Order Number:
145404

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
3FV5J29AF99	12/30/2025	12/30/2025 to 2/27/2026	1FW00003714301	458178

Patient's Name and Address:
JAMIE HATFIELD (682) 429-0572
2151 GREEN OAKS ROAD
FORT WORTH, TX 76116-1721

Provider's Name, Address and Telephone Number:
BRIDGEWAY HEALTH SERVICES DBA RELIANT AT HOME - F: (817) 332-0411
3880 HULEN ST., SUITE 670
FORT WORTH, TX 76107- P: (817) 332-0400

Physician's Name & Address: P: (682)321-7007 F: (682)321-7036

MARY B. SNELLINGS, MD
5802 BERRYHILL DR.
ARLINGTON, TX 76017

Patient's Date of Birth: 7/3/1934
Patient's Gender: FEMALE
Order Date: 12/30/2025 10:41 AM
Verbal Order: Y
Verbal Date: 12/30/2025
Verbal Time: 11:30 AM

Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature)
CHERYL RAY, RN / AMBER VICE RN 12/30/2025

Date HHA Received Signed POC

Patient's Expressed Goals:
TO RETURN TO PLOF

ICD-10 Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	M47.816	SPONDYLOSIS W/O MYELOPATHY OR RADICULOPATHY, LUMBAR REGION	EXACERBATION	12/30/2025
2	I12.9	HYPERTENSIVE CHRONIC KIDNEY DISEASE W STG 1-4/UNSP CHR KDNY	EXACERBATION	12/30/2025
3	N18.2	CHRONIC KIDNEY DISEASE, STAGE 2 (MILD)	EXACERBATION	12/30/2025
4	M10.30	GOUT DUE TO RENAL IMPAIRMENT, UNSPECIFIED SITE	EXACERBATION	12/30/2025
5	G62.9	POLYNEUROPATHY, UNSPECIFIED	EXACERBATION	12/30/2025
6	M81.0	AGE-RELATED OSTEOPOROSIS W/O CURRENT PATHOLOGICAL FRACTURE	EXACERBATION	12/30/2025
7	G43.909	MIGRAINE, UNSP, NOT INTRACTABLE, WITHOUT STATUS MIGRAINOSUS	EXACERBATION	12/30/2025
8	G47.00	INSOMNIA, UNSPECIFIED	EXACERBATION	12/30/2025
9	J30.9	ALLERGIC RHINITIS, UNSPECIFIED	EXACERBATION	12/30/2025
10	M41.9	SCOLIOSIS, UNSPECIFIED	EXACERBATION	12/30/2025
11	L57.0	ACTINIC KERATOSIS	EXACERBATION	12/30/2025
12	R29.6	REPEATED FALLS	EXACERBATION	12/30/2025
13	Z79.83	LONG TERM (CURRENT) USE OF BISPHOSPHONATES	EXACERBATION	12/30/2025
14	Z96.611	PRESENCE OF RIGHT ARTIFICIAL SHOULDER JOINT	EXACERBATION	12/30/2025
15	Z96.612	PRESENCE OF LEFT ARTIFICIAL SHOULDER JOINT	EXACERBATION	12/30/2025
16	Z96.653	PRESENCE OF ARTIFICIAL KNEE JOINT, BILATERAL	EXACERBATION	12/30/2025
17	Z91.81	HISTORY OF FALLING	EXACERBATION	12/30/2025
18	M62.81	MUSCLE WEAKNESS (GENERALIZED)	EXACERBATION	01/05/2026

Frequency/Duration of Visits:
SN 1WK2
PT EFFECTIVE 01/04/2026 1WK8
OT EFFECTIVE 01/11/2026 1WK1

Orders of Discipline and Treatments:
POC WAS APPROVED BY DR. SNELLINGS 12/30/25 11:30 AM GAVE THE VERBAL OKAY FOR ESTABLISHED POC.

SKILLED NURSE TO PERFORM OBSERVATION/ASSESSMENT OF GENITOURINARY STATUS AND INTERVENE TO MINIMIZE COMPLICATIONS OF DISEASE PROCESS. SKILLED NURSE TO PROVIDE INSTRUCTION REGARDING MANAGEMENT OF DISEASE PROCESS, INCLUDING PATHOPHYSIOLOGY, NUTRITIONAL/FLUID REQUIREMENTS AND MEDICATION REGIMEN.

PHYSICAL THERAPIST TO EVALUATE TO DETERMINE CONDITION, PHYSICAL THERAPY PLANS AND REHABILITATION POTENTIAL; EVALUATE HOME ENVIRONMENT TO ELIMINATE STRUCTURAL BARRIERS AND IMPROVE SAFETY TO INCREASE FUNCTIONAL INDEPENDENCE (RAMPS, ADAPTIVE WHEELCHAIR, BATHROOM AIDES) AND DEVELOP PHYSICAL THERAPY PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN. THERAPIST MAY PERFORM O2 SATURATION LEVELS AT EVALUATION VISIT AND PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS OR WITH O2 USE.

OCCUPATIONAL THERAPIST TO EVALUATE FOR OT SERVICES AND DEVELOP PLAN OF CARE FOR PHYSICIAN SIGNATURE TO INCLUDE PHYSICAL AND PSYCHOSOCIAL TEST RESULTS, ESTABLISHMENT OF A PLAN OF TREATMENT, REHABILITATION GOALS, AND EVALUATING THE HOME ENVIRONMENT FOR ACCESSIBILITY AND SAFETY AND RECOMMENDING MODIFICATION. THERAPIST MAY PERFORM O2 SATURATION LEVEL AT EVALUATION VISIT AND PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS OR WITH O2 USE.

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan. I further certify that this patient had a Face-to-Face Encounter performed by a physician or allowed non-physician practitioner that was related to the primary reason the patient requires Home Health services on 12/23/2025.

Attending Physician's Signature and Date Signed

Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal funds may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

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Patient's Name	Provider's Name
JAMIE HATFIELD	BRIDGEWAY HEALTH SERVICES DBA RELIANT AT HOME - FORT WORTH

Orders of Discipline and Treatments:

SKILLED NURSE TO EVALUATE AND DEVELOP PLAN OF CARE TO BE COUNTERSIGNED BY PHYSICIAN. SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING WEAKNESSES AND KNOWLEDGE DEFICIT AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. HOLD ALL HOME HEALTH SERVICES IF THE PATIENT IS HOSPITALIZED; MAY RESUME CARE POST-HOSPITALIZATION. MAY TAKE ORDERS FROM ALL REFERRING PHYSICIANS.

SKILLED NURSE TO PROVIDE AND INSTRUCT REGARDING FALL PREVENTION INTERVENTIONS.

SKILLED NURSE TO MONITOR PLAN FOR CURRENT TREATMENT OF DEPRESSION SUCH AS EFFECTS OF MEDICATION AND/OR NEED FOR REFERRAL FOR OTHER TREATMENT.

SKILLED NURSE TO PROVIDE/INSTRUCT REGARDING INTERVENTION(S) TO MONITOR AND MITIGATE PAIN.

SKILLED NURSE TO PROVIDE INSTRUCT REGARDING INTERVENTION(S) TO PREVENT PRESSURE ULCERS.

PHYSICAL THERAPIST TO EVALUATE/ASSESS AND DEVELOP PHYSICAL THERAPY PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN. HOLD ALL HOME HEALTH SERVICES IF THE PATIENT IS HOSPITALIZED; MAY RESUME CARE POST-HOSPITALIZATION. MAY TAKE ORDERS FROM ALL REFERRING PHYSICIANS.PHYSICAL THERAPY TO ESTABLISH/UPGRADE HOME EXERCISE PROGRAM AND PROVIDE THERAPEUTIC EXERCISES AND SOFT TISSUE/JOINT MOBILIZATION DESIGNED TO RESTORE FUNCTIONAL STRENGTH AND ROM.PHYSICAL THERAPIST TO EDUCATE PATIENT IN FALL PREVENTION AND PROVIDE BALANCE TRAINING INTERVENTIONS TO REDUCE FALL RISK AND ENHANCE FUNCTIONAL MOBILITY.PHYSICAL THERAPY TO EVALUATE GAIT AND PROVIDE GAIT TRAINING USING APPROPRIATE ASSISTIVE DEVICE TO ENSURE PATIENT SAFETY.PHYSICAL THERAPIST TO PROVIDE INSTRUCTION REGARDING PAIN CONTROL INCLUDING PHARMACOLOGIC AND NON-PHARMACOLOGIC METHODS.POC WAS APPROVED BY DR. SNELLINGS ON 1/5/26 AT 1:40 AND GAVE THE VERBAL OKAY FOR ESTABLISHED POC.

THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS ON THIS POC ATTESTS THAT THE PHYSICIAN'S ORDERS WERE RECEIVED ON 12/30/2025.

LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FALLING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS. TEMP<95>100.4 PULSE<50>100 RESP<12>28 SYSTOLICBP<90>160 DIASTOLICBP<50>90 FBS<50>200 RBS<60>300 PAIN>7 O2SAT<90

Goals/Rehabilitation Potential/Discharge Plans:

GENITOURINARY SYSTEM WILL BE EVALUATED AND EXACERBATIONS IDENTIFIED WITH INTERVENTIONS IMPLEMENTED TO MINIMIZE COMPLICATIONS. PATIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE ABILITY MANAGE GENITOURINARY DISEASE AS EVIDENCED BY DECREASED SYMPTOMS AND NO UNPLANNED HOSPITALIZATIONS BY 4 WEEKS
A PHYSICAL THERAPY EVALUATION WILL BE COMPLETED AND A PLAN OF CARE TO INCREASE FUNCTIONAL INDEPENDENCE WILL BE ESTABLISHED FOR THE PHYSICIAN'S REVIEW AND SIGNATURE.
AN OCCUPATIONAL THERAPY EVALUATION WILL BE COMPLETED AND A PLAN OF CARE WILL BE ESTABLISHED FOR THE PHYSICIAN'S SIGNATURE FOR THE ENHANCEMENT OF THE PATIENT'S REHABILITATION POTENTIAL, AND ELIMINATION OF SAFETY HAZARDS TO INCREASE FUNCTIONAL INDEPENDENCE.
A PLAN OF CARE WILL BE ESTABLISHED THAT MEETS THE PATIENT'S NURSING NEEDS AND COUNTERSIGNED BY PHYSICIAN.
CHANGES IN PATIENT CO-MORBID STATUS WILL BE PROMPTLY IDENTIFIED AND REPORTED TO THE PHYSICIAN. PATIENT/CAREGIVER VERBALIZE/DEMONSTRATE MEASURES TO PREVENT FALLS BY 2/27/26
CHANGES IN PATIENT CO-MORBID STATUS WILL BE PROMPTLY IDENTIFIED AND REPORTED TO THE PHYSICIAN. PATIENT/CAREGIVER VERBALIZE/DEMONSTRATE ABILITY TO PROPERLY MANAGE DEPRESSION BY 2/27/26
CHANGES IN PATIENT CO-MORBID STATUS WILL BE PROMPTLY IDENTIFIED AND REPORTED TO THE PHYSICIAN. PATIENT/CAREGIVER VERBALIZE/DEMONSTRATE ABILITY TO PROPERLY MANAGE PAIN BY 2/27/26
CHANGES IN PATIENT CO-MORBID STATUS WILL BE PROMPTLY IDENTIFIED AND REPORTED TO THE PHYSICIAN. PATIENT/CAREGIVER VERBALIZE/DEMONSTRATE MEASURES TO PREVENT PRESSURE ULCERS BY 2/27/26

A PHYSICAL THERAPY PLAN OF CARE WILL BE ORDERED BY PHYSICIAN AND PROVIDED BY PHYSICAL THERAPY. ALL GOALS TO BE MET BY END OF CURRENTLY APPROVED PLAN OF CARE.
PATIENT WILL DEMONSTRATE IMPROVED FUNCTION IN RESPONSE TO SPECIFIC EXERCISE(S) AND/OR MANUAL THERAPY TECHNIQUE(S), AS EVIDENCED BY INCREASED INDEPENDENCE IN ACTIVITIES OF DAILY LIVING BY 8 WEEKS.
PATIENT WILL DEMONSTRATE/VERBALIZE KNOWLEDGE OF INTERVENTIONS TO REDUCE FALL RISK AND IMPROVE FUNCTIONAL MOBILITY AS EVIDENCED BY NO FALLS BY 8 WEEKS.
PATIENT WILL DEMONSTRATE SAFE GAIT TECHNIQUE WITH 4WW AS NEEDED TO IMPROVE FUNCTIONAL MOBILITY AND MINIMIZE RISK OF INJURY BY 8 WEEKS.
PATIENT / CAREGIVER WILL VERBALIZE EFFECTIVE PAIN CONTROL AND UNDERSTAND BOTH PHARMACOLOGIC AND NON-PHARMACOLOGIC PAIN CONTROL METHODS BY 3 WEEKS.

Signature of Physician	Date
Optional Name/Signature Of CHERYL RAY, RN / AMBER VICE RN	Date 12/30/2025

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JAMIE HATFIELD	BRIDGEWAY HEALTH SERVICES DBA RELIANT AT HOME - FORT WORTH

Rehab Potential:
FAIR TO ACHIEVE GOALS AS STATED BY 2/27/26

DC Plans:
DC TO CARE OF FAMILY UNDER SUPERVISION OF MD WHEN GOALS ARE MET

DME and Supplies:
DME-CANE; DME-RAILS/GRAB BARS; DME-SHOWER/TUB EQUIPMENT; DME-WALKER-ROLLING ; GAUZE; GLOVES

Prognosis:
FAIR

Functional Limitations:
BOWEL/BLADDER (INCONTINENCE); ENDURANCE; AMBULATION; DYSPNEA WITH MINIMAL EXERTION

Safety Measures:
AS TOLERATED, EMERGENCY PLAN, MED PRECAUTIONS, UNIVERSAL PRECAUTIONS

Activities Permitted:
UP AS TOLERATED; EXERCISES PRESCRIBED; WALKER

Nutritional Requirements:
CARDIAC DIET

Advance Directives:
MED. PWR. OF ATTY

Mental Statuses:
ORIENTED; FORGETFUL

Supporting Documentation for Cognitive Status:
(C1) (QM) (PRA) (M1700) COGNITIVE FUNCTIONING: PATIENT'S CURRENT (DAY OF ASSESSMENT) LEVEL OF ALERTNESS, ORIENTATION, COMPREHENSION, CONCENTRATION, AND IMMEDIATE MEMORY FOR SIMPLE COMMANDS.
0 - ALERT/ORIENTED, ABLE TO FOCUS AND SHIFT ATTENTION, COMPREHENDS AND RECALLS TASK DIRECTIONS INDEPENDENTLY.
(QM) (M1710) WHEN CONFUSED (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:
1 - IN NEW OR COMPLEX SITUATIONS ONLY
(QM) (M1720) WHEN ANXIOUS (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:
2 - DAILY, BUT NOT CONSTANTLY
(C1) (QM) (PRA) (M1740) COGNITIVE, BEHAVIORAL, AND PSYCHIATRIC SYMPTOMS THAT ARE DEMONSTRATED AT LEAST ONCE A WEEK (REPORTED OR OBSERVED): (MARK ALL THAT APPLY.)
7 - NONE OF THE ABOVE BEHAVIORS DEMONSTRATED

Supporting Documentation for Psychosocial Status:
(QM) (M1100B) PATIENT LIVES WITH OTHER PERSON(S) IN THE HOME: WHICH OF THE FOLLOWING BEST DESCRIBES THE PATIENT'S AVAILABILITY OF ASSISTANCE AT THEIR RESIDENCE?
07 - REGULAR DAYTIME

Supporting Documentation for Risk of Hospital Readmission:
(PRA) (M1033) RISK FOR HOSPITALIZATION: WHICH OF THE FOLLOWING SIGNS OR SYMPTOMS CHARACTERIZE THIS PATIENT AS AT RISK FOR HOSPITALIZATION? (MARK ALL THAT APPLY.)
1 - HISTORY OF FALLS (2 OR MORE FALLS - OR ANY FALL WITH AN INJURY - IN THE PAST 12 MONTHS) || 5 - DECLINE IN MENTAL, EMOTIONAL, OR BEHAVIORAL STATUS IN THE PAST 3 MONTHS || 6 - REPORTED OR OBSERVED HISTORY OF DIFFICULTY COMPLYING WITH ANY MEDICAL INSTRUCTIONS (FOR EXAMPLE, MEDICATIONS, DIET, EXERCISE) IN THE PAST 3 MONTHS || 7 - CURRENTLY TAKING 5 OR MORE MEDICATIONS || 8 - CURRENTLY REPORTS EXHAUSTION

Allergies:
ADHESIVE TAPE; PENICILLIN

Signature of Physician	Date
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Medications:

Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
ALENDRONATE 70 MG TABLET *1 tablet* Reason: BONES Instructions:	*WEEKLY*	ORAL			
ALLOPURINOL 100 MG TABLET *1 tablet* Reason: GOUT Instructions:	*DAILY*	ORAL			
IBUPROFEN 600 MG TABLET *1 tablet* Reason: PAIN Instructions:	*EVERY 8 HOURS/PRN*	ORAL			
MIRTAZAPINE 15 MG TABLET *1 tablet* Reason: DEPRESSION Instructions:	*DAILY*	ORAL			
OMEPRAZOLE 20 MG CAPSULE,DELAYED RELEASE *1 capsule* Reason: GERD Instructions:	*2 TIMES DAILY*	ORAL			
PRAVASTATIN 20 MG TABLET *1 tablet* Reason: CHOLESTEROL Instructions:	*DAILY*	ORAL			
PREGABALIN 75 MG CAPSULE *1 capsule* Reason: PAIN Instructions:	*2 TIMES DAILY*	ORAL			
SERTRALINE 50 MG TABLET *1 tablet* Reason: DEPRESSION Instructions:	*DAILY*	ORAL			
VALSARTAN 80 MG-HYDROCHLOROTHIAZIDE 12.5 MG TABLET *1 tablet* Reason: BP Instructions:	*DAILY*	ORAL			
VITAMIN D3 125 MCG (5,000 UNIT) TABLET *1 tablet* Reason: VITAMIN Instructions:	*DAILY*	ORAL			

Supporting Documentation for Home Health Eligibility:

IMPAIRED BODY FUNCTIONS THAT EITHER REQUIRE HOME HEALTH INTERVENTION OR WILL IMPACT THE PLAN OF CARE:
CARDIOVASCULAR FUNCTIONS, NEUROMUSCULOSKELETAL AND MOVEMENT RELATED FUNCTIONS

ACTIVITY LIMITATIONS AND PARTICIPATION RESTRICTIONS:
LEARNING AND APPLYING KNOWLEDGE, MOBILITY, SELF MANAGEMENT OF HEALTH CONDITIONS

THE PATIENT IS HOMEBOUND BECAUSE OF THESE ENVIRONMENTAL AND/OR PHYSICAL CONDITIONS:
FALL RISK, IMPAIRED GAIT, POOR BALANCE, REQUIRES ASSISTIVE DEVICE FOR SAFE AMBULATION, WEAKNESS

DUE TO ILLNESS OR INJURY, THE PATIENT IS RESTRICTED FROM LEAVING HOME EXCEPT WITH:
THE AID OF SUPPORTIVE DEVICES SUCH AS CRUTCHES, WHEELCHAIRS, OR WALKERS, THE ASSISTANCE OF ANOTHER PERSON

DOES THE PATIENT HAVE A NORMAL INABILITY TO LEAVE HOME SUCH THAT LEAVING HOME REQUIRES CONSIDERABLE AND TAXING EFFORT?
YES

Signature of Physician	Date
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Therapy Short Term/Long Term Goals:

Discipline: PT

FUNCTIONAL TESTS (PT)

TINETTI BALANCE AND GAIT SCORE (/28)

STG: 12	LTG: 17
TARGET DATE: 2/6/2026	TARGET DATE: 2/27/2026

MOBILITY/GAIT

MOBILITY: WALK 150FT IN CORRIDOR

STG: 05 - SETUP OR CLEAN-UP ASSISTANCE	LTG: 06 - INDEPENDENT
TARGET DATE: 2/6/2026	TARGET DATE: 2/27/2026

STRENGTH (PT)

RIGHT LOWER EXTREMITY

STG: 4/GOOD	LTG: 4+/GOOD+
TARGET DATE: 2/6/2026	TARGET DATE: 2/27/2026

LEFT LOWER EXTREMITY

STG: 4-/GOOD-	LTG: 4+/GOOD+
TARGET DATