7/21/2015  
 FC : C  
 SEX: F  
 AGE : 005Yr  
 SER: WIC DR: COWANS, RODNEY

Name: DOB:

Allergies/Describe Reaction: Amoxi

LIST BELOW ALL OF THE PATIENT'S MEDICATIONS PRIOR TO ADMISSION INCLUDING OVER-THE-COUNTER AND HERBAL MEDS

| Name of Medication/Dose | Route/<br>Frequency | Last<br>Dose | Reason for Medication | Continue<br>on<br>Admission | Continue<br>on<br>Transfer | Continue<br>After<br>Surgery | Conti<br>on<br>Discha |
|-------------------------|---------------------|--------------|-----------------------|-----------------------------|----------------------------|------------------------------|-----------------------|
| 1. Cetow Un hormone     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 2.                      |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 3.                      |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 4.                      |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 5.                      |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 6.                      |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 7.                      |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 8.                      |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 9.                      |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 10.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 11.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 12.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 13.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 14.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 15.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 16.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 17.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 18.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 19.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 20.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 21.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 22.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 23.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |
| 24.                     |                     |              |                       | Y                           | N                          | Y                            | N                     |

New Medications Added

| Date | Name of Medication/Dose | Route/Frequency/Duration | Reason | Provider Name |
|------|-------------------------|--------------------------|--------|---------------|
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |
|      |                         |                          |        |               |

## Source of Medication List

- Patient Medication List
- Patient/Family Recall
- Pharmacy:
- Primary Care Physician List
- Previous Discharge Paperwork
- Reconciling Prescriber (MD/DO)

## Medication List Recorded/Reviewed by RN/MD/DO/PA/NP/LPN/RPh

By: *[Signature]* Date: 9/20/2020  
 By: \_\_\_\_\_ Date: \_\_\_\_\_  
 By: \_\_\_\_\_ Date: \_\_\_\_\_  
 By: \_\_\_\_\_ Date: \_\_\_\_\_  
 By: \_\_\_\_\_ Date: \_\_\_\_\_

Physician

Date

Physician

Date

**EXHIBIT NO. B17F  
PAGE: 91 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477503  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 20,2020 11:17  
ATTENDING:  
-----

----- PRESCRIPTION COPY (SCANNED) -----  
DATE OF NOTE: SEP 20,2020@14:03 ENTRY DATE: SEP 21,2020@14:03:55  
AUTHOR: HALE,DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned copy of Prescription(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 09/21/2020 14:04

EXHIBIT NO. B17F  
PAGE: 92 OF 152

Name : ADAMS, NEVAEH H  
 DOB / SEX : JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN : WEL000138580  
 ACT : WEL006477503  
 ADM : Sep 20, 2020 11:17

ADAMS, NEVAEH H  
 ADM: 8/20/20  
 DOB: 7/21/2015 ACT#: 0008477503  
 SEX: F MED#: 138580  
 SFR: WIC FC: C  
 DR: COWANS RUMNEY AGE: 005Y yr

**49843 WELCH COMMUNITY HOSPITAL**  
 Supervisor: Rodney H. Cowans, MD Julietta Sisso, PA-C  
 WV Lic#: 454 McDowell St., Welch, WV 24801 NPI# 1306883921  
 Exp: (304) 436-8461 DEA# MS2130716

Name: Nevaeh Adams Date: 9-20-20  
 Address:   
 FAX Printing, Welch, WV 304-436-8111-WCH D17  
 THIS PRESCRIPTION MAY BE FILLED WITH A GENERIALLY EQUIVALENT DRUG PRODUCT UNLESS THE WORDS "BRAND NECESSARY" OR THE WORDS "THIRDS NEUTRALALLY RECOMMENDED" ARE WRITTEN IN THE PRESCRIBER'S OWN HANDWRITING ON THIS PRESCRIPTION FORM.  
 THIS IS A SECURITY RX

Cefdinir 250 mg/5 ml  
 Sig: 3 ml PO q6h x 10 days  
 drg 60 ml  
 Refill NR 1 2 3 4 5

1-24  
 25-49  
 50-74  
 75-100  
 101-150  
 151 and over

*[Handwritten signature]*

Prescription is void if more than one (1) prescription is written per blank

**EXHIBIT NO. B17F  
PAGE: 93 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477503  
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ATTENDING:  
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----- CLINIC NOTE (SCANNED) -----  
DATE OF NOTE: SEP 20,2020@14:02 ENTRY DATE: SEP 21,2020@14:02:58  
AUTHOR: HALE,DIANNE M EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Clinic Note(s).

/es/ DIANNE M HALE  
OFFICE ASSISTANT  
Signed: 09/21/2020 14:04

EXHIBIT NO. B17F  
PAGE: 94 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
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 ADM: Sep 20, 2020 11:17

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                  |                                              |                                                                  |                      |  |                                                                                                                                                                                                                                     |  |                                                                                                         |  |                                                                                                                                                                                                                                                                      |  |                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------|------------------------------------------------------------------|----------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 14      Welch Community Hospital RHC<br>URGENT CARE RECORD<br>•Pediatric Illness•                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                  |                                              |                                                                  |                      |  |                                                                                                                                                                                                                                     |  |                                                                                                         |  |                                                                                                                                                                                                                                                                      |  |                                                                                             |  |
| DATE: 9-20-20 TIME: 1134 ROOM: WIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                  |                                              |                                                                  |                      |  |                                                                                                                                                                                                                                     |  |                                                                                                         |  |                                                                                                                                                                                                                                                                      |  |                                                                                             |  |
| <b>HISTORIAN:</b> patient parent caregiver _____<br><b>MODE OF ARRIVAL:</b> ambulatory other _____<br><b>chief complaint:</b> fever cough / congested fussy pulling ears<br>not eating less active vomiting diarrhea rash Ingestion<br><i>SO reflexes</i> earaches<br><i>vomiting</i><br><i>diarrhea</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                  |                                              |                                                                  |                      |  |                                                                                                                                                                                                                                     |  |                                                                                                         |  |                                                                                                                                                                                                                                                                      |  |                                                                                             |  |
| <b>HPI</b><br><table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">onset / duration: _____ min / hrs / days ago</td> <td style="width: 50%;">continues in clinic<br/>gone now / better<br/>intermittent / worse</td> </tr> <tr> <td colspan="2"><i>early this AM</i></td> </tr> <tr> <td colspan="2"> <b>context:</b> sick contacts home school other<br/> <i>Tylenol @ 5 AM</i><br/> <i>Motrin - an hour ago</i><br/> <i>4x vomiting</i><br/> <i>2x diarrhea = #30 loose, watery</i><br/> <i>Refused COVID testing, Lab work</i><br/> <i>→ X-ray</i> </td> </tr> <tr> <td colspan="2"> <b>severity:</b> fever to _____ °F / °C oral rectal axillary TM<br/>   not measured - subjective none noted         </td> </tr> <tr> <td colspan="2"> <b>associated symptoms:</b><br/>   acting differently<br/> <i>fussy crying more not sleeping less active inconsolable</i><br/> <i>drinking eating less</i><br/> <i>not drinking fast feeding / liquids</i><br/> <i>decreased urination fast urinated</i><br/> <i>sleeping more</i> </td> </tr> <tr> <td colspan="2"> <i>Similar symptoms previously</i><br/> <i>Recently seen/treated by doctor / hospitalized</i> </td> </tr> </table> |                                                                  | onset / duration: _____ min / hrs / days ago | continues in clinic<br>gone now / better<br>intermittent / worse | <i>early this AM</i> |  | <b>context:</b> sick contacts home school other<br><i>Tylenol @ 5 AM</i><br><i>Motrin - an hour ago</i><br><i>4x vomiting</i><br><i>2x diarrhea = #30 loose, watery</i><br><i>Refused COVID testing, Lab work</i><br><i>→ X-ray</i> |  | <b>severity:</b> fever to _____ °F / °C oral rectal axillary TM<br>not measured - subjective none noted |  | <b>associated symptoms:</b><br>acting differently<br><i>fussy crying more not sleeping less active inconsolable</i><br><i>drinking eating less</i><br><i>not drinking fast feeding / liquids</i><br><i>decreased urination fast urinated</i><br><i>sleeping more</i> |  | <i>Similar symptoms previously</i><br><i>Recently seen/treated by doctor / hospitalized</i> |  |
| onset / duration: _____ min / hrs / days ago                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | continues in clinic<br>gone now / better<br>intermittent / worse |                                              |                                                                  |                      |  |                                                                                                                                                                                                                                     |  |                                                                                                         |  |                                                                                                                                                                                                                                                                      |  |                                                                                             |  |
| <i>early this AM</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                  |                                              |                                                                  |                      |  |                                                                                                                                                                                                                                     |  |                                                                                                         |  |                                                                                                                                                                                                                                                                      |  |                                                                                             |  |
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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ADAMS, NEVAEH H</b><br>ADM: 9/20/20 ACT#: 0006477503 MED#: 138580<br>DOB: 7/21/2015 FC: C SEX: F AGE: 005Y yr SFR: WIC DR: COWANS, RONNIE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                    |
| <b>ROS</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"> <b>ENT</b><br/> <i>pulling at ears R/L</i><br/> <i>tubby nose</i><br/> <i>sore throat / mouth</i><br/> <b>EYES</b><br/> <i>red eyes / discharge</i><br/> <b>RESPIRATORY</b><br/> <i>cough</i><br/> <i>trouble breathing</i><br/> <b>GI</b><br/> <i>vomiting / diarrhea</i><br/> <i>abdominal distention</i><br/> <i>blood in stools</i><br/> <b>GU</b><br/> <i>painful / swollen genital area</i><br/> <i>problems urinating</i><br/> <b>LYMPH</b><br/> <i>swollen glands</i><br/> <b>PSYCH</b><br/> <i>anxiety / depression</i> </td> <td style="width: 50%;"> <b>CVS</b><br/> <i>palpitations</i><br/> <b>NEURO</b><br/> <i>seizure</i><br/> <b>MS</b><br/> <i>extremity pain / swelling</i><br/> <b>SKIN</b><br/> <i>rash</i><br/> <i>facial trunk extremities diffuse</i><br/> <i>diaper rash</i><br/> <b>Other</b><br/> <i>none</i> </td> </tr> </table> |                                                                                                                                                                                                                                                    | <b>ENT</b><br><i>pulling at ears R/L</i><br><i>tubby nose</i><br><i>sore throat / mouth</i><br><b>EYES</b><br><i>red eyes / discharge</i><br><b>RESPIRATORY</b><br><i>cough</i><br><i>trouble breathing</i><br><b>GI</b><br><i>vomiting / diarrhea</i><br><i>abdominal distention</i><br><i>blood in stools</i><br><b>GU</b><br><i>painful / swollen genital area</i><br><i>problems urinating</i><br><b>LYMPH</b><br><i>swollen glands</i><br><b>PSYCH</b><br><i>anxiety / depression</i> | <b>CVS</b><br><i>palpitations</i><br><b>NEURO</b><br><i>seizure</i><br><b>MS</b><br><i>extremity pain / swelling</i><br><b>SKIN</b><br><i>rash</i><br><i>facial trunk extremities diffuse</i><br><i>diaper rash</i><br><b>Other</b><br><i>none</i> |
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| <input type="checkbox"/> except as marked positive, all systems above reviewed and found negative                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                    |
| <b>• CONST components also addressed in HPI</b><br>reviewed and updated: Past Hx Family Hx Social Hx<br>Location: in chart Date:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                    |
| <b>PAST HX</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"> <b>Birth HX</b><br/> <i>birth wt</i><br/> <i>complications at birth</i><br/> <i>premature birth _____ wks</i><br/> <i>diabetes Type I insulin</i><br/> <i>asthma</i><br/> <i>bronchitis / bronchiolitis</i><br/> <i>cardiac problems</i><br/> <i>congenital heart disease</i><br/> <i>development delay</i> </td> <td style="width: 50%;"> <i>ear infection(s)</i><br/> <i>febrile seizure</i><br/> <i>pharyngitis</i><br/> <i>pneumonia</i><br/> <i>seizure disorder</i><br/> <i>sickle cell disease</i><br/> <i>urinary tract infection(s)</i> </td> </tr> </table>                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                    | <b>Birth HX</b><br><i>birth wt</i><br><i>complications at birth</i><br><i>premature birth _____ wks</i><br><i>diabetes Type I insulin</i><br><i>asthma</i><br><i>bronchitis / bronchiolitis</i><br><i>cardiac problems</i><br><i>congenital heart disease</i><br><i>development delay</i>                                                                                                                                                                                                  | <i>ear infection(s)</i><br><i>febrile seizure</i><br><i>pharyngitis</i><br><i>pneumonia</i><br><i>seizure disorder</i><br><i>sickle cell disease</i><br><i>urinary tract infection(s)</i>                                                          |
| <b>Birth HX</b><br><i>birth wt</i><br><i>complications at birth</i><br><i>premature birth _____ wks</i><br><i>diabetes Type I insulin</i><br><i>asthma</i><br><i>bronchitis / bronchiolitis</i><br><i>cardiac problems</i><br><i>congenital heart disease</i><br><i>development delay</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <i>ear infection(s)</i><br><i>febrile seizure</i><br><i>pharyngitis</i><br><i>pneumonia</i><br><i>seizure disorder</i><br><i>sickle cell disease</i><br><i>urinary tract infection(s)</i>                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                    |
| <i>Turner syndrome, Hypothyroidism, and the VWD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                    |
| <b>Surgeries / Procedures</b> none<br>VP shunt <i>hyp</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                    |
| <b>Immunizations:</b> UTD / referred to PCP<br><b>Medications:</b> none see nurses note <b>Allergies:</b> NKDA<br>aspirin ibuprofen acetaminophen see nurses note last dose <i>Anix</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                    |
| <b>SOCIAL HX</b> smoker / 2 <sup>nd</sup> hand exposure<br>alcohol (recent / occasional) drugs<br>attends daycare / school caretaker / foster care<br><b>FAMILY HX</b> adopted                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                    |

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Rev. 09 / 16

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| <b>PHYSICAL EXAM</b>                                          |                                               |
|---------------------------------------------------------------|-----------------------------------------------|
| <b>General Appearance</b>                                     |                                               |
| <input checked="" type="checkbox"/> no acute distress         | mild / moderate / severe distress             |
| <input checked="" type="checkbox"/> active / playful / smiles | fussy / crying / cries on exam / irritable    |
| <input checked="" type="checkbox"/> attentiveness nml         | lethargic / weak cry                          |
| <input checked="" type="checkbox"/> good eye contact          |                                               |
| <input checked="" type="checkbox"/> sleeping/easily aroused   |                                               |
| <b>*INFANTS:</b>                                              |                                               |
| <input checked="" type="checkbox"/> nml consolability         | poor consolability / poor intake suck         |
| <input checked="" type="checkbox"/> nml feeding / suck        | poor muscle tone                              |
| <input checked="" type="checkbox"/> flat anter. fontanel      | closed / bulging / sunken anter. fontanel     |
| <b>HEENT</b>                                                  |                                               |
| <input checked="" type="checkbox"/> conjunct. & lids nml      | tenderness / swelling                         |
| <input checked="" type="checkbox"/> PERL                      | conjunctival injection                        |
| <input checked="" type="checkbox"/> ears nml                  | EOM palsy / anisocoria / conjunctival exudate |
| <input checked="" type="checkbox"/> nose nml                  | sunken eyes / photophobia                     |
| <input checked="" type="checkbox"/> pharynx nml               | TM erythema / dullness (R / L) <i>mild</i>    |
| <input checked="" type="checkbox"/> moist mucous membranes    | loss of TM landmarks (R / L)                  |
| <b>NECK</b>                                                   |                                               |
| <input checked="" type="checkbox"/> supple                    | TM obscured by wax (R / L)                    |
| <input checked="" type="checkbox"/> no masses                 | rhinorrhea / purulent nasal drainage          |
| <b>RESPIRATORY</b>                                            |                                               |
| <input checked="" type="checkbox"/> no resp. distress         | pharyngeal erythema / tonsilar exudate        |
| <input checked="" type="checkbox"/> breath sounds nml         | ulcerations / vesicles                        |
| <b>CVS</b>                                                    |                                               |
| <input checked="" type="checkbox"/> reg. rate & rhythm        | drooling / trismus / mass                     |
| <input checked="" type="checkbox"/> heart sounds nml          | dry mucous membranes                          |
| <input checked="" type="checkbox"/> strong periph pulses      | meningismus / Brudzinski / Kernig's           |
| <input checked="" type="checkbox"/> nml capillary refill      | lymphadenopathy                               |
| <b>ABDOMEN</b>                                                |                                               |
| <input checked="" type="checkbox"/> non-tender                | respiratory distress                          |
| <input checked="" type="checkbox"/> no distension             | retractions / accessory muscle use            |
| <input checked="" type="checkbox"/> no organomegaly           | prolonged expirations                         |
| <b>GENITALIA</b>                                              |                                               |
| <input checked="" type="checkbox"/> nml inspection            | decreased air movement                        |
| <input checked="" type="checkbox"/> circumcised (male)        | grunting (infants)                            |
| <input checked="" type="checkbox"/> uncircumcised (male)      | stridor                                       |
| <b>EXTREMITIES</b>                                            |                                               |
| <input checked="" type="checkbox"/> non-tender                | wheezes / rales / rhonchi                     |
| <input checked="" type="checkbox"/> nml ROM                   | murmur grade ___/6 sys / dias                 |
| <b>SKIN</b>                                                   |                                               |
| <input checked="" type="checkbox"/> no rash / lesions         | peripheral pulses weak / thready              |
| <input checked="" type="checkbox"/> no petechiae              | slow cap refill sec                           |
| <input checked="" type="checkbox"/> normal color              |                                               |
| <input checked="" type="checkbox"/> warm, dry                 |                                               |
| <b>NEURO</b>                                                  |                                               |
| <input checked="" type="checkbox"/> sensation nml             | tenderness / guarding / rebound               |
| <input checked="" type="checkbox"/> motor nml                 | hepatomegaly / splenomegaly / mass            |
| <input checked="" type="checkbox"/> CN's nml (2-10)           | abnml bowel sounds                            |
| <input checked="" type="checkbox"/> mood / affect nml         |                                               |
| <b>ADDITIONAL NOTES</b>                                       |                                               |
| <i>Mother refused lab work<br/>&amp; COVID testing.</i>       |                                               |

Pediatric Illness - 14     Reportable Measure

**ADAMS, NEVAEH H**  
ADM : 9/20/20 ACT# : 0008477503  
MED# : 138580  
DOB : 7/21/2015 FC : C  
SEX : F AGE : 005Y yr  
SER : WIC DR : COWANS, RODNEY

**LABS & XRAYS**CBC \_\_\_\_\_ UA \_\_\_\_\_  
BMP \_\_\_\_\_ Preg \_\_\_\_\_XRAYS  Interp. by me  Viewed by me  Discsd w/ radiologistCXR  
nml / NAD no infiltrates nml heart size nml mediastinum

Other

**PROCEDURES**

LP discussed risks, benefits, alternatives; parent/guardian consents.  
Time: \_\_\_\_\_ fluid color: \_\_\_\_\_ RBC: \_\_\_\_\_ WBC: \_\_\_\_\_  
betadine prep glucose: \_\_\_\_\_ polys: \_\_\_\_\_ lymph: \_\_\_\_\_  
L3-4 L4-5 protein: \_\_\_\_\_ monos: \_\_\_\_\_ gm/stn: \_\_\_\_\_

**PROGRESS**

Time: \_\_\_\_\_ unchanged improved re-examined

*ETC A1B > Negative*

Sputum

Pharyngitis 3-18y / strep A test / antibiotic

URI - 3m-18y / No antibiotic

measure exclusions: refused / not indicated / indicated / contraindicated / not available / dispensed

**CLINICAL IMPRESSION**

|                                   |                             |
|-----------------------------------|-----------------------------|
| Fever                             | Meningitis                  |
| Vomiting / Diarrhea               | Otis Media - R-L            |
| Dehydration                       | Pharyngitis - Strep / Mono  |
| Asthma / Reactive Airway Disease  | Pneumonia (location)        |
| acute exacerb. status asthmaticus | Sepsis / SIRS - severe      |
| Bronchitis / Bronchiolitis - RSV  | Septic Shock                |
| Croup                             | Sinusitis                   |
| Gastroenteritis / Enteritis       | Upper Respiratory Infection |
| Hypoxemia                         | UTI / Pyelonephritis        |
| Ingestion                         | Viral Syndrome              |
| Influenza seasonal H1N1           |                             |

*Vocal gastroenteritis*

**TREATMENT PLAN / DISCHARGE MEDICATION**

*OTC tylenol  
Zofran @ home*

Discussed with Dr. \_\_\_\_\_  
will see patient in office / clinic / hospitalized  
C counseled patient / family regarding \_\_\_\_\_  
lab results diagnosis need for follow-up smoking / drug / alcohol cessation  
for only concern

Time spent/counseling: \_\_\_\_\_ minutes Admit orders written: \_\_\_\_\_

DISPOSITION:  home  admit  transfer *12/16*

DISPO TIME: *6/1 E.R.*

FOLLOW-UP:  PCP  return to clinic *if getting worse*

CONDITION:  unchanged  improved  stable

total face-to-face time: \_\_\_\_\_ minutes

I have reviewed the chart and agree with the documentation as recorded by the MLP, including the assessment, treatment plan, and disposition.  
 I personally evaluated and examined the patient in conjunction with the MLP and agree with the management and disposition of the patient.

*RJH NP PA  
MD DO  
Template Complete  
advised to give am fibox if diarrhea  
is better*

CONSISTENT © 1996 - 2016 T-System, Inc.

**EXHIBIT NO. B17F  
PAGE: 96 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006477503  
ADM: Sep 20,2020 11:17

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----  
DATE OF NOTE: SEP 20,2020@13:52 ENTRY DATE: SEP 20,2020@13:52:06  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 09/20/2020 13:52

EXHIBIT NO. B17F  
PAGE: 97 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477503  
 ADM: Sep 20, 2020 11:17



|                 |                     |
|-----------------|---------------------|
| ADAMS, NEVAEH H |                     |
| ADM : 9/20/20   | ACT# : 0006477503   |
| MED# : 138580   |                     |
| DOB : 7/21/2015 | FC : C              |
| SEX : F         | AGE : 005Y yr       |
| SER : WIC       | DR : COWANS, RODNEY |

WELCH COMMUNITY HOSPITAL  
 454 McDowell Street  
 WELCH, WV 24801

## CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

*Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.*

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct; if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

EXHIBIT NO. B17F  
PAGE: 98 OF 152

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.
7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

EXHIBIT NO. B17F  
PAGE: 99 OF 152

If you would like to opt out of HIV testing, please initial the line below. There may be some instances where patients are not allowed to opt out. For further information, please refer to the information sheet given to you upon registration.

Initials of patient/patient representative: \_\_\_\_\_



8. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: \_\_\_\_\_



I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

9. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.
10. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

I object to having my name, location and general condition listed in the facility directory.

**EXHIBIT NO. B17F  
PAGE: 100 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477503  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 20,2020 11:17  
ATTENDING:  
-----

----- IDENTIFICATION CARD/DRIVERS LICENCE -----  
DATE OF NOTE: SEP 20,2020@13:51 ENTRY DATE: SEP 20,2020@13:51:07  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

ID Card /Drivers License attached as scanned image.  
none

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 09/20/2020 13:52

----- INSURANCE CARD -----  
DATE OF NOTE: SEP 20,2020@13:51 ENTRY DATE: SEP 20,2020@13:51:16  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.  
INSURANCE CARD BACK (SCANNED):

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 09/20/2020 13:52

**EXHIBIT NO. B17F  
PAGE: 101 OF 152**

Name : ADAMS,NEVAEH H  
 DOB/SEX: JUL 21,2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:  
 -----

MRN: WEL000138580  
 ACT: WEL006477503  
 ADM: Sep 20,2020 11:17

2727917231

Elig Inquiry Date: 09/20/2020

**Eligibility Report**

Elig Check: 09/20/2020

Print Date: 09/20/2020 11:24:58 AM

**Patient**

The patient is the subscriber or contract holder for the insurance plan.

**Primary**

Insured Number: 00405164305  
 Name: ADAMS, NEVAEH H  
 Address: PO BOX 46  
 City, State Zip: BIG SANDY, WV 24816  
 Date of Birth: 07/21/2015  
 Gender: Female  
 Insured Status: Active  
 Effective Date: 09/20/2020  
 Expire Date: 09/20/2020

**Insurance**

For Member Eligibility Verification and Claim Status inquiries, please contact the payer using the number on the back of the member's card.

Provider Number: 1134158900

**Additional Payer Information**

Name: TPL  
 Identifier: PLAN SPONSOR  
 Insurance Type: C1 - Commercial  
 Dates:  
 ELIGIBILITY 09/20/2020 - 09/20/2020  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: H18015644  
 PLAN BEGIN 11/01/2019  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: H18015644

**Payer Information Contacts**  
 2040 - HEALTH PLAN OF UPPER OHIO VALLEY

Name: TPL  
 Identifier: PLAN SPONSOR  
 Insurance Type: C1 - Commercial  
 Dates:  
 ELIGIBILITY 09/20/2020 - 09/20/2020  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: H1801564406  
 PLAN BEGIN 11/01/2019  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: H1801564406

**Payer Information Contacts**  
 2040 - HEALTH PLAN OF UPPER OHIO VALLEY

**Payer Information Contacts**  
 7846 - EXPRESS SCRIPTS

Page 1

**EXHIBIT NO. B17F  
PAGE: 102 OF 152**

2727917231

Elig Inquiry Date: 09/20/2020

## Eligibility Report

Elig Check: 09/20/2020

Print Date: 09/20/2020 11:24:59 AM

Name:  
Identifier:

TPL  
PLAN SPONSOR

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**EXHIBIT NO. B17F  
PAGE: 103 OF 152**

2727917231

Elig Inquiry Date: 09/20/2020

**Eligibility Report**

Elig Check: 09/20/2020

Print Date: 09/20/2020 11:24:59 AM

Insurance Type: C1 - Commercial  
 Dates:  
 ELIGIBILITY 09/20/2020 - 09/20/2020  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: H18015644  
 PLAN BEGIN 11/01/2019  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: H18015644

|                 |                              |                                     |
|-----------------|------------------------------|-------------------------------------|
| Name:           | TPL                          | Payer Information Contacts          |
| Identifier:     | PLAN SPONSOR                 | 8426 - DAVIS VISION / FASHION FOCUS |
| Insurance Type: | C1 - Commercial              |                                     |
| Dates:          |                              |                                     |
| ELIGIBILITY     | 09/20/2020 - 09/20/2020      |                                     |
| ID Qualifier:   | MEMBER IDENTIFICATION NUMBER |                                     |
| ID:             | 235376313                    |                                     |
| PLAN BEGIN      | 01/01/2019                   |                                     |
| ID Qualifier:   | MEMBER IDENTIFICATION NUMBER |                                     |
| ID:             | 235376313                    |                                     |

**Benefits**

| Benefit                                                                           | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type | Coverage Level        | Date        | Date Qualifier |
|-----------------------------------------------------------------------------------|--------|---------|--------|----------|-----------|------------|----------------|-----------------------|-------------|----------------|
| <b>HEALTH BENEFIT PLAN COVERAGE - 30</b>                                          |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 09/20/2020-09/20/2020 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 09/20/2020-09/20/2020 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 09/20/2020-09/20/2020 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICALLY             |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 09/20/2020-09/20/2020 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 09/20/2020-09/20/2020 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                       |             |                |

Page 3

**EXHIBIT NO. B17F  
PAGE: 104 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477503  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 20,2020 11:17  
ATTENDING:  
-----

----- PRESENTING SHEET (SCANNED) -----  
DATE OF NOTE: SEP 20,2020@13:51 ENTRY DATE: SEP 20,2020@13:51:34  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 09/20/2020 13:52

**EXHIBIT NO. B17F  
PAGE: 105 OF 152**

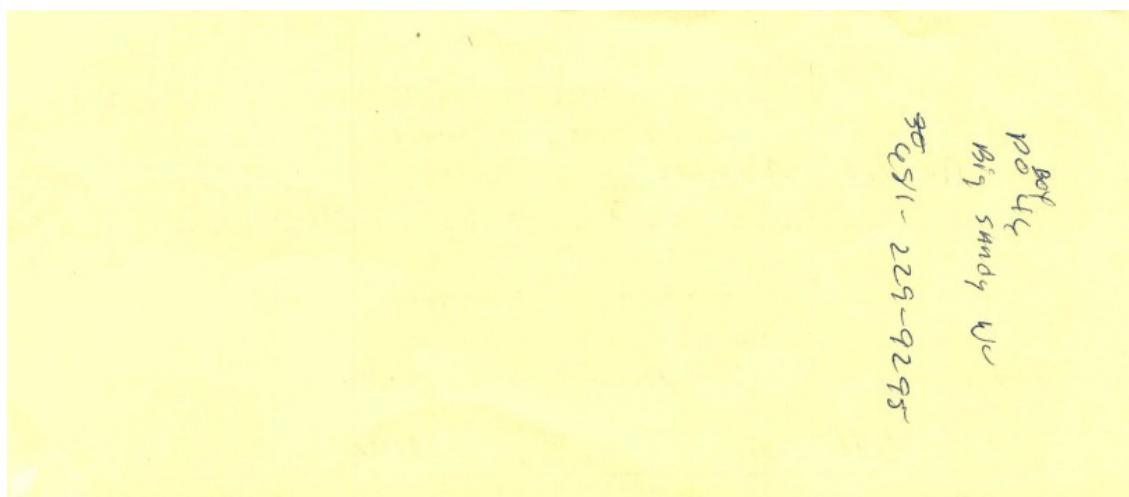
Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477503  
 ADM: Sep 20, 2020 11:17

---

|                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------|
| <b><u>RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION FORM</u></b>                                                                                                                                                                                                                                                                                                                                                     |                     |                          |
| PLEASE FILL OUT TOP PORTION ONLY                                                                                                                                                                                                                                                                                                                                                                                         |                     |                          |
| NAME: <u>Nevaeh Adams</u>                                                                                                                                                                                                                                                                                                                                                                                                | TODAY'S DATE: _____ |                          |
| TIME: _____                                                                                                                                                                                                                                                                                                                                                                                                              | AGE: <u>3</u>       | BIRTHDAY: <u>7/21/15</u> |
| ***TO BE FILLED OUT BY HOSPITAL STAFF***<br>DISPOSITION: WIC PEDS IM SURG OBGYN<br>Registration Complaint: <u>Sore throat Belly Ach.</u>                                                                                                                                                                                                                                                                                 |                     |                          |
| <div style="border: 1px solid black; padding: 2px; display: inline-block;">           ADAMS, NEVAEH H<br/>           ADM: 9/20/20<br/>           DOB: 7/21/2015<br/>           SEX: F<br/>           SER: WIC         </div> <div style="margin-left: 20px;">           ACT# : 0006477503<br/>           MED# : 138580<br/>           FC: C<br/>           AGE: 005Y YR<br/>           DR: COWANS, RODNEY         </div> |                     |                          |
| NURSE: <u>61C</u>                                                                                                                                                                                                                                                                                                                                                                                                        | TIME: _____         | <u>1145-</u>             |

**EXHIBIT NO. B17F  
PAGE: 106 OF 152**



**EXHIBIT NO. B17F  
PAGE: 107 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477503  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 20,2020 11:17  
ATTENDING:  
-----

----- PRIVACY NOTICE (SCANNED) -----  
DATE OF NOTE: SEP 20,2020@13:51 ENTRY DATE: SEP 20,2020@13:51:49  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Privacy notice attached as scanned document.

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 09/20/2020 13:52

**EXHIBIT NO. B17F  
PAGE: 108 OF 152**

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477503  
 ADM: Sep 20, 2020 11:17

**Bureau for Behavioral Health and Health Facilities (BBHHF)/  
WELCH COMMUNITY HOSPITAL**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE  
AND DISCLOSE FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS PURPOSES**

**PATIENT/RESIDENT**

|                      |                     |                   |
|----------------------|---------------------|-------------------|
| Name: _____          | ADAMS, NEVAEH H     |                   |
|                      | ADM : 9/20/20       | ACT# : 0006477503 |
| Date of Birth: _____ | DOB : 7/21/2015     | MED# : 138580     |
|                      | SEX : F             | FC : C            |
|                      | SER : WIC           | AGE : 005Y yr     |
|                      | DR : COWANS, RODNEY |                   |

I hereby consent for the BBHHF/Welch Community Hospital to use and disclose my protected health information for treatment, payment and health care operations purposes. These purposes are described, and examples of each purpose are given, in the BBHHF/Welch Community Hospital's attached Notice of Privacy Rights. This also acknowledges that I have received a copy of the BBHHF/Welch Community Hospital Notice of Privacy Practices. This consent does not apply to protected health information for psychotherapy notes and marketing purposes, where an authorization is required under 45 CFR § 164.508. I retain the right to request restrictions on how and to whom the protected health information may be released, although the BBHHF/Welch Community Hospital does not have to accept my restrictions.

A person or organization that receives my information because of this consent may have the legal right to disclose this information to other people or organizations without my knowledge or consent.

The Welch Community Hospital values your privacy of information. However, in the unlikely incidence that a breach or inappropriate access or use of your information occurs, we wish to contact you most expeditiously based on your preferred method of contact.

- US Mail
- By Telephone
- By Email

If this authorization is signed by someone who is not the patient/resident listed at the top of this form, provide a description of the signer's authority to act for the patient.

Type of Authority: \_\_\_\_\_

Documentation Provided: \_\_\_\_\_ Yes \_\_\_\_\_ No

Signature: LTS

Date: 9-20-2020

Witness: \_\_\_\_\_

Witness: J. Walker

Disposition: To be filed in the patient's medical record. May also be filed with the Privacy Official.

**EXHIBIT NO. B17F  
PAGE: 109 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

\*\*\* END \*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 110 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477503  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 20,2020 11:17  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

Order Date: St: Requestor: Start Date: Stop Date:  
 Nature of Order: Signature:  
 Item Ordered:  
 =====

09/20/20 12:01:26 c SISON,JULIETA B 09/20/20 12:01 09/20/20 12:01  
 ELECTRONICALLY ENTERED ON CHART w/written orders

Treating Specialty:

Ordering Location: RHC WALK IN CLINIC

- Activity:
- 09/20/2020 12:01 New Order entered by HARMON,KRISTIN N (LICENSED PRACTI)
- Order Text: FLU B-WEL NP WASH NASOPHARYNX WC
- Nature of Order: ELECTRONICALLY ENTERED
- Ordered by: SISON,JULIETA B (PHYSICIAN ASSIS)
- 

09/20/20 12:01:18 c SISON,JULIETA B 09/20/20 12:01 09/20/20 12:01  
 ELECTRONICALLY ENTERED ON CHART w/written orders

Treating Specialty:

Ordering Location: RHC WALK IN CLINIC

- Activity:
- 09/20/2020 12:01 New Order entered by HARMON,KRISTIN N (LICENSED PRACTI)
- Order Text: FLU A-WEL NP WASH NASOPHARYNX WC
- Nature of Order: ELECTRONICALLY ENTERED
- Ordered by: SISON,JULIETA B (PHYSICIAN ASSIS)
- 

09/20/20 12:01:06 c SISON,JULIETA B 09/20/20 12:00 09/20/20 12:01  
 ELECTRONICALLY ENTERED ON CHART w/written orders

Treating Specialty:

Ordering Location: RHC WALK IN CLINIC

- Activity:
- 09/20/2020 12:01 New Order entered by HARMON,KRISTIN N (LICENSED PRACTI)
- Order Text: STREP SCREEN GROUP A-WEL SWAB-TH PHARYNX WC
- Nature of Order: ELECTRONICALLY ENTERED
- Ordered by: SISON,JULIETA B (PHYSICIAN ASSIS)
- 

\*\*\* END \*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 111 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477503  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 20,2020 11:17  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

Report Released Date/Time: Sep 20, 2020@12:01  
 Provider: SISON,JULIETA B  
 Specimen: NASOPHARYNX. WHEM 0920 17  
 Specimen Collection Date: Sep 20, 2020@12:01

| Test name | Res      | Result Flg units | Ref. | range | Site | Result Dt/Time |
|-----------|----------|------------------|------|-------|------|----------------|
| FLU B-WEL | NEGATIVE |                  |      |       | [68] | 09/20/20 12:01 |

Performing Lab Sites  
 [68] WEL  
 454 McDOWELL STREET WELCH, WV 24801  
 ----- END -----

Report Released Date/Time: Sep 20, 2020@12:01  
 Provider: SISON,JULIETA B  
 Specimen: NASOPHARYNX. WHEM 0920 16  
 Specimen Collection Date: Sep 20, 2020@12:01

| Test name | Res      | Result Flg units | Ref. | range | Site | Result Dt/Time |
|-----------|----------|------------------|------|-------|------|----------------|
| FLU A-WEL | NEGATIVE |                  |      |       | [68] | 09/20/20 12:01 |

Performing Lab Sites  
 [68] WEL  
 454 McDOWELL STREET WELCH, WV 24801  
 ----- END -----

Report Released Date/Time: Sep 20, 2020@12:01  
 Provider: SISON,JULIETA B  
 Specimen: PHARYNX. WHEM 0920 15  
 Specimen Collection Date: Sep 20, 2020@12:00

| Test name | Res      | Result Flg units | Ref. | range | Site | Result Dt/Time |
|-----------|----------|------------------|------|-------|------|----------------|
| STREP W   | NEGATIVE |                  |      |       | [68] | 09/20/20 12:01 |

Performing Lab Sites  
 [68] WEL  
 454 McDOWELL STREET WELCH, WV 24801  
 ----- END -----

\*\*\* END \*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 112 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006477503  
ADM: Sep 20,2020 11:17

\*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 113 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006477503  
ADM: Sep 20,2020 11:17

\*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 114 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 115 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

ADRs: No ADRs on file.

Allergies: PENICILLIN  
=====

\*\*\*\*NO MEDICATIONS FOUND\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

[ [ [ END ] ] ] Patient Encounter(s) History Report Sep 30, 2020@09:15

**EXHIBIT NO. B17F  
PAGE: 116 OF 152**

Patient Encounter(s) History Report Sep 30, 2020@09:16

(From: 09/25/20 --- Thru: 09/26/20)

Name : ADAMS,NEVAEH H MRN: WEL000138580  
 DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477912  
 HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 25,2020 13:46  
 ATTENDING:  
 -----

\*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

Insomnia |  
 SNOMED-CT: Insomnia  
 Primary ICD-9-CM: Z73.819 [BEHAVIORAL INSOMNIA OF CHILDHOOD, UNSPECIFIED TYPE]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Turner syndrome |  
 SNOMED-CT: Turner syndrome  
 Primary ICD-9-CM: Q96.4 [MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME]  
 Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
 Updated: 6/5/17

==== END ===

Anorexia symptom |  
 SNOMED-CT: Anorexia symptom  
 Primary ICD-9-CM: R63.0 [ANOREXIA]

Onset:  
 Status: ACTIVE  
 SC Cond: UNKNOWN  
 Exposure: None

Provider:  
 Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
 Entered: 6/5/17, by HAMPTON,CHARLOTTE G

**EXHIBIT NO. B17F  
PAGE: 117 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

-----

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25,2020 13:46

Updated: 6/5/17

==== END ===

Hallucinations |  
SNOMED-CT: Hallucinations  
Primary ICD-9-CM: R44.3 [HALLUCINATIONS, UNSPECIFIED]

Onset:  
Status: ACTIVE  
SC Cond: UNKNOWN  
Exposure: None

Provider:  
Clinic:

Recorded: , by HAMPTON,CHARLOTTE G  
Entered: 6/5/17, by HAMPTON,CHARLOTTE G  
Updated: 6/5/17

==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL PROBLEM LIST SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 118 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25,2020 13:46

\*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

Causative agent: PENICILLIN  
Nature of Reaction: Allergy

Signs/symptoms: RASH (4/9/16@12:53)

Drug Classes: (INACTIVE) PENICILLINS  
PENICILLIN-G RELATED PENICILLINS  
PENICILLINS,AMINO DERIVATIVES  
(INACTIVE) PENICILLIN G-RELATED PENICILLINS

Originator: WELLMAN,MELISSA J (LICENSED PRACTICAL NURSE)  
Originated: Apr 09, 2016@12:53:56

Verified: WELLMAN,MELISSA J  
Observed/Historical: Historical  
==== END ===

\*\*\* END \*\*\*\*\* CONFIDENTIAL ALLERGIES/ADVERSE REACTIONS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 119 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25,2020 13:46

\*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*  
\*\*\* END \*\*\*\*\* CONFIDENTIAL VITALS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 120 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25,2020 13:46

\*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

----- PRESENTING SHEET (SCANNED) -----  
DATE OF NOTE: SEP 25,2020@14:20 ENTRY DATE: SEP 25,2020@14:20:07  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached Presenting Sheet document(s).

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 09/25/2020 14:20

EXHIBIT NO. B17F  
PAGE: 121 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477912  
 ADM: Sep 25, 2020 13:46

**RURAL HEALTH CLINIC (WALK IN CLINIC) REGISTRATION FORM**

**PLEASE FILL OUT TOP PORTION ONLY**

NAME: Nevaeh Adams TODAY'S DATE: 9-25-20  
 TIME: \_\_\_\_\_ AGE: 5 BIRTHDAY: 7-21-15

|                                      |                     |
|--------------------------------------|---------------------|
| ADAMS, NEVAEH H                      | ACT# : 0006477912   |
| ADM : 9/25/20                        | MED# : 138580       |
| DOB : 7/21/2015                      | FC : C              |
| SEX : F                              | AGE : 005Y yr       |
| SER : PDC                            | DR : KOBBAH, PIAYON |
| Other Complaint: <u>Immunization</u> |                     |

**\*\*TO BE FILLED OUT BY HOSPITAL STAFF\*\*\***

SPOSITION: WIC  PEDS  IM  SURG  OBGYN

NURSE: M. Carter, LPN TIME: 13:45

**EXHIBIT NO. B17F  
PAGE: 122 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477912  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 25,2020 13:46  
ATTENDING:  
-----

----- AUTHORIZATION FOR MEDICAL TREATMENT (SCANNED) -----  
DATE OF NOTE: SEP 25,2020@14:20 ENTRY DATE: SEP 25,2020@14:20:20  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Scanned document attached.

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 09/25/2020 14:20

EXHIBIT NO. B17F  
PAGE: 123 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477912  
 ADM: Sep 25, 2020 13:46



|                 |                     |
|-----------------|---------------------|
| ADAMS, NEVAEH H | ACT# : 0006477912   |
| ADM : 9/25/20   | MED# : 138580       |
| DOB : 7/21/2015 | FC : C              |
| SEX : F         | AGE : 005Y yr       |
| SER : PDC       | DR : KOBBAH, PIAYON |

WELCH COMMUNITY HOSPITAL  
 454 McDOWELL STREET  
 WELCH, WV 24801

## CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

*Please read carefully and sign the necessary authorization, releases and agreements so that we may proceed with the care and treatment ordered by your physicians.*

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s), and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
2. **MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
3. **PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct, if I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master, if any account is referred to an attorney or collection agency for collection. I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be

EXHIBIT NO. B17F  
PAGE: 124 OF 152

deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
6. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.
7. **INFECTION CONTROL CONSENT:** To protect against possible transmission of bloodborne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital, if for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employees blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

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PAGE: 125 OF 152

If you would like to opt out of HIV testing, please initial the line below. There may be some instances where patients are not allowed to opt out. For further information, please refer to the information sheet given to you upon registration.

Initials of patient/patient representative: KH



- 8. RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS/OTHER HEALTH CARE PROVIDERS:** I understand that: Most or all of the healthcare providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PAs), Nurse Practitioners (NPs), and Certified Registered Nurse Anesthetists (C.R.N.A.s) are independent contractors and are not employee, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

Initials of patient/patient representative: KH



I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

- 9. NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

- 10. PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

I object to having my name, location and general condition listed in the facility directory.

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PAGE: 126 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477912  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 25,2020 13:46  
ATTENDING:  
-----

----- IDENTIFICATION CARD/DRIVERS LICENCE -----  
DATE OF NOTE: SEP 25,2020@14:19 ENTRY DATE: SEP 25,2020@14:19:47  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

ID Card /Drivers License attached as scanned image.  
none

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 09/25/2020 14:20

----- INSURANCE CARD -----  
DATE OF NOTE: SEP 25,2020@14:19 ENTRY DATE: SEP 25,2020@14:19:54  
AUTHOR: WALKER,JENNIFER R EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

Insurance Card attached as scanned image.  
INSURANCE CARD BACK (SCANNED):

/es/ JENNIFER R WALKER  
OFFICE ASSISTANT  
Signed: 09/25/2020 14:20

**EXHIBIT NO. B17F  
PAGE: 127 OF 152**

Name : ADAMS, NEVAEH H  
DOB/SEX: JUL 21, 2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25, 2020 13:46



[www.healthplan.org](http://www.healthplan.org)

PayerCompass

**EXHIBIT NO. B17F  
PAGE: 128 OF 152**

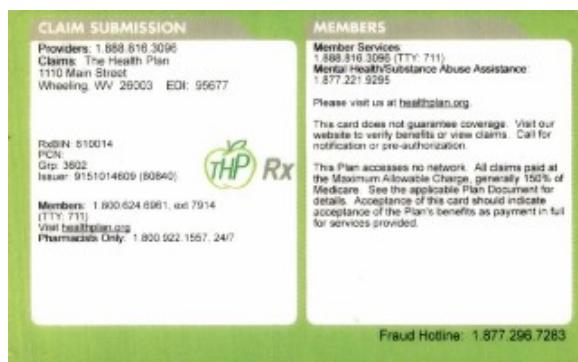


EXHIBIT NO. B17F  
PAGE: 129 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477912  
 ADM: Sep 25, 2020 13:46

| UNAUTHORIZED USE IS A FRAUDULENT PRACTICE AND WILL BE PROSECUTED TO THE FULLEST EXTENT OF THE LAW |                |            |
|---------------------------------------------------------------------------------------------------|----------------|------------|
| West Virginia Medical ID Card                                                                     |                |            |
| MA ID                                                                                             | Member Name    | Birth Date |
| 00405209776                                                                                       | KYRA B ADAMS   | 07/16/2016 |
| 00405164305                                                                                       | NEVAEH H ADAMS | 07/21/2015 |
| 00403605747                                                                                       | HAILEY DANIELS | 05/04/2010 |
| 00202691194                                                                                       | NORMA ADAMS    | 03/03/2008 |
| 00600285620                                                                                       | KELLI ADAMS    | 04/02/1991 |

This card does not guarantee coverage. Verify coverage at [www.wvmmis.com](http://www.wvmmis.com) or 888-483-0793. Prior Authorization may be required for certain services.

For more information about Medicaid services, co-payments for certain services, Non-Emergency Medical Transportation (NEMT) for scheduled medical appointments and treatments, and more see 'Your Guide to Medicaid' at [www.dhhr.wv.gov/tms](http://www.dhhr.wv.gov/tms).

If you have questions about your Medicaid eligibility, call Client Services at 800-642-8509 or 304-558-2400; hearing impaired 304-558-3515.

If you have questions about Managed Care Organizations (MCO), call 800-419-8466. If you are enrolled in Managed Care, you will also receive an MCO card that must be taken to your healthcare provider. Questions about services or billing should be directed to the MCO you are enrolled in.

If you are not in Managed Care and have questions about services or billing, call Member Services at 888-483-0797.

For more information about NEMT, please contact the broker at 844-549-8353.

Case: 4016414547

Date: 04/04/19

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**EXHIBIT NO. B17F  
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**EXHIBIT NO. B17F  
PAGE: 131 OF 152**

Name : ADAMS,NEVAEH H  
 DOB/SEX: JUL 21,2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477912  
 ADM: Sep 25,2020 13:46

---

2731778752

Elig Inquiry Date: 09/25/2020

**Eligibility Report**

Elig Check: 09/25/2020

Print Date: 09/25/2020 02:19:41 PM

**Patient**

The patient is the subscriber or contract holder for the insurance plan.

**Primary**

Insured Number: 00405164305  
 Name: ADAMS, NEVAEH H  
 Address: PO BOX 46  
 City, State Zip: BIG SANDY, WV 24816  
 Date of Birth: 07/21/2015  
 Gender: Female  
 Insured Status: Active  
 Effective Date: 09/25/2020  
 Expire Date: 09/25/2020

**Insurance**

For Member Eligibility Verification and Claim Status inquiries, please contact the payer using the number on the back of the member's card.

Provider Number: 1134158900

**Additional Payer Information**

Name: TPL  
 Identifier: PLAN SPONSOR  
 Insurance Type: C1 - Commercial  
 Dates:  
 ELIGIBILITY 09/25/2020 - 09/25/2020  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: H18015644  
 PLAN BEGIN 11/01/2019  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: H18015644

**Payer Information Contacts**  
 2040 - HEALTH PLAN OF UPPER OHIO VALLEY

Name: TPL  
 Identifier: PLAN SPONSOR  
 Insurance Type: C1 - Commercial  
 Dates:  
 ELIGIBILITY 09/25/2020 - 09/25/2020  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: H1801564406  
 PLAN BEGIN 11/01/2019  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: H1801564406

**Payer Information Contacts**  
 2040 - HEALTH PLAN OF UPPER OHIO VALLEY

**Payer Information Contacts**  
 7846 - EXPRESS SCRIPTS

Page 1

**EXHIBIT NO. B17F  
PAGE: 132 OF 152**

2731778752

Elig Inquiry Date: 09/25/2020

## Eligibility Report

Elig Check: 09/25/2020

Print Date: 09/25/2020 02:19:41 PM

Name:  
Identifier:

TPL  
PLAN SPONSOR

Page 2

**EXHIBIT NO. B17F  
PAGE: 133 OF 152**

2731778752

Elig Inquiry Date: 09/25/2020

**Eligibility Report**

Elig Check: 09/25/2020

Print Date: 09/25/2020 02:19:41 PM

Insurance Type: C1 - Commercial  
 Dates: 09/25/2020 - 09/25/2020  
 ELIGIBILITY MEMBER IDENTIFICATION NUMBER  
 ID Qualifier: H18015644  
 ID: H18015644  
 PLAN BEGIN 11/01/2019  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: H18015644

Name: TPL Payer Information Contacts  
 Identifier: PLAN SPONSOR 8426 - DAVIS VISION / FASHION FOCUS  
 Insurance Type: C1 - Commercial  
 Dates: 09/25/2020 - 09/25/2020  
 ELIGIBILITY MEMBER IDENTIFICATION NUMBER  
 ID Qualifier: 235376313  
 ID: 235376313  
 PLAN BEGIN 01/01/2019  
 ID Qualifier: MEMBER IDENTIFICATION NUMBER  
 ID: 235376313

**Benefits**

| Benefit                                                                           | Amount | Percent | Period | Quantity | Qualifier | In-Network | Insurance Type | Coverage Level        | Date        | Date Qualifier |
|-----------------------------------------------------------------------------------|--------|---------|--------|----------|-----------|------------|----------------|-----------------------|-------------|----------------|
| <b>HEALTH BENEFIT PLAN COVERAGE - 30</b>                                          |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 09/25/2020-09/25/2020 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICAL               |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES                        |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 09/25/2020-09/25/2020 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICAL               |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 09/25/2020-09/25/2020 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-CATEGORICAL               |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 09/25/2020-09/25/2020 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0797 |        |         |        |          |           |            |                |                       |             |                |
| ACTIVE COVERAGE                                                                   |        |         |        |          |           | Medicaid   |                | 09/25/2020-09/25/2020 | ELIGIBILITY |                |
| Plan Description: WV MOUNTAIN HEALTH TRUST BENEFIT PLAN-TIER 1 COPAY              |        |         |        |          |           |            |                |                       |             |                |
| Entity: PLAN SPONSOR, Name: WV BUREAU FOR MEDICAL SERVICES , Phone: (888)483-0793 |        |         |        |          |           |            |                |                       |             |                |

Page 3

**EXHIBIT NO. B17F  
PAGE: 134 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25,2020 13:46

----- CORONAVIRUS (2019-NCOV QUESTIONNAIRE (SCANNED) -----  
DATE OF NOTE: SEP 25,2020@12:26 ENTRY DATE: SEP 28,2020@12:26:45  
AUTHOR: PRUITT,STANLEY EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Coronavirus (2019-nCoV) Questionnaire document(s).

/es/ STANLEY PRUITT  
OFFICE ASSISTANT  
Signed: 09/28/2020 12:27

EXHIBIT NO. B17F  
PAGE: 135 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSPT : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477912  
 ADM: Sep 25, 2020 13:46

|                                                     |                                                                                                                                   |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| <b>ADAMS, NEVAEH H</b>                              |                                                                                                                                   |
| Patient                                             | ADM : 9/25/20 ACT# : 0006477912<br>DOB : 7/21/2015 MED# : 138580<br>SEX : F FC : C<br>AGE : 005Y yr SER : PDC DR : KOBBAH, PIAYON |
| <b>Novel Coronavirus Disease 2019 (COVID-19) S.</b> |                                                                                                                                   |

|                                     |                                        |
|-------------------------------------|----------------------------------------|
| Patient Name: <i>Nevaeh Adams</i>   | Patient Phone: <i>304-681-229-9295</i> |
| DOB: <i>7/21/15</i>                 | Date of Symptom Onset:                 |
| Person Screening: <i>n1 Symptom</i> | County of Residence: <i>McDowell</i>   |
| <i>9/25/20</i>                      |                                        |

| <b>Screening Questions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Does the individual have any signs and symptoms in the past 14 days?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| <input type="checkbox"/> fever <input type="checkbox"/> shortness of breath <input type="checkbox"/> a new or worsening cough <input type="checkbox"/> sore throat <input type="checkbox"/> headache <input type="checkbox"/> nausea <input type="checkbox"/> vomiting<br><input type="checkbox"/> diarrhea <input type="checkbox"/> abdominal pain <input type="checkbox"/> muscle aches <input type="checkbox"/> fatigue <input type="checkbox"/> runny nose <input type="checkbox"/> loss of taste <i>none</i><br>Other : _____ |  |
| <b>AND have you traveled:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| <input type="checkbox"/> Out of the country in the last 14 days? <i>none</i><br><input type="checkbox"/> Out of state greater than 75 miles within the last 14 days?<br><input type="checkbox"/> Or to any beach or any other destination that is considered a High Alert Area by the CDC or the State of West Virginia within the last 14 days?                                                                                                                                                                                   |  |
| <b>OR is the individual at highest risk of poor health outcomes including any of the following? (check all that apply):</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| <input type="checkbox"/> Over the age of 60<br><input type="checkbox"/> Serious underlying medical conditions* or immunocompromised+ <i>none</i><br><input type="checkbox"/> Pregnant<br><input type="checkbox"/> Hospitalized with severe lower respiratory illness                                                                                                                                                                                                                                                               |  |
| <b>OR has the individual been in close contact with a sick person with confirmed COVID-19? (Check all that apply):</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| <input type="checkbox"/> Living in the same household as a sick person with COVID-19 <i>none</i><br><input type="checkbox"/> Caring for a sick person with COVID-19<br><input type="checkbox"/> Being within 6 feet of a sick person with COVID-19 for about 10 minutes<br><input type="checkbox"/> Being in direct contact with secretions from a sick person with COVID-19 (being coughed on, kissing, sharing utensils, etc.).                                                                                                  |  |
| <b>OR does the individual live or work in any of the following situations? (check all that apply):</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| <input type="checkbox"/> Any setting where healthcare services are being delivered (hospital, behavioral health facilities, long-term care facilities, corrections, etc.). <i>none</i><br><input type="checkbox"/> Public safety occupation (law enforcement, firefighter, EMS, etc.)<br><input type="checkbox"/> Critical infrastructure occupation (grocery stores, pharmacist, restaurants, gas stations, public utilities, etc.).                                                                                              |  |
| <b>Testing is recommended for anyone who is symptomatic AND is at highest risk for poor health outcomes OR is a close contact of confirmed COVID-19 OR lived or works in a high-risk situation.</b>                                                                                                                                                                                                                                                                                                                                |  |

Temperature *97*  
 Less than 100.0

Date collected: \_\_\_\_\_  
 Specimen type: \_\_\_\_\_  
 Lab type:  State  Commercial  Hospital

\*Underlying medical conditions include chronic lung disease, moderate to severe asthma, and serious heart conditions. People of any age with severe obesity (BMI >40) or other certain medical conditions particularly if not well controlled, such as diabetes, renal failure, or liver disease may be at risk for severe illness.

+Many conditions can cause a person to be immunocompromised, including cancer treatment, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications.

**EXHIBIT NO. B17F  
PAGE: 136 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477912  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 25,2020 13:46  
ATTENDING:  
-----

----- TB & CONTAGIOUS RESP ILLNESS ASSESSMENT (SCANNED) -----  
DATE OF NOTE: SEP 25,2020@12:25 ENTRY DATE: SEP 28,2020@12:25:48  
AUTHOR: PRUITT,STANLEY EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Tuberculosis and Contagious Respiratory Illness Assessment document(s).

/es/ STANLEY PRUITT  
OFFICE ASSISTANT  
Signed: 09/28/2020 12:26

EXHIBIT NO. B17F  
PAGE: 137 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477912  
 ADM: Sep 25, 2020 13:46

**Tuberculosis and Contagious Respiratory Illness Assessment****1. Do you have any prior history of Tuberculosis (TB) or a positive TB skin test?**

Yes  No

**2. Have you had any close contact with a person(s) who has TB?**

Yes  No

**3. Have you had any close contact with a person(s) with an influenza-like illness, within the last 14 days? (Fever > 100°F and a cough or sore throat).**

Yes  No

**4. Are you experiencing or have experienced in the last 14 days, any of the following symptoms?**

Fever (> 100°F) and/or chills

Body aches

ADAMS, NEVAEH H ACT# : 0006477912

ADM : 9/25/20 MED# : 138580

Coughing

DOB : 7/21/2015 FC : C

Sore throat

SEX : F AGE : 005Y yr

None of the above SER : PDC DR : KOBBAH, PIAYON

If the patient answered yes to either question #1 or #2, they are considered "positive" for symptoms suggestive of tuberculosis (TB), ensure a mask has been placed on the patient. Contact the appropriate healthcare provider for a CXR if a recent one is not available. Remove patient from other patients/visitors as much as possible. Notify the receiving department the patient is positive for suggestive TB. If the patient is to be admitted, ensure the patient is placed in Airborne Precautions. \_\_\_\_\_ Initials

If the patient answered yes to question #3, they are considered "positive" for symptoms suggestive of contagious respiratory infection, ensure a mask has been placed on the patient and notify the receiving department. Remove the patient from other patients/visitors as much as possible. If the patient is to be admitted, ensure the patient is placed in Droplet Precautions. \_\_\_\_\_ Initials

Signature: Nealey Carliza date/time: 9-25-2020

**EXHIBIT NO. B17F  
PAGE: 138 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477912  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 25,2020 13:46  
ATTENDING:  
-----

----- MEDICATION RECONCILIATION (SCANNED) -----  
DATE OF NOTE: SEP 25,2020@12:21 ENTRY DATE: SEP 28,2020@12:21:36  
AUTHOR: PRUITT,STANLEY EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Medication Reconciliation document(s).

/es/ STANLEY PRUITT  
OFFICE ASSISTANT  
Signed: 09/28/2020 12:22

**EXHIBIT NO. B17F**  
**PAGE: 139 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25, 2020 13:46

**WELCH COMMUNITY HOSPITAL  
MEDICATION RECONCILIATION FORM**

ADAMS, NEVAEH H

ADM : 9/25/20

ACT#:0006477912

MED# 13858n

FC

FC : C  
AGE : 005Y

**Source of Medication Use**

- Patient Medication List
  - Patient/Family Recall
  - Pharmacy: \_\_\_\_\_
  - Primary Care Physician List
  - Previous Discharge Paperwork
  - Reconciling Prescriber (MD/DO)

Medication List Recorded/Reviewed by RN/MD/DO/PA/NP/LPN/RP

By: \_\_\_\_\_ Date: 4/25  
By: \_\_\_\_\_  
By: \_\_\_\_\_  
By: \_\_\_\_\_  
By: \_\_\_\_\_  
By: \_\_\_\_\_

---

Physician

Date

---

**Physician**

Balte

**EXHIBIT NO. B17F  
PAGE: 140 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477912  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 25,2020 13:46  
ATTENDING:  
-----

----- RURAL HEALTH CLINIC ASSESSMENT (SCANNED) -----  
DATE OF NOTE: SEP 25,2020@12:20 ENTRY DATE: SEP 28,2020@12:20:52  
AUTHOR: PRUITT,STANLEY EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Rural Health Clinic Assessment document(s).

/es/ STANLEY PRUITT  
OFFICE ASSISTANT  
Signed: 09/28/2020 12:21

EXHIBIT NO. B17F  
PAGE: 141 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSPT : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477912  
 ADM: Sep 25, 2020 13:46

ADAMS, NEVAEH H  
 ADM: 9/25/20 ACT#: 0006477912  
 MED#: 138580  
 DOB: 7/21/2015 FC: C  
 SEX: F AGE: 005Y yr  
 SER: PDC DR: KOBBAH, PIAYON

## RURAL HEALTH CLINIC

Name: Nevaeh Adams Age: 5 DOB: 7-21-15

Date of Arrival: \_\_\_\_\_ Time: 13:33

Reason for Visit:

Immunization

ALLERGIES:  NKDA  Iodine  Latex  IV Contrast  Sulfa  PCN / Amoxicillin

Other \_\_\_\_\_

BP 120/62 HR 99 Temp 98.2 RR 24 Pulse Ox 99% Ht 40 Wt 45  
 Pain (0-10) \_\_\_\_\_ Location \_\_\_\_\_ LMP \_\_\_\_\_  PREGNANT \_\_\_\_\_ months/weeks

Medical History:  No chronic medical conditions

HTN  Hyperlipidemia  Diabetes  Heart Disease (A-fib MI CHF)  CVA / TIA  
 Seizures  Migraines  Gout  GERD  Chronic Pain \_\_\_\_\_  
 COPD  Asthma  Thyroid  Psych (Anxiety / Depression)  Cancer \_\_\_\_\_

Other: \_\_\_\_\_

Surgical History:  No Surgeries

Appendix  Gallbladder  Cardiac (Stent / Bypass)  Hysterectomy  BTx  C-section  Hernia  
 Tonsils/Adenoids  Dental  Ear Tubes  Ortho bif bld

Other: \_\_\_\_\_

Social History:  Denies tobacco/alcohol/drug use

Cigarettes PPD / Quit  Smokeless Tobacco  Vape  Alcohol  Drugs  IVDU (current/former)

Primary Care Provider: Kobban  No PCP

Nurse Signature: Melly Carter LPN

\*\*\*\* PATIENT REQUIRES HIGHER LEVEL OF CARE \*\*\*\*

Focused assessment completed by Qualified Medical Provider, recommended that patient go to emergency department for evaluation for the following reasons:

Medical Provider: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**EXHIBIT NO. B17F  
PAGE: 142 OF 152**

Name : ADAMS,NEVAEH H MRN: WEL000138580  
DOB/SEX: JUL 21,2015, FEMALE ACT: WEL006477912  
HOSP : WELCH COMMUNITY HOSPITAL ADM: Sep 25,2020 13:46  
ATTENDING:  
-----

----- VACCINE RECORD (SCANNED) -----  
DATE OF NOTE: AUG 9,2018@12:22 ENTRY DATE: SEP 28,2020@12:23:11  
AUTHOR: PRUITT,STANLEY EXP COSIGNER:  
URGENCY: STATUS: COMPLETED

See attached scanned Vaccine Record document(s).

/es/ STANLEY PRUITT  
OFFICE ASSISTANT  
Signed: 09/28/2020 12:23

EXHIBIT NO. B17F  
PAGE: 143 OF 152

Name : ADAMS, NEVAEH H  
 DOB/SEX: JUL 21, 2015, FEMALE  
 HOSP : WELCH COMMUNITY HOSPITAL  
 ATTENDING:

MRN: WEL000138580  
 ACT: WEL006477912  
 ADM: Sep 25, 2020 13:46

08/28/2017 9:19PM FAX

0005/0007

## Vaccine Administration Record

Name: Nevaeh H. Adams DOB: 7/21/15  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Physician: \_\_\_\_\_

Client Name / Adr.: Nas Al-Attar, MD  
 296 New Hope Road, Suite 3  
 Princeton, WV 24740  
 (304) 487-0446

I have read (or have had explained) the information contained in the Vaccine Information Statement forms about the diseases and vaccines. I understand the benefits and risks of the vaccines. I request the vaccines indicated below be given to me or the person named on this record for whom I am authorized to make this request. I understand the provider of these immunizations may release this record to other medical or school personnel for the purpose of determining emergency or other medical needs or providing a record of compliance with applicable school laws/childcare regulation.

| Vaccine                                                                                                  | Type of Vaccine (generic abbreviation) | Elig. Code *                                | Date Given | Site ** | Vaccine |     | Vaccine Information Statement |            |                          | Vaccination Initials |
|----------------------------------------------------------------------------------------------------------|----------------------------------------|---------------------------------------------|------------|---------|---------|-----|-------------------------------|------------|--------------------------|----------------------|
|                                                                                                          |                                        |                                             |            |         | Lot#    | Mfr | Date On VIS                   | Date Given | Parent/Guardian Initials |                      |
| Hepatitis B<br>(e.g., HepB, Hib-HepB, DTaP-Hib-B-IPV) Give IM.                                           | Hib 1<br>Hib 2<br>Hib 4<br>Hib 3       | 7/21/15<br>9/28/15<br>12/24/16<br>12/21/15  |            |         |         |     |                               |            |                          |                      |
| Diphtheria, Tetanus,<br>Pertussis<br>(e.g., DTaP, DTaP-Hib, DTaP-P-Hib, DTaP-IPV, DT, Tdap, TD) Give IM. | DTaP 1<br>DTaP 3<br>DTaP 2             | 9/28/15<br>12/24/16<br>12/21/15             |            |         |         |     |                               |            |                          |                      |
| Haemophilus influenzae type B<br>(e.g., Hib, Hib-HepB, DTaP-Hib) Give IM.                                | Hib 1<br>Hib 2<br>Hib 4<br>Hib 3       | 9/28/15<br>12/21/15<br>10/29/16<br>12/24/16 |            | TRN97   |         |     |                               |            | XRA CMM                  |                      |
| Polio<br>(e.g., IPV, DTaP-Hib-IPV)<br>Give IPV SC or IM.<br>Give DTaP-Hib-IPV IM.                        | IPV<br>IPV<br>IPV                      | 9/28/15<br>12/21/15<br>12/24/16             |            |         |         |     |                               |            |                          |                      |
| Pneumococcal<br>(e.g., PCV, conjugate; PPV, polysaccharide) Give PCV IM.<br>Give PPV SC or IM.           | PCV<br>PCV<br>PCV                      | 9/28/15<br>12/21/15<br>12/24/16             |            |         |         |     |                               |            |                          |                      |
| Rotavirus (RV)<br>Give oral                                                                              | RV<br>RV                               | 9/28/15<br>12/21/15                         |            |         |         |     |                               |            |                          |                      |
| Measles, Mumps, Rubella<br>Give SC.                                                                      |                                        |                                             |            |         |         |     |                               |            |                          |                      |
| Varicella<br>Give SC.                                                                                    | VAR                                    | 6/24/16                                     |            | M019641 |         |     |                               |            | XRA CMM                  |                      |
| Hepatitis A (Hep A)<br>Give IM.                                                                          |                                        |                                             |            |         |         |     |                               |            |                          |                      |
| Meningococcal<br>(e.g., MCV4; MPSV4) Give MCV4 IM and MPSV4 SC.                                          |                                        |                                             |            |         |         |     |                               |            |                          |                      |
| Human Papillomavirus (e.g., HPV) Give IM.                                                                |                                        |                                             |            |         |         |     |                               |            |                          |                      |

## \* Elig. Code Legend

VFC Eligible  
M = Medicaid  
NA = Native American  
AN = Alaska Native  
AW = Alaskan Native  
INRN = Under-Insured

Non-VFC Eligible  
PI = Private Insurance  
CH = WIC/CHIP

| Nurse's Signature | Init | Authorized Signature | Init |
|-------------------|------|----------------------|------|
| Wendy Adams MA    | WR   |                      |      |
|                   |      |                      |      |
|                   |      |                      |      |

Parent Signature: &amp; Kelli Adams

WVHR-WAR-35

\*\* Site Given Legend  
 LD = Left Deltoid LDQ = Left Subscapular LVL = Left Vastus Lateralis CRL = Oral  
 RD = Right Deltoid RDQ = Right Subscapular RVL = Right Vastus Lateralis  
 AS = Alternative Site

EXHIBIT NO. B17F  
PAGE: 144 OF 152

| Vaccine Administration Record                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                           |              |            |               |                         |                               | Patient Information  |            |                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------|------------|---------------|-------------------------|-------------------------------|----------------------|------------|----------------------|--|
| Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | DOB:                                                      | City:        |            | ADAMS, NEVAEH |                         |                               | ACT# : 006416081     |            |                      |  |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                           |              |            |               |                         |                               | MED# : 139580        |            |                      |  |
| Phone:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                           | Male         |            | Female        |                         | DOB : 7/21/2015               | FC : CO              |            |                      |  |
| Parent/Guardian                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           |              |            |               |                         | SEX : F                       | AGE : 3 yr           |            |                      |  |
| Physician:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                           |              |            |               |                         | SER : PDC                     | DR : KOBBAH, PIAYON  |            |                      |  |
| <p>I have read (or have had explained) the information contained in the Vaccine Information Statement forms about the diseases and vaccines. I understand the benefits and risks of the vaccines. I request the vaccines indicated below be given to me or the person named on this record for whom I am authorized to make this request. I understand the provider office immunizations may release this record to other medical or school personnel for the purpose of determining emergency or other medical needs or providing a record of compliance with applicable school law/childcare regulation.</p> |                                                           |              |            |               |                         |                               |                      |            |                      |  |
| Vaccine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Type of Vaccine (generic abbreviation)                    | Elig. Code * | Date Given | Site **       | Vaccine                 | Vaccine Information Statement |                      |            | Vaccines by lot/date |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           |              |            |               | Lot#                    | Mfr                           | Date On/Off          | Date Given |                      |  |
| <b>Hepatitis B</b><br>(e.g., HepB, Hib-HepB, DTaP-Hib, HepB-IPV) Give IM.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                           |              |            |               |                         |                               |                      |            |                      |  |
| <b>Diphtheria, Tetanus, Pertussis</b><br>(e.g., DTaP, DTaP-Hib, DTaP-Hib-IPV, DT, Tdap, TD) Give IM.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                           |              |            |               |                         |                               |                      |            |                      |  |
| MMR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 8/10/18 LT                                                | CH22AS       | OSK        | 5/10/17       | 8/10/18                 | KA                            | 3B1m                 |            |                      |  |
| Kinrix                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 8/20/16 LT                                                | 4271NL       | OSK        | 8/20/16       | 8/20/16                 | KA                            | 3B1a                 |            |                      |  |
| <b>Haemophilus influenzae type B</b><br>(e.g., Hib, Hib-HepB, DTaP-Hib) Give IM.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                           |              |            |               |                         |                               |                      |            |                      |  |
| <b>Polio</b><br>(e.g., IPV, DTaP-Hib-IPV) Give IPV SC or IM, Give DTaP-Hib-IPV IM.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                           |              |            |               |                         |                               |                      |            |                      |  |
| Kinrix                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 8/20/16 LT                                                | 4271NL       | OSK        | 8/20/16       | 8/20/16                 | KA                            | 3B1p                 |            |                      |  |
| <b>Pneumococcal</b><br>(e.g., RSV, conjugate, PPV, polysaccharide) Give PCV IM, Give PPV SC or IM.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                           |              |            |               |                         |                               |                      |            |                      |  |
| PCV13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 8/10/18 LT                                                | T623165      | Wright     | 11/05/15      | 8/10/18                 | KA                            | 3B1m                 |            |                      |  |
| <b>Rotavirus (RV)</b><br>Give oral                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                           |              |            |               |                         |                               |                      |            |                      |  |
| Merck, Mumpo, Rubella Give SC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 9/10/18                                                   | AT           | MS1304     | Merck         | 3/10/18                 | 9/10/18                       | KA                   | 3B1a       |                      |  |
| Varicella Give SC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 9/10/18                                                   | AT           | MS2584     | Merck         | 3/10/18                 | 8/20/19                       | KA                   | 3B1a       |                      |  |
| Hepatitis A (Hep A) Give IM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9/10/18                                                   | AT           | MS38701    | Merck         | 8/15/19                 | 9/25/2020                     | KA                   | 3B1m       |                      |  |
| Hepatitis A (Hep A) Give IM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9/10/18                                                   | AT           | MS6552     | Merck         | 7/14/19                 | 6/15/19                       | KA                   | 3B1a       |                      |  |
| Meningococcal<br>(e.g., MCV4, MPSV4) Give MCV4 IM and MPSV4 SC.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 9/25/2020                                                 | AT           | PA99T      | OSK           | 7/26/2020               | 9/25/2020                     | KA                   | 3B1m       |                      |  |
| Human Papillomavirus (e.g., HPV) Give IM.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                           |              |            |               |                         |                               |                      |            |                      |  |
| * Elig. Code Legend                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                           |              |            |               | Nurse's Signature       | Init.                         | Authorized Signature | Init.      |                      |  |
| VFC Eligible<br>M = Medicaid N = Native American<br>AN = Alaskan Native U = Uninsured<br>UND = Under-insured                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Non-VFC Eligible<br>PI = Private Insurance<br>CH = WVCHIP | Boosley, L   | JBL        |               |                         |                               |                      |            |                      |  |
| ** Site Given Legend                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                           |              |            |               | Parent Signature: _____ |                               |                      |            |                      |  |
| LD = Left Deltoid LSQ = Left Subscapular LVL = Left Vastus Lateralis ORL = Oral RD = Right Deltoid RSQ = Right Subscapular RVL = Right Vastus Lateralis AS = Alternative Site                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                           |              |            |               | WVIP-VAR-167            |                               |                      |            |                      |  |

**EXHIBIT NO. B17F**  
**PAGE: 145 OF 152**

08/29/2017 9:20PM FAX

0007/0007

| Patient name:                                                                                                                                                   | Hawley, Adams                                                                                                                                                                                                                                                                             |                        | Birthdate:              |                   | 7-21-2015 |      | Office Name / Address:              |                         | CHOKAR, M.D.<br>1322 STADIUM DRIVE<br>BLUEFIELD, WV 24701<br>(304) 325-7031 |                           |                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------|-------------------|-----------|------|-------------------------------------|-------------------------|-----------------------------------------------------------------------------|---------------------------|----------------------------------------------------------|
| Chart number:                                                                                                                                                   | Before administering any vaccines, give copies of all pertinent Vaccine Information Statements (VISs) to the child's parent or legal representative and make sure he/she understands the risks and benefits of the vaccines. Always provide or update the patient's personal record card. |                        |                         |                   |           |      |                                     |                         |                                                                             |                           |                                                          |
| Vaccine                                                                                                                                                         | Type of Vaccine <sup>1</sup>                                                                                                                                                                                                                                                              | Date given (mo/day/yr) | Elig. Code <sup>2</sup> | Site <sup>3</sup> | Vaccine   |      | Vaccine Information Statement (VIS) |                         |                                                                             | Parents/Guardian Initials | Vaccinat <sup>4</sup> signature/<br>initials             |
| Hepatitis B <sup>5</sup><br>(e.g., HepB, Hib-HepB,<br>DTaP-HepB-IPV)<br>Give IM. <sup>7</sup>                                                                   | hepb                                                                                                                                                                                                                                                                                      | 7-21-15                |                         |                   | Lot #     | Mfr. | Date on VIS <sup>6</sup>            | Date given <sup>4</sup> |                                                                             |                           |                                                          |
| Diphtheria, Tetanus,<br>Pertussis <sup>8</sup><br>(e.g., DTaP, DTaP/Hib,<br>DTaP-HepB-IPV, DT,<br>DTaP-IPV/Hib, Tdap,<br>DTaP-IPV, Td)<br>Give IM. <sup>7</sup> | DTaP                                                                                                                                                                                                                                                                                      | 9-28-15                |                         |                   |           |      |                                     |                         |                                                                             |                           |                                                          |
| Haemophilus influenzae type b <sup>6</sup><br>(e.g., Hib, Hib-HepB,<br>DTaP-IPV/Hib,<br>DTaP/Hib) Give IM. <sup>7</sup>                                         | Hib                                                                                                                                                                                                                                                                                       | 9-28-15                |                         |                   |           |      |                                     |                         |                                                                             |                           |                                                          |
| Polio <sup>9</sup><br>(e.g., IPV, DTaP-HepB-IPV,<br>DTaP-IPV/Hib, DTaP-IPV)<br>Give IPV SC or IM. <sup>7</sup><br>Give all others IM. <sup>7</sup>              | DTaP                                                                                                                                                                                                                                                                                      | 9-28-15                |                         |                   |           |      |                                     |                         |                                                                             |                           |                                                          |
| Pneumococcal<br>(e.g., PCV7, PCV13,<br>conjugate;<br>PPSV23, polysaccharide)<br>Give PCV IM. <sup>7</sup><br>Give PPSV SC or IM. <sup>7</sup>                   | PCV13                                                                                                                                                                                                                                                                                     | 9-23-15                |                         |                   |           |      |                                     |                         |                                                                             |                           |                                                          |
| Rotavirus (RV1, RV5)<br>Give orally (po).                                                                                                                       | Rix                                                                                                                                                                                                                                                                                       | 9-29-15                |                         |                   |           |      |                                     |                         |                                                                             |                           |                                                          |
| Rix                                                                                                                                                             | 12-17-15                                                                                                                                                                                                                                                                                  |                        |                         |                   |           |      |                                     |                         |                                                                             |                           |                                                          |
| Rix                                                                                                                                                             | 9-24-16                                                                                                                                                                                                                                                                                   |                        |                         |                   |           |      |                                     |                         |                                                                             |                           |                                                          |
| See page 2 to record measles, mumps, rubella, varicella, hepatitis A, meningococcal, HPV, influenza, and other vaccines (e.g., travel vaccines).                |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | Abbreviation              | Trade Name & Manufacturer                                |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | CTaP                      | Daptacel (sanofi pasteur) GSK; Lipiodol (sanofi pasteur) |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | CT (pediatric)            | Generic (sanofi pasteur)                                 |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | CTaP-HepB-IPV             | Pediarix (GSK)                                           |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | CTaP/Hib                  | TriHIBIT (sanofi pasteur)                                |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | CTaP-IPV//Hib             | Pentacel (sanofi pasteur)                                |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | DTaP-IPV                  | Kinrix (GSK)                                             |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | cPnR                      | Engerix-B (GSK); Recomb (Merck)                          |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | DT                        | ActHIB, s; Hiberix, G; Pedvax, M                         |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | DTaP-HibD                 | Convax (Merck)                                           |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | IPV                       | Ipol (sanofi pasteur)                                    |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | PCV13//PPSV23             | Pneumovax 13 (Merck)/Pneumovax                           |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | RV1/RV5                   | Rotarix (GSK)/RotaTeq (Merck)                            |
|                                                                                                                                                                 |                                                                                                                                                                                                                                                                                           |                        |                         |                   |           |      |                                     |                         |                                                                             | DTaP-IPV                  | Adacel // Rotarix G; Hiberix, MAA                        |

**EXHIBIT NO. B17F  
PAGE: 146 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25,2020 13:46

\*\*\* END \*\*\*\*\* CONFIDENTIAL CLINICAL NOTES SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 147 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25,2020 13:46

\*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

Order Date: St: Requestor: Start Date: Stop Date:  
Nature of Order: Signature:  
Item Ordered:  
=====

\*\*\* END \*\*\*\*\* CONFIDENTIAL ORDERS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 148 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25,2020 13:46

\*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL LAB RESULTS SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 149 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25,2020 13:46

\*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL RADIOLOGY IMAGING TEXT SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 150 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25,2020 13:46

\*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

No data available.

\*\*\* END \*\*\*\*\* CONFIDENTIAL DISCHARGE SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
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Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:  
-----

\*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

**EXHIBIT NO. B17F  
PAGE: 152 OF 152**

Name : ADAMS,NEVAEH H  
DOB/SEX: JUL 21,2015, FEMALE  
HOSP : WELCH COMMUNITY HOSPITAL  
ATTENDING:

MRN: WEL000138580  
ACT: WEL006477912  
ADM: Sep 25, 2020 13:46

ADRs: No ADRs on file.

Allergies: PENICILLIN

\*\*\*\*\*NO MEDICATIONS FOUND\*\*\*\*\*

\*\*\* END \*\*\*\*\* CONFIDENTIAL MEDICATION ADMINISTRATION SUMMARY \*\*\*\*\*

[ [ [ END ] ] ] Patient Encounter(s) History Report Sep 30, 2020@09:16

EXHIBIT NO. B18F  
PAGE: 1 OF 7



As required under 20 CFR §404.1512(a) and/or 20 CFR §416.912(a), we are obligated to submit non-redacted and complete copies of all documents we receive that relate to our client's claim.

Accordingly, please make the enclosed medical record a part of the record in this claim.

Please note that if the medical provider returned to us the copies of form SSA-1696, our client's medical release and our cover letter requesting records, we are not enclosing copies of those documents as they do not relate to the issue of our client's disability. We do have those pages available and will submit them upon your request.

Finally, please also make this letter a part of the record in this matter.

Adams, Nevaeh (MRN E2228804) DOB: 07/21/2015

Encounter Date: 03/14/2019

**EXHIBIT NO. B18F  
PAGE: 2 OF 7**

## Adams, Nevaeh

MRN: E2228804

**Office Visit** 3/14/2019  
WVUPC-PEDS ENDOCRINE

Provider: Dye, Amanda, MD (PEDIATRIC MEDICINE)

Primary diagnosis: Polyuria

Reason for Visit: Turner Syndrome; Referred by Muzaffer, Rahmet, MD

### Progress Notes

Dye, Amanda, MD (Physician) • PEDIATRIC MEDICINE

**CHILDRENS MEDICAL OFFICE BLDG-WVUPC**  
**WVUPC-PEDS ENDOCRINE**  
**830 Pennsylvania Ave**  
**Charleston WV 25302-3302**  
**304-388-1552**

Name: Nevaeh Adams  
 MRN: E2228804  
 Date of Birth: 7/21/2015

Referring Provider: Rahmet Muzaffer, MD  
 PCP: Welch Emergency Hospital  
 Date of Service: 03/14/19

**Informant:** mother

Nevaeh Adams is a 3 y.o. female who presents for follow-up of Turner Syndrome (45-XO) and short stature.

**Initial Presentation:** Nevaeh was initially evaluated here in endocrine clinic in 5/2018 (age 2 years). She diagnosed in utero with Turner Syndrome and confirmed with chromosome analysis after birth. Nevaeh had been following with a genetics, cardiology (bicuspid aortic valve), ophthalmology and orthopedics (hip dysplasia). Once Nevaeh's growth velocity began to decrease, she was referred to endocrine for evaluation of growth/potential growth hormone therapy. Nevaeh did not demonstrate interval linear growth at all between her first two endocrine appointments. She was started on hGH therapy in January 2019 after clearance from orthopedics.

**Interval History:** last visit-Oct 2018. Nevaeh has grown 5.4 cm since October 2018. This is an annualized height velocity of ~ 12 cm/year. She was started on hGH therapy in early January 2019. She is starting to have leg pains frequently at night. She requires Tylenol for leg pains at least 2-3 times/week. No gait disturbances above her baseline. She has a follow-up with orthopedics at Shriners next week for re-imaging of her hips. She is more thirsty than she was previously and is urinating more than previously. She is going through 7-8 saturated pull ups per day which is more than previously. Mother reports that Nevaeh can not tolerate BP measurements due to anxiety/fear. At her cardiology appointment in Oct 2018, BP was markedly elevated for age but she was "screaming and resisting" the entire time.

**Nevaeh's Medical Team:**

Dr. Lori Miller - cardiologist, Roanoke  
 Dr. Doherty - Geneticist, Roanoke  
 Dr. Mucko--Ortho at Shriners  
 Vista Star - ophthalmology, Roanoke  
 Developmental specialist with BTT

Adams, Nevaeh (MRN E2228804) DOB: 07/21/2015

Encounter Date: 03/14/2019

**EXHIBIT NO. B18F  
PAGE: 3 OF 7****Current Outpatient Medications**

| Medication                                                                  | Sig                                | Dispense  | Refill |
|-----------------------------------------------------------------------------|------------------------------------|-----------|--------|
| • Insulin Needles, Disposable, (NANO PEN NEEDLE) 32 gauge x 5/32" Needle    | Use to inject growth hormone daily | 100 Each  | 1      |
| • NORDITROPIN FLEXPRO 10 mg/1.5 mL (6.7 mg/mL)<br>Subcutaneous Pen Injector | Inject 0.7 mg SQ daily             | 2 Syringe | 5      |

No current facility-administered medications for this visit.

**Past Medical History:**

| Diagnosis                               | Date |
|-----------------------------------------|------|
| • Bicuspid aortic valve                 |      |
| • Developmental delay                   |      |
| • Heart defect                          |      |
| • Hip dysplasia, congenital             |      |
| • Hospitalism (in children)             |      |
| • Otitis media                          |      |
| • Turner syndrome<br>45, X0             |      |
| • Visual impairment<br><i>esotropia</i> |      |

**Family Medical History:**

| Problem           | Relation (Age of Onset)        |
|-------------------|--------------------------------|
| No Known Problems | Mother, Father, Sister, Sister |

**Review of Systems:**

Constitutional: negative for fever or weight loss

Eyes: + esotropia, negative for diplopia, blurry vision, or scotoma

HEENT: + recurrent AOM

Cardiovascular: + bicuspid aortic valve, mild aortic narrowing

Respiratory: negative for wheezing, dyspnea, or cough

Gastrointestinal: negative for constipation, diarrhea, hematochezia, or abdominal pain

GU: + horseshoe kidneys

Endocrine: +Turner syndrome, short stature

Musculoskeletal: negative for back pain, joint pain, or trauma

Neurologic: negative for paresthesias, headaches, or dizziness

Integument: negative for rashes, bruising, or hyperpigmentation

**Physical Exam:****Vitals:**

03/14/19 0912

Weight: 15.6 kg (34 lb 6.3 oz)

Height: 0.936 m (3' 0.85")

BMI: 17.84

94 %ile (Z= 1.53) based on CDC (Girls, 2-20 Years) BMI-for-age based on BMI available as of 3/14/2019.

General: well appearing, no distress

Adams, Nevaeh (MRN E2228804) DOB: 07/21/2015

Encounter Date: 03/14/2019

**EXHIBIT NO. B18F  
PAGE: 4 OF 7**

Eyes: pupils equal and reactive to light and accomodation, no nystagmus  
 HEENT: + esotropia, clear nasal drainage, moist mucous membranes, no lymphadenopathy  
 Chest: broad chest with widely spaced nipples  
 Cardiovascular: regular rate and rhythm, no murmur, +2 peripheral pulses  
 Respiratory: clear to auscultation bilaterally, no wheezing, no crackles or rales  
 Abdomen: soft, non-tender, non-distended, no masses or organomegaly  
 Musculoskeletal: moves all four extremities well, no joint edema, warmth, or tenderness  
 Neurologic: cranial nerves II-XII grossly intact, no focal deficits  
 Integument: no rashes, hyperpigmentation, or discoloration  
 Neck: webbing of neck, thyroid normal to palpation, no lymphadenopathy

## Pertinent Lab Review:

|                                                                        | Ref. Range                                       | 5/9/2018 | 1/2/2019 |
|------------------------------------------------------------------------|--------------------------------------------------|----------|----------|
| TSH                                                                    | Latest Ref<br>Range: 0.400 -<br>6.000<br>mclU/mL | 1.790    | 2.970    |
| THYROXINE,<br>FREE (FREE<br>T4)                                        | Latest Ref<br>Range: 0.9 -<br>1.8 ng/dL          | 1.2      | 1.3      |
| THYROGLOB<br>ULIN<br>ANTIBODY,<br>SERUM                                |                                                  | < 15     |          |
| THYROPERO<br>XIDASE (TPO)<br>ANTIBODIES,<br>SERUM                      |                                                  | < 28     |          |
| HEMOGLOBI<br>N A1C                                                     | Latest Units: %                                  | 4.7      |          |
| ESTIMATED<br>AVERAGE<br>GLUCOSE                                        | Latest Ref<br>Range: 77 -<br>114 mg/dL           | 88       |          |
| C-REACTIVE<br>PROTEIN<br>HIGH<br>SENSITIVITY<br>(INFLAMMATI<br>ON)     | Latest Ref<br>Range: 0.0 -<br>2.9 mg/L           |          | <2.9     |
| IMMUNOGLO<br>BULIN A                                                   | Latest Ref<br>Range: 27.0 -<br>195.0 mg/dL       | 58.5     | 77.6     |
| ANTI-<br>MULLERIAN<br>HORMONE                                          |                                                  | < 0.1    |          |
| ENDOMYSIAL<br>ANTIBODIES<br>(IGA), SERUM                               |                                                  |          | Negative |
| GLIADIN<br>(DEAMIDATE<br>D)<br>ANTIBODIES<br>EVALUATION,<br>IGG, SERUM | Latest Ref<br>Range: 0.4 -<br>7.0 EU/mL          |          | <6.3     |

Adams, Nevaeh (MRN E2228804) DOB: 07/21/2015

Encounter Date: 03/14/2019

**EXHIBIT NO. B18F  
PAGE: 5 OF 7**

|                                                      |                                   |          |      |
|------------------------------------------------------|-----------------------------------|----------|------|
| INSULIN-LIKE GROWTH FACTOR-1 (IGF-1) - ESOTERIX      |                                   | 49 ng/mL |      |
| TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGG, SERUM | Latest Ref Range: 0.6 - 7.0 EU/mL |          | <6.0 |
| TISSUE TRANSGLUTAMINASE (TTG) ANTIBODIES, IGA, SERUM | Latest Ref Range: 0.1 - 7.0 EU/mL | <2.4     | <2.4 |

***Radiology Review:***

Bone Age film (5/2018)-CAMC: consistent with the 2 year standard of Greulich & Pyle at chronological age 2 years 9 months (concordant)

***Point of Care Testing Today:***

Hemoglobin A1c: 5.1%

**Assessment:** Nevaeh Adams is a 3 y.o. female with Turner Syndrome, 45-XO, short stature, bicuspid aortic valve, horseshoe kidney

***Plan:***

**1. Short stature:** hGH therapy initiated in January 2019 with subsequent profound increase in linear height velocity and bilateral leg pains frequently. No gait abnormalities or hip/knee pain but at risk for hip pathology given previous hip dysplasia and open reduction bilaterally. Follow-up next week with Orthopedics at Shriners. Reduce dose of hGH to 0.5 mg nightly.

**2. Bicuspid aortic valve:** Nevaeh follows with cardiology at Roanoke (last appointment Oct 2018) and will be followed in 2 years.

**3. Horseshoe kidney:** no history of UTI in past. Will image in future. BP unable to be obtained but will need to monitor BP closely. May require Nephrology evaluation in future.

**4. Turner Syndrome maintenance:** Nevaeh is at higher risk of autoimmune conditions and will be monitored clinically and with annual autoimmune screening for thyroid disease, celiac disease and diabetes.

**5. Increased urination and thirst:** Hemoglobin A1c today 5.1%. Will monitor given association of growth hormone therapy with insulin resistance/hyperglycemia--will follow in future.

Total time spent with patient/family was 25 minutes with more than 50% in counseling.

Adams, Nevaeh (MRN E2228804) DOB: 07/21/2015

Encounter Date: 03/14/2019

**EXHIBIT NO. B18F  
PAGE: 6 OF 7**

*Amanda S. Dye, MD*  
 Assistant Professor of Pediatrics  
 Pediatric Endocrinology  
 WVU-Charleston Division

## Other Notes

All notes

## Instructions

-  Return in about 3 months (around 6/14/2019).
- Reduce GH to 0.5 mg nightly

*Amanda S. Dye, MD*  
 Assistant Professor of Pediatrics  
 Pediatric Endocrinology  
 WVU-Charleston Division

[After Visit Summary \(Printed 3/14/2019\)](#), [After Visit Summary \(Printed 3/14/2019\)](#)

## Additional Documentation

Vitals: Ht 0.936 m (3' 0.85") Wt 15.6 kg (34 lb 6.3 oz) BMI 17.81 kg/m<sup>2</sup> BSA 0.64 m<sup>2</sup>

Encounter Info: [Billing Info](#), [History](#), [Allergies](#), [Detailed Report](#)

## Communications

-  Letter sent to Welch Emergency Hospital
-  Chart Routed to Lowery, Elisabeth L, RN

## Patient-Level Documents:

- Coverage ID Card - Scan on 10/4/2018 1057 by Skeens, Meghan Kathleen: 1 UNICARE
- Other - Scan on 5/9/2018 1347 by Carroll, Brittany A: MY CHART
- Coverage ID Card - Scan on 5/9/2018 1246 by Tanner, Jennifer Suzanne, RN
- Other - Scan on 1/31/2017 0912 by Stamper, Patricia, RTR: NEW REFERRAL/KEVIN LEWIS

## Orders Placed

[A1C \(POINT OF CARE\)](#)

## Medication Changes

As of 3/14/2019 9:44 AM

|                                                                                    | Refills | Start Date | End Date  |
|------------------------------------------------------------------------------------|---------|------------|-----------|
| Changed: NORDITROPIN FLEXPRO 10 mg/1.5 mL<br>(6.7 mg/mL) Subcutaneous Pen Injector | 5       | 3/14/2019  | 3/15/2019 |

Inject 0.5 mg SQ daily  
 Notes to Pharmacy: Spoke to Kortney, pharmacist at Briova

Adams, Nevaeh (MRN E2228804) DOB: 07/21/2015

Encounter Date: 03/14/2019

**EXHIBIT NO. B18F  
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| Refills                            | Start Date | End Date |
|------------------------------------|------------|----------|
| Previously: Inject 0.7 mg SQ daily |            |          |

### Visit Diagnoses

Polyuria R35.8

EXHIBIT NO. B19F  
PAGE: 1 OF 5



As required under 20 CFR §404.1512(a) and/or 20 CFR §416.912(a), we are obligated to submit non-redacted and complete copies of all documents we receive that relate to our client's claim.

Accordingly, please make the enclosed medical record a part of the record in this claim.

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Finally, please also make this letter a part of the record in this matter.

**EXHIBIT NO. B19F  
PAGE: 2 OF 5**

| PATIENT INFORMATION                                                                                                                                                                                                                                     |                                                                                                                                                                      |                                                                                                                                               |                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Name: Adams, Nevaeh Hope<br>NickName:<br>DOB: 07/21/15 Age: 5 Years Sex: Female<br>Race: White<br>Language: English [Interpreter Required: No]<br>Emergency Contact: Mother Cell<br>Alternate MRN:<br>Patient email:<br>Parents Marital Status: Unknown | MRN: 3279454<br>Home: (304) 938-6159<br>Alt 1:<br>Alt 2:<br>Alt 3:<br>Emergency: (681) 229-9295<br>Living With:                                                      | FIN: 9685100<br>Home Address: 250 MELVIN ST<br>City/State/Zip: BIG SANDY, WV 24816<br>Country: USA<br>Mailing Address: PO BOX 46              | City/State/Zip: BIG SANDY, WV 24816<br>Country: USA                                   |
| MOTHER INFORMATION                                                                                                                                                                                                                                      |                                                                                                                                                                      |                                                                                                                                               |                                                                                       |
| Name: Adams, Kelli<br>Relationship to Patient: Mother<br>Sex: Female DOB: 04/20/91                                                                                                                                                                      | Home: (304) 938-6159<br>Alt 1:<br>Alt 2:                                                                                                                             | Home Address: 250 MELVIN ST<br>City/State/Zip: BIG SANDY, WV 24816<br>Country: USA                                                            |                                                                                       |
| FATHER INFORMATION                                                                                                                                                                                                                                      |                                                                                                                                                                      |                                                                                                                                               |                                                                                       |
| Name: Adams, Rico<br>Relationship to Patient: Father<br>Sex: Male DOB: 05/19/90                                                                                                                                                                         | Home:<br>Alt 1:<br>Alt 2:                                                                                                                                            | Home Address: 250 MELVIN ST<br>City/State/Zip: BIG SANDY, WV 24816<br>Country: USA                                                            |                                                                                       |
| LEGAL GUARDIAN INFORMATION                                                                                                                                                                                                                              |                                                                                                                                                                      |                                                                                                                                               |                                                                                       |
| Name: Adams, Kelli<br>Rel to Pat: Mother<br>Sex: Female DOB: 04/20/91                                                                                                                                                                                   | Home: (304) 938-6159<br>Alt 1:<br>Alt 2:                                                                                                                             | Home Address: 250 MELVIN ST<br>City/State/Zip: BIG SANDY, WV 24816<br>Country:                                                                |                                                                                       |
| SECONDARY GUARDIAN INFORMATION                                                                                                                                                                                                                          |                                                                                                                                                                      |                                                                                                                                               |                                                                                       |
| Name: Adams, Rico<br>Rel to Pat: Father<br>Sex: Male DOB: 05/19/90                                                                                                                                                                                      | Home:<br>Alt 1:<br>Alt 2:                                                                                                                                            | Home Address: 250 MELVIN ST<br>City/State/Zip: BIG SANDY, WV 24816<br>Country:                                                                |                                                                                       |
| INSURANCE INFORMATION                                                                                                                                                                                                                                   |                                                                                                                                                                      |                                                                                                                                               |                                                                                       |
| 1 Company Name: The Health Plan<br>Health Plan Name: The Health Plan of the Upper Ohio Valley<br>Other Health Plan Name:<br>Health Plan Phone: (800) 624-6961<br>Auth Nbr(s): [A-1] No [-2] [-3]                                                        | Subscriber #: H18015644<br>Pt. Member #: H18015644<br>Rel to Pt: Self<br>Date Verified: 09/28/20                                                                     | Address: 52160 NATIONAL ROAD EAST<br>City/State/Zip: ST CLAIRSVILLE, OH 43950-9365<br>Group Number:<br>Health Plan Type: Managed Care/HMO/PPO |                                                                                       |
| 2 Company Name: UniCare Health Plan of West Virginia<br>Health Plan Name: UniCare Health Plan of West Virginia<br>Other Health Plan Name:<br>Health Plan Phone: (866) 655-7423<br>Auth Nbr(s): [-1] [-2] [-3]                                           | Subscriber #: 00405164305<br>Pt. Member #: 00405164305<br>Rel to Pt: Self<br>Date Verified:                                                                          | Address: PO BOX 91<br>City/State/Zip: CHARLESTON, WV 25321-0091<br>Group Number: 1863100001<br>Health Plan Type: Medicaid Managed Care        |                                                                                       |
| 3 Company Name:<br>Health Plan Name:<br>Other Health Plan Name:<br>Health Plan Phone:<br>Auth Nbr(s): [-1] [-2] [-3]                                                                                                                                    | Subscriber #:<br>Pt. Member #:<br>Rel to Pt:<br>Date Verified:                                                                                                       | Address:<br>City/State/Zip:<br>Group Number:<br>Health Plan Type:                                                                             |                                                                                       |
| VISIT INFORMATION                                                                                                                                                                                                                                       |                                                                                                                                                                      |                                                                                                                                               |                                                                                       |
| Admit Date/Time: 02/10/20 09:05 EST<br>Medical Service: Ortho<br>Location: zzLXT Clinic                                                                                                                                                                 | Admit Clerk: Dobson, Kacy L<br>Enc Type: Outpatient Clinic                                                                                                           | Admit Mode: Personal Transp<br>Accident Related Visit?: No<br>Care Manager RN:<br>Social Worker:                                              | Admit Type: Elective<br>Room/Bed: /<br>Fain RN, Allison B                             |
| PHYSICIAN INFORMATION                                                                                                                                                                                                                                   |                                                                                                                                                                      |                                                                                                                                               |                                                                                       |
| Referring Physician: Muchow MD, Ryan David 4362365<br>110 Conn Terrace<br>Lexington, KY 40508                                                                                                                                                           | Attending Physician: Muchow MD, Ryan David<br>Primary Care Physician: Al-Attar MD, Inas H 5514209<br>143 Undercliff Terrace<br>Princeton, WV 24740<br>(304) 487-0415 |                                                                                                                                               |                                                                                       |
| PREVIOUS ENCOUNTER INFORMATION                                                                                                                                                                                                                          |                                                                                                                                                                      | TEMPLE INFORMATION                                                                                                                            |                                                                                       |
| 07/25/18 12:40 EDT<br>11/27/17 15:28 EST<br>07/24/17 14:18 EDT<br>05/01/17 14:07 EDT                                                                                                                                                                    | Outpatient Clinic<br>Outpatient Clinic<br>Outpatient Clinic<br>Outpatient Clinic                                                                                     | Muchow MD, Ryan David<br>Muchow MD, Ryan David<br>Muchow MD, Ryan David<br>Muchow MD, Ryan David                                              | Referring Temple:<br>Coord Temple: Beni Kedem<br>Referring Shriner:<br>Coord Shriner: |

Adams, Nevaeh Hope Female / 5 Years MRN: 3279454 FIN: 9685100



\*9685100\*

(HST: PROD: SHCIS\_FACESHEET\_XR\_PDF)

PATIENT ADMIT RECORD

10/07/20 16:05

Page 1 of 4

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**EXHIBIT NO. B19F  
PAGE: 3 OF 5**



**Shriners Hospitals for Children**  
**Lexington Ambulatory Surgical Center**  
**110 Conn Terrance**  
**Lexington, KY 40508-3206**

**Progress Notes**

|                      |                                                                                      |
|----------------------|--------------------------------------------------------------------------------------|
| DOCUMENT NAME:       | Outpatient Progress Note                                                             |
| SERVICE DATE/TIME:   | 2/10/2020 12:40 EST                                                                  |
| RESULT STATUS:       | Modified                                                                             |
| PERFORM INFORMATION: | Muchow MD,Ryan David (2/19/2020 09:48 EST); Marcum APRN,Katy A (2/10/2020 12:40 EST) |
| SIGN INFORMATION:    | Muchow MD,Ryan David (2/19/2020 09:48 EST); Marcum APRN,Katy A (2/14/2020 13:22 EST) |

**Addendum by Muchow MD, Ryan David on February 19, 2020 9:48 EST**

**AttestationStatement:** I saw the patient with the ARNP/PA-C. I discussed the case with the ARNP/PA-C and agree with the ARNP/PA-C's findings and plan as documented in the ARNP/PA-C's note.

*Electronically Signed: Muchow MD, Ryan David  
Sign Date and Time: 02/19/2020 09:48 EST*

**OutpatientNote**

PATIENT: Adams, Nevaeh Hope MRN: 3279454

EXAM DATE: 02/10/2020

ATTENDING PROVIDER: Ryan Muchow, MD

DICTATING PROVIDER: Katy A. Marcum, APRN

**OUTPATIENT VISIT PROGRESS NOTE**

**HISTORY:**

Nevaeh is a 4-year-old female with a history of Turner syndrome and bilateral developmental hip dysplasia. She underwent a right open reduction with adductor tenotomy in January 2017, and had an open reduction and adductor tenotomy on the left in July 2017. She was placed into a spica cast after both, and did well with her recovery. She was last seen on 07/25/2018. At that time she was doing well and was out of the cast. She had no issues with hip range of motion,

Patient Name: Adams, Nevaeh Hope  
Admit Date: 2/10/2020 09:05EST  
Attending: Muchow MD,Ryan David  
MRN: 3279454  
FIN: 009685100  
DOB: 7/21/2015 Gender: Female

This document contains Confidential Patient Information from the SHCIS Medical Record. This information is not for general use and should only be used and/or disposed of in accordance with SHC Policies and Procedures pertaining to the protection of Patient Privacy and Confidentiality.

User ID: Picart,Kenia N

Report Request ID: 42750916

Page 2 of 4

Print Date/Time: 10/7/2020 16:05 EDT

**Shriners Hospitals for Children**  
**Lexington Ambulatory Surgical Center**

**Progress Notes**

and was on human growth hormone prescribed to her by her endocrinologist for the Turner syndrome. The plan was for her to follow up in 6 months.

Today she is accompanied by her parents. Mother says that they have had difficulties with getting to follow-ups due to transportation issues. She reports that since her last visit with us, Nevaeh has been doing well and is very active. She has not noticed her limping, and does not have any difficulties with getting her dressed. She says occasionally Nevaeh's hip will feel like it pops, but has never been concerned as it does not seem to be followed by pain.

Of note, Nevaeh is still taking growth hormone for the Turner syndrome. Due to increased speed of growth causing her some discomfort, mother says that they have lowered the dose somewhat, and this has improved Nevaeh's overall comfort. She says they follow up with endocrinology in a couple months. Otherwise, Nevaeh has been a perfectly healthy. No recent coughs, colds, fevers, or chills.

**PHYSICAL EXAMINATION:**

Four-year-old girl in no acute distress. She is alert, running about the room, and is cooperative for the exam. She demonstrates a heel-to-toe gait, without antalgia or limp. She has excellent range of motion to bilateral hips that is painless. She demonstrates a wide hip abduction that is symmetrical, as well as symmetrical internal and external hip rotation. Galeazzi is negative. Extremities are warm and well perfused, and she is neurovascularly intact distally.

**IMAGING STUDIES:**

Two views of the pelvis were obtained today, and reviewed by Dr. Muchow. On the frog view, hips remain well reduced. On the AP view, femoral head shape is nice and round, and there is no sign of AVN (avascular necrosis). Bilateral acetabulum are developing well. She has improved acetabular ankles bilaterally, as well as improved of femoral head coverage. Teardrop signs on both are similar in size and shape.

**ASSESSMENT:**

Four-year-old girl with a history of Turner syndrome and bilateral developmental hip dysplasia. The hips remain well reduced and acetabular development is improving.

**PLAN:**

Discussed findings on clinical exam, as well as x-ray images with Nevaeh's family. Assured that she continues to do well, and the development of her hips continues to improve. We would like to follow up with her in 1 year, with a

---

Patient Name: Adams, Nevaeh Hope  
MRN: 3279454  
DOB: 7/21/2015 Gender: Female

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Page 3 of 4

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**Shriners Hospitals for Children**  
**Lexington Ambulatory Surgical Center**

**Progress Notes**

repeat AP view of the pelvis. Parents were agreeable to the plan of care today. They were encouraged to call with any questions or concerns prior to followup.

DD: 02/10/2020 12:40:00 EDT  
TD: 02/11/2020 10:44:39 EDT/SR

*Electronically Signed: Marcum APRN, Katy A*  
*Sign Date and Time: 02/14/2020 13:22 EST*

---

Patient Name: Adams, Nevaeh Hope  
MRN: 3279454  
DOB: 7/21/2015 Gender: Female

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Page 4 of 4

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EXHIBIT NO. B20F  
PAGE: 1 OF 6



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From: &lt;ScanSTAT Technologies&gt;

To: JAN DILS ATTORNEYS AT LAW

Page: 6/10

Date: 11/29/2020 2:53:28 PM

**EXHIBIT NO. B20F**  
**PAGE: 2 OF 6**

## **Mercer Medical Group**

PRINCETON COMMUNITY HOSPITAL

**Primary Care \* Cardiology \* ENT \* General Surgery****Nephrology \* Neurology \* Pulmonology****Urology \* Women's Health**

|                                    |                                               |
|------------------------------------|-----------------------------------------------|
| <b>Patient:</b> Adams,Nevaeh H     | <b>ACCT #:</b> MM0000135381                   |
| <b>DOB:</b> 07/21/2015             | <b>Age/Sex:</b> 5Y 03M/F                      |
| <b>Provider:</b> Mark A Weitzel DO | <b>PCP:</b> Piayan Kobbah M.D.                |
| <b>Date of Service:</b> 10/29/20   | <b>Referring Provider:</b> Kobbah,Piayan M.D. |

### **ENT Office Visit**

Signed

## **HPI**

### **ENT-AMB**

Grandmother states that she has been sensitive to loud noises. Patient had audiogram in Jan. States last infection was 3-4 weeks, but is unsure of how many infections in the last 6 months. Denies fever/chills, otorrhea, otalgia or recurrent strep. Receiving speech therapy and speech is improving.

Location: EARS

Characteristics of symptom or complaint: LOUD NOISES HURT EARS

Aggravating or associated factors: NA

Relieving factors: NA

## **Intake**

### **Vital Signs**

|                    |                           |
|--------------------|---------------------------|
|                    | <b>10/29/20<br/>09:49</b> |
| <b>Weight</b>      | 20.865 kg                 |
| <b>Respiration</b> | 18 L                      |

Chief Complaint: RC ON EARS. HAD AUDIO DONE IN JANUARY AND WAS UNABLE TO FOLLOW UP AFTER. COMPLAINS THAT LOUD NOISES HURT HER EARS.

Add today's problem/HPI: ENT Child Established

Referred by: KOBBAH.P

### **Allergies**

| Allergy/AdvReac | Type    | Severity | Reaction | Status   | Date / Time    |
|-----------------|---------|----------|----------|----------|----------------|
| amoxicillin     | Allergy | Severe   | RASH     | Verified | 02/12/20 15:39 |

Report #: 1029-00170

---

CC: MMGEMPTY; KOBBAH.P

Page 1 of 5

Mercer Medical Group ENT \* 122 12th Street \* Third Floor- Suite A \* Princeton, WV 24740 \* (304) 487-3407

From: &lt;ScanSTAT Technologies&gt;

To: JAN DILS ATTORNEYS AT LAW

Page: 7/10

Date: 11/29/2020 2:53:28 PM

**EXHIBIT NO. B20F  
PAGE: 3 OF 6****Mercer Medical Group****Princeton Community Hospital**

Primary Care \* Cardiology \* ENT \* General Surgery  
 Nephrology \* Neurology \* Pulmonology  
 Urology \* Women's Health

|                                |                             |
|--------------------------------|-----------------------------|
| <b>PATIENT:</b> Adams,Nevaeh H | <b>ACCT #:</b> MM0000135381 |
|--------------------------------|-----------------------------|

**Medication List**

| Medication     | Instructions | Recorded | Confirmed |
|----------------|--------------|----------|-----------|
| No Medications |              | 02/12/20 | 10/29/20  |

**Patient Problem List/History**Active Problem List (Updated 10/29/20 @ 10:27 by Mark A Weitzel, DO)

Speech delay (Acute) F80.9  
 Recurrent acute otitis media (Acute) H66.90  
 Eustachian tube dysfunction (Acute) H69.80

Past Medical History (Reviewed 10/29/20 @ 10:22 by Mark A Weitzel, DO)

Acid reflux K21.9  
 Birth defect Q89.9  
 Cardiac disease I51.9  
 Hearing loss H91.90

Surgical History (Reviewed 10/29/20 @ 10:22 by Mark A Weitzel, DO)

History of dental surgery Z92.89  
 History of hip surgery Z98.890

Family History (Reviewed 10/29/20 @ 10:22 by Mark A Weitzel, DO)Other

Asthma  
 DM2 (diabetes mellitus, type 2)

Report #: 1029-00170

CC: MMGEMPTY; KOBAH.P

Page 2 of 5

Mercer Medical Group ENT \* 122 12th Street \* Third Floor- Suite A \* Princeton, WV 24740 \* (304) 487-3407

From: &lt;ScanSTAT Technologies&gt;

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Page: 8/10

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**EXHIBIT NO. B20F  
PAGE: 4 OF 6****Mercer Medical Group****Princeton Community Hospital**

Primary Care \* Cardiology \* ENT \* General Surgery  
 Nephrology \* Neurology \* Pulmonology  
 Urology \* Women's Health

|                                |                             |
|--------------------------------|-----------------------------|
| <b>PATIENT:</b> Adams,Nevaeh H | <b>ACCT #:</b> MM0000135381 |
|--------------------------------|-----------------------------|

**Social History** (Reviewed 10/29/20 @ 10:22 by Mark A Weitzel, DO)**second hand exposure:** No**ROS****Const**

Reports system reviewed and no additional complaints, except as documented

**ENT**

Reports otalgia (WITH LOUD NOISES)

**Resp**

Reports system reviewed and no additional complaints, except as documented

**GI**

Reports system reviewed and no additional complaints, except as documented

**ENT Exam-AMB****GENERAL APPEARANCE**

normal weight

**MOOD AND AFFECT**

normal

**COMMUNICATION**

normal

**NEURO EXAM**

cranial II-XII intact, grossly intact and alert and oriented x3

**HEAD & NECK**

Lesions: No

Scars: No

Normal Facial Function: Yes

Normal Parotid Gland: Yes

Normal Submandibular Gland: Yes

Neck Mass: No

Neck Tenderness: No

Report #: 1029-00170

---

CC: MMGEMPTY; KOBBAH.P

Page 3 of 5

Mercer Medical Group ENT \* 122 12th Street \* Third Floor- Suite A \* Princeton, WV 24740 \* (304) 487-3407

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**EXHIBIT NO. B20F  
PAGE: 5 OF 6****Mercer Medical Group****Princeton Community Hospital**

Primary Care \* Cardiology \* ENT \* General Surgery  
 Nephrology \* Neurology \* Pulmonology  
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|                                |                             |
|--------------------------------|-----------------------------|
| <b>PATIENT:</b> Adams,Nevaeh H | <b>ACCT #:</b> MM0000135381 |
|--------------------------------|-----------------------------|

Lymphadenopathy: No

Thyroid Normal: Yes

**NOSE**

Normal to Inspection: Yes

Hyperemic

**ORAL CAVITY**

Normal Gums, Lips, Teeth: Yes

Oropharynx Normal: Yes

**RIGHT EAR**

Normal to Inspection: Yes

Tympanic Membrane: Intact

External Ears Normal: Yes

**LEFT EAR**

Normal to Inspection: Yes

Tympanic Membrane: Intact

External Ears Normal: Yes

**A/P****Assessment & Plan**

(1) Eustachian tube dysfunction:

Status: Acute

Code(s):

H69.80 - Other specified disorders of Eustachian tube, unspecified ear

(2) Recurrent acute otitis media:

Status: Acute

Code(s):

H66.90 - Otitis media, unspecified, unspecified ear

(3) Speech delay:

Status: Acute

Code(s):

F80.9 - Developmental disorder of speech and language, unspecified

Plan - Mark A Weitzel, DO:

Will repeat audiogram

Follow up after repeat audiogram.

Report #: 1029-00170

---

CC: MMGEMPTY; KOBBAH.P

Page 4 of 5

Mercer Medical Group ENT \* 122 12th Street \* Third Floor- Suite A \* Princeton, WV 24740 \* (304) 487-3407

From: <ScanSTAT Technologies> To: JAN DILS ATTORNEYS AT LAW Page: 10/10 Date: 11/29/2020 2:53:28 PM

**EXHIBIT NO. B20F  
PAGE: 6 OF 6**

**Mercer Medical Group**  
**Princeton Community Hospital**  
Primary Care \* Cardiology \* ENT \* General Surgery  
Nephrology \* Neurology \* Pulmonology  
Urology \* Women's Health

**PATIENT:** Adams,Nevaeh H **ACCT #:** MM0000135381

**Clinic Tympanogram**

**Tympanogram**

"NOTE: For complete documentation of TYMPANOMETRY visit, please refer to scanned document section of Meditech Chart."

COMPLETED:: yes

Dictated By:Weitzel D.O., Mark A.

Signed By: <Electronically signed by Mark A. Weitzel D.O.>

10/29/20 1028

Dictated Date/Time: 10/29/20 0948

Report #: 1029-00170

---

CC: MMGEMPTY; KOBBAH.P

Page 5 of 5

Mercer Medical Group ENT \* 122 12th Street \* Third Floor- Suite A \* Princeton, WV 24740 \* (304) 487-3407

EXHIBIT NO. B21F  
PAGE: 1 OF 12



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3044364149

McDowell County BOE Special E

11:00:50 a.m. 12-11-2020

2 / 19

*Due 12*  
**EXHIBIT NO. B21F**  
**PAGE: 2 OF 12**

**ELIGIBILITY COMMITTEE REPORT**

McDowell County Schools

Student Full Name Nevaeh AdamsDate December 12, 2019School Fall River ElementaryDate of Birth July 21, 2015Parent(s)/Guardian(s) Kelli AdamsGrade PKAddress 250 Melvin StreetWVEIS # 600022696City/State/Zip Big Sandy, WV 24816Telephone 304-938-6159 Initial Reevaluation**The Eligibility Committee (EC) considered the following multi-disciplinary reports and other relevant information.**

- |                                                           |                                                                  |                                                             |
|-----------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------|
| <input checked="" type="checkbox"/> Academic Information  | <input type="checkbox"/> Developmental Skills                    | <input type="checkbox"/> Social Skills                      |
| <input type="checkbox"/> Achievement                      | <input type="checkbox"/> Health                                  | <input type="checkbox"/> Transition Assessments             |
| <input type="checkbox"/> Classroom Performance            | <input type="checkbox"/> Hearing                                 | <input type="checkbox"/> Functional Vocational Evaluation   |
| <input checked="" type="checkbox"/> Teacher Report        | <input checked="" type="checkbox"/> Information from the Parents | <input type="checkbox"/> Vocational Aptitudes               |
| <input type="checkbox"/> Adaptive Skills                  | <input type="checkbox"/> Intellectual Ability                    | <input type="checkbox"/> Interests/Preferences              |
| <input type="checkbox"/> Assistive Technology             | <input type="checkbox"/> Motor Skills                            | <input type="checkbox"/> Vision                             |
| <input type="checkbox"/> Behavioral Performance           | <input type="checkbox"/> Observation(s)                          | <input type="checkbox"/> Orientation and Mobility           |
| <input type="checkbox"/> Functional Behavioral Assessment | <input type="checkbox"/> Perceptual-Motor                        | <input checked="" type="checkbox"/> Other <u>Evaluation</u> |
| <input checked="" type="checkbox"/> Communication         |                                                                  |                                                             |

**A student cannot be identified as a student in need of special education services if the primary reason for the decision is due to any of the following:**

- A lack of appropriate instruction in the essential components of reading; or
- A lack of instruction in mathematics; or
- Limited English proficiency

**For initial evaluation or reevaluation, the student meets the three-prong test of eligibility:**

- Meets the eligibility requirements for one of the specific exceptionailities; **and**
- Experiences an adverse effect on educational performance; **and**
- Needs special education.

**For reevaluation only:**

If a student no longer meets the eligibility criteria in one of the designated exceptionailities, the EC must provide the justification for continued eligibility. \_\_\_\_\_

**The Eligibility Committee has determined the student's primary area of exceptionality is (only one):**

- |                                                              |                                                                                                       |                                                                     |
|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Autism (AU)                         | <input type="checkbox"/> Exceptional Gifted (EG)                                                      | <input type="checkbox"/> Developmental Delay (PS)                   |
| <input type="checkbox"/> Emotional/Behavioral Disorders (BD) | <input type="checkbox"/> Gifted (GF)                                                                  | <input type="checkbox"/> Specific Learning Disability (LD)          |
| <input type="checkbox"/> Blindness and Low Vision (VI)*      | <input type="checkbox"/> Orthopedic Impairment (PH)                                                   | <input checked="" type="checkbox"/> Speech/Language Impairment (CD) |
| <input type="checkbox"/> Deafblindness (DB) *                | <input type="checkbox"/> Other Health Impairment (OH)                                                 | <input type="checkbox"/> Traumatic Brain Injury (TB)                |
| <input type="checkbox"/> Deafness (DF) *                     | <input type="checkbox"/> Intellectual Disability (Designate                                           | <input type="checkbox"/> None                                       |
| <input type="checkbox"/> Hard of Hearing (HI) *              | <u>WVEIS Code</u> <input type="checkbox"/> MM <input type="checkbox"/> MD <input type="checkbox"/> MS |                                                                     |

\* Provide information pertaining to the West Virginia Schools for the Deaf and Blind.

Additional evaluation data are needed in the following areas: \_\_\_\_\_

The Eligibility Committee has determined the student is not eligible for special education and submits the following recommendations for consideration by the school team (e.g., SAT or instruction and intervention team): \_\_\_\_\_

**Eligibility Committee Members****Signature**

| Signature                  | Position                         |
|----------------------------|----------------------------------|
| <i>Sheri Younger</i>       | Administrator/Principal/Designee |
| <i>Tricia Baurne, MSEd</i> | Evaluator/Specialist             |
| <i>Phyllis Jenkins</i>     | General and/or Special Educator  |
| <i>Karen M. Adams</i>      | Parent/Guardian/Adult Student    |
|                            | Student                          |
|                            | Other _____                      |

West Virginia Department of Education

March 2017

3044364149

McDowell County BOE Special E

11:01:29 a.m. 12-11-2020

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**INDIVIDUALIZED EDUCATION PROGRAM  
MCDOWELL COUNTY BOARD OF  
EDUCATION**

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Student's Full Name ADAMS,NEVAEH

IEP Meeting Date April 23, 2020

**PART I: STUDENT INFORMATION**

|                                  |                                     |                                             |            |                   |
|----------------------------------|-------------------------------------|---------------------------------------------|------------|-------------------|
| Student's Full Name:             | <u>ADAMS,NEVAEH</u>                 |                                             | DOB:       | <u>07/21/2015</u> |
| Parent(s)/Guardian(s)/Surrogate: | <u>ADAMS, KELLI</u>                 |                                             | Age:       | <u>4</u>          |
| Address:                         | <u>PO BOX 46</u>                    |                                             | Grade:     | <u>E1</u>         |
| (Address continued):             | <u>BIG SANDY, WV 24816</u>          |                                             | IEP Grade: | <u>E1</u>         |
| School:                          | <u>FALL RIVER ELEMENTARY SCHOOL</u> |                                             | WVEIS#:    | <u>600022696</u>  |
| Telephone                        | Home:                               | Work:                                       |            |                   |
|                                  | <u>(304) 9386159</u>                | <u>MOTHER - (0) 0 ext:<br/>- (0) 0 ext:</u> |            |                   |

Reevaluation Due Date: December 12, 2022Applicable Eligibility: CD

## Meeting Type:

Initial       Annual Review       Reevaluation Review  
 Other: \_\_\_\_\_

Transferred From:

Transferred date:

**PART II: Documentation of Attendance**

| Position                    | Name                    | Signature                         |
|-----------------------------|-------------------------|-----------------------------------|
| Parent                      | <u>Kelli Adams</u>      | <u>Kelli.adams.1990@gmail.com</u> |
| Parent                      |                         |                                   |
| Student                     |                         |                                   |
| General Education Teacher   | <u>Phyllis Perkins</u>  | <u>Phyllis Perkins</u>            |
| Special Education Teacher   |                         |                                   |
| Chairperson                 | <u>Lori Howington</u>   | <u>Lori Howington</u>             |
| Speech/Language Pathologist | <u>Vicki T. Bourene</u> | <u>Vicki.Bourene,msc@wdep</u>     |
|                             |                         |                                   |
|                             |                         |                                   |
|                             |                         |                                   |
|                             |                         |                                   |

The following people participated in the IEP Team meeting via an alternate method:

| Name | Position | Alternate Method |
|------|----------|------------------|
|      |          |                  |
|      |          |                  |
|      |          |                  |
|      |          |                  |

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**PART III A: EXTENDED SCHOOL YEAR (ESY) DETERMINATION**

Will ESY be considered while developing this IEP?

Yes  No (for gifted only)

The IEP Team in making its determination of a student's need for ESY shall review documentation that the student exhibits, or may exhibit:

- Significant regression during an interruption in educational programming;
- A limited ability to recoup, or relearn skills once programming has resumed;
- Regression/recoupmment problem(s) that interfere with the maintenance of identified critical skills as described in the current IEP; and
- Other factors that interfere with the maintenance of identified critical skills as described in the current IEP , such as predictive data; degree of progress; emerging skills and breakthrough opportunities; interfering behaviors; nature and/or severity of the disability; and special circumstances.

*(The lack of clear evidence of such factors may not be used to deny a student ESY services, if the IEP Team determines the need for such services and includes ESY in the IEP .)*

Does the student need extended school year services?

Yes  No  Defer until: June 2021

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**PART IV: CONSIDERATION OF FACTORS FOR IEP DEVELOPMENT/ANNUAL REVIEWS**

The IEP team must consider the following factors for all students:

- The strengths of the student
- The concerns of the parent
- Results of the initial or most recent evaluation of the student. If additional evaluations are needed (specify): No
- Academic, developmental and functional needs of the student

Do the following special considerations apply? If, yes, document in appropriate section(s) of the IEP.

Yes      No

|    |                                                                                                                                                 |   |   |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------|---|---|
| 1. | Is the student identified as gifted?                                                                                                            |   | ✓ |
| 2. | Does the student need assistive technology devices or services?                                                                                 |   | ✓ |
| 3. | <b>Does the student have communication needs?</b><br><i>If yes, address in the IEP.</i>                                                         | ✓ |   |
| 4. | Does the student's behavior impede his or her learning or that of others?                                                                       |   | ✓ |
| 5. | Does the student have blindness or low vision?                                                                                                  |   | ✓ |
| 6. | Is the student deaf or hard of hearing?                                                                                                         |   | ✓ |
| 7. | Does the student have limited English proficiency?                                                                                              |   | ✓ |
| 8. | Does the IEP team intend to invite a representative from a participating agency to a future IEP meeting which will discuss transition services? |   | ✓ |
| 9. | Will this IEP address Transition Services?                                                                                                      |   | ✓ |

If the student understands instructional content at grade level, but is unable to read with sufficient accuracy and fluency to support comprehension at the same rate as his/her peers; or cannot physically manipulate the print medium; or due to blindness/low vision cannot see standard print materials, then click the links to learn more about Accessible Educational Materials. Please refer to the Accessible Educational Materials guidance documents on the WVDE website.)

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**PART V: ASSESSMENT DATA**

| TEST YEAR | R/LA |    |    | Math |    |    | Science |    | Social Studies |    |
|-----------|------|----|----|------|----|----|---------|----|----------------|----|
|           | SS   | PL | LX | SS   | PL | QT | SS      | PL | SS             | PL |
| 2016      |      |    |    |      |    |    | N/A     |    | N/A            |    |
| 2017      |      |    |    |      |    |    |         |    | N/A            |    |
| 2018      |      |    |    |      |    |    |         |    | N/A            |    |
| 2019      |      |    |    |      |    |    |         |    | N/A            |    |

(SS = scale score) (PL = performance level) (LX = lexile score) (QT = quantile score)

| TEST YEAR | R/LA | Math | Science | Social Studies |
|-----------|------|------|---------|----------------|
|           | PL   | PL   | PL      | PL             |
| 2016      |      |      |         |                |
| 2017      |      |      |         |                |
| 2018      |      |      |         |                |
| 2019      |      |      |         |                |

(PL = performance level)

**Interim, Formative, Transition and Additional Assessment Data**

Using current, annual data, list the interim, formative, and transition assessments that have been used with the student and describe the results and implications for specially designed instruction. This could include data relevant to student behavior, setting demands, work habits/ learning skills, technology skills, workplace skills, independent living skills, performance based assessments. Describe the results and implications for specially designed instruction.

| Assessment                             | Date       | Description                                                              |
|----------------------------------------|------------|--------------------------------------------------------------------------|
| Battelle Developmental Inventory       | 05/02/2019 | Delays in Adaptive, Personal-social, communication, motor, and cognitive |
| The Preschool Language Scale-5 (PLS-5) | 11/14/2019 | Mild Language Delay                                                      |
| Goldman-Fristoe 3 Test of Articulation | 11/14/2019 | Normal to very mild articulation delay                                   |
|                                        |            |                                                                          |
|                                        |            |                                                                          |

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**PART VII: PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE****Narrative Descriptions of Present Levels of Academic Achievement and Functional Performance (refer to IEP instructions).****Speech-Language Grade Level Expectations - Grade Pre:**

Preschoolers (age 3) participate in basic conversation up to three exchanges using four-word sentences. They talk to themselves while playing make believe. Their speech is 75% intelligible and fluent without repetition of syllables or words. They say m, w, h, b and p sounds. They understand primary colors, shapes, family members and most body parts. They have 900 to 1,000 words. Students ask "why", "when" "how" questions, use pronouns (I, you, me), refer to others (he, him, she, her) and answer simple "wh" questions. They use grammatical forms including plural and possessive (-s), (-ing), and (-ed). Students follow two-step directions, take turns and play cooperatively.

Preschoolers (age 4) describe personal experiences, resolve disputes with language and begin dramatic play. They talk about what happened during the day using about 4 sentences with four + words. Their speech is 90% intelligible and fluent without repeating sounds or words. Sounds they say include t, d, k, g, n and f. They answer "is" and "when" questions, label family members, name letters and numbers using 1600 words. Students identify order and time words (first, yesterday, etc.) and abstract adjectives (tame, etc.). They are developing compound sentences (and) and using irregular plurals and past tense words (children, ran, etc.) and pronouns (its, our him, myself, yourself, etc.).

**Speech-Language Present Level:**

Due to Nevaeh's starting therapy in December and with school closure due to Covid-19, her present levels, goals, and service time will remain the same.

Nevaeh is a beautiful 4 year, 3-month-old young lady who was evaluated on November 14, 2019. Nevaeh has been diagnosed with Turner's Syndrome, which is a chromosomal condition that effects development in females. She has a leaky aortic valve. Turner Syndrome girls may have speech problems. She has a missing top central incisor which makes her sound productions very difficult. She speaks in complete sentences (i.e: "I want my mommy to come back"). She needs constant cues to stay on tasks as she gets easily distracted. Nevaeh's fluency skills, vocal pitch, intensity, and quality for age and gender are within normal limits. Nevaeh's strengths include speaking in complete sentences and intelligible speech. She presents with developmentally appropriate speech errors which are stimulable and difficult to produce with missing teeth. This articulation delay is considered normal to mild. Her language scores place her in the mild range which do not interfere with her communication especially on the informal assessments but may interfere with basic academic and social skills. Nevaeh is enrolled in a structured-language rich classroom which will provide opportunities for pre-linguistic activities, language activities and structure. She will be able to imitate the activities of the other children as peers are children's greatest teachers. Nevaeh has met the criteria for speech services established by the West Virginia Department of Education for speech services. (see attached Eligibility Determination Checklist). It is recommended that Nevaeh be seen for 90 minutes per month for speech therapy services.

**Impact Statement:**

These language delays impact Nevaeh's classroom performance in language arts, verbal interaction, and basic comprehension in overall communication skills. The classroom teacher will model, praise, and encourage Nevaeh's language skills; however, specialized instruction in speech therapy is needed for remediation of language skills. Many error sounds are developmental in nature and not expected for a child of this age. These sound errors impact Nevaeh's classroom performance in phonemic awareness activities, phonic segmentation, language arts, and oral expression, as well as the ability to communicate wants and needs with family and others. The classroom teacher will model, praise, and encourage Nevaeh's sound productions; however, specialized instruction in special therapy is necessary to correct placement and production of target sounds.

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**PART VIII: ANNUAL GOALS****Progress:**

How and when will the student's progress toward the IEP goals be reported to the parent(s)? Specify.

How? Midterm Grading Period

When? Every Midterm Grading Period

**Goal 1: Access Skills - Speech-Language Therapy**

Critical:✓

By June 2021, through skilled training and instruction with cues and prompts, Nevaeh will correct placement for productions of /s/, /z/, voiceless /th/, /l/, /s/, /r/ blends and production of these sounds in isolation and words to a level of 80% accuracy as measured and recorded on the anecdotal log.

**Goal 2: Access Skills - Speech-Language Therapy**

By June 2021, through skilled training and instruction with cues and prompts, Nevaeh will increase attention to task, follow specific directions, answer questions logically, and understand negative in sentences, analogies, and quantitative (more, most) to a level of 80% accuracy as measured and recorded on the anecdotal log.

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**PART IX: SERVICES**

| A. Supplementary Aids,<br>Services/Program<br>Modifications | Location of<br>Services | Extent/Frequency                     | Initiation Date<br>m/d/y | Duration<br>m/y |
|-------------------------------------------------------------|-------------------------|--------------------------------------|--------------------------|-----------------|
| modeling, praising and encouraging to correct behaviors     | regular classroom       | daily                                | 08/10/2020               | 06/2021         |
|                                                             |                         |                                      |                          |                 |
|                                                             |                         |                                      |                          |                 |
|                                                             |                         |                                      |                          |                 |
|                                                             |                         |                                      |                          |                 |
| B. Special Education Services                               | Location of<br>Services | Extent/Frequency<br>per _____        | Initiation Date<br>m/d/y | Duration<br>m/y |
| Speech-Language Therapy                                     | D SEE                   | 90.00 minutes per Month              | 08/20/2020               | 06/2021         |
|                                                             |                         |                                      |                          |                 |
| C. Related Services                                         | Location of Services    | Extent/Freq<br>Location Add'l Detail | Initiation               | Duration        |
|                                                             |                         |                                      |                          |                 |
|                                                             |                         |                                      |                          |                 |
|                                                             |                         |                                      |                          |                 |
|                                                             |                         |                                      |                          |                 |
|                                                             |                         |                                      |                          |                 |

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**PART X: Placement** - Grade Preschool

Explain the extent, if any, to which the student WILL NOT participate in the general education classroom and/or extracurricular and other non-academic activities. Present levels of academic achievement and functional performance must explain why full participation is not possible.

Due to Neveah's articulation and language errors, specialized instruction is needed. Nevaeh will participate in general education classes with the exception of speech.

| Grades K-12                                                                                       |                                                                                    |
|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| Percentage of time in:                                                                            | <u>99</u> % General Education Environment <u>1</u> % Special Education Environment |
|                                                                                                   | <b>WVEIS LRE Code</b>                                                              |
| <input checked="" type="checkbox"/> General Education: Full-Time (FT) 80% or more                 | 0                                                                                  |
| <input type="checkbox"/> General Education: Part-Time (PT) 40% to 79%                             | 1                                                                                  |
| <input type="checkbox"/> Special Education: Separate Class (SC) (general education less than 40%) | 2                                                                                  |
| <input type="checkbox"/> Special Education: Special School (SS) Public or Private                 | 3                                                                                  |
| <input type="checkbox"/> Special Education: Out-of-School Environment (OSE)                       | 5                                                                                  |
| <input type="checkbox"/> Residential Facility (RF) Public or Private                              | 6                                                                                  |
| <input type="checkbox"/> Parentally placed in private school (Service Plan only)                  | 8                                                                                  |
| <input type="checkbox"/> Correctional facility                                                    | 9                                                                                  |

**Least Restrictive Environment (LRE) Considerations:** The IEP team has considered:

- Annual placement determination based on IEP.
- Only schools and classroom settings appropriate to the student's chronological age.
- Education in a general classroom with the use of supplementary aids and services.
- Potentially harmful effects on the selected LRE placement on the student and the quality of the student's services.
- Education with age-appropriate non-exceptional peers.
- Placement as close to home as possible, in the school the student would normally attend if not exceptional, unless IEP requires other arrangements.

Targeted Case Management may be provided based upon medical necessity.

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**PART XI: Statewide Testing(Please check all appropriate boxes)**

1) Indicate the appropriate WV Measures of Academic Progress Assessment (WVMAP) by checking standard conditions or standard conditions w/accommodations.

2) If the district requires a "District Wide Assessment", all selected WV MAP accommodations apply.

|                                                               |                                                               |
|---------------------------------------------------------------|---------------------------------------------------------------|
| <b>All WV-MAP Grades 3-11</b>                                 | <b>Alternate Assessment Grades 3-11</b>                       |
| <input type="checkbox"/> Standard Conditions                  | <input type="checkbox"/> Standard Conditions                  |
| <input type="checkbox"/> Standard Conditions w/Accommodations | <input type="checkbox"/> Standard Conditions w/Accommodations |

**NOTE:** For Alternate Assessment eligibility, the student **must** exhibit significant intellectual disabilities, be instructed through Alternate Academic Achievement Standards and be pursuing an alternate (modified) diploma (ages 14+).

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**PART XII: PRIOR WRITTEN NOTICE OF DISTRICT'S PROPOSAL/REFUSAL**

Dear Parent/Adult Student:

As a result of :

- an Individualized Education Program (IEP) Team Meeting conducted on **04-23-2020**.
- A disciplinary action occurring on: \_\_\_\_\_.
- other \_\_\_\_\_

The district is  proposing or  refusing to  initiate or  change:

- the educational evaluation or reevaluation of the student.
- the educational placement of the student.
- the provision of a free appropriate public education (FAPE) to the student.

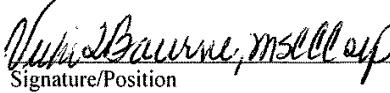
Specifically, the district is proposing to initiate:  
speech services for the student.

The district is proposing this action because:

This action will provide the student with appropriate training and instruction for communication skills.The evaluation procedure(s), assessment(s), record(s), or report(s) the district used as a basis for the proposed action include:  
Documentation of progress, observation, parent and / or teacher input.Other options the district considered, but rejected include:  
to not continue speech services for the student.The reasons the above options were rejected include:  
the student's present functional level does not support this action at this time.Other factors relevant to the district's proposal include:  
The team agrees specialized instruction will benefit the student for effective communication with teachers and peers in the classroom setting.

Exceptional students and their parents have protections under the procedural safeguards. A copy of the Procedural Safeguards Brochure and assistance in understanding the provisions of the procedural safeguards may be obtained by contacting the Director of Special Education at 304-436-8441, if available, the local Parent Educator Resource Center at 304-436-8441 and/or the West Virginia Department of Education, Office of Special Education at 304-558-2696 or 1-800-642-8541.

Sincerely,


4-27-20

Signature/Position

Date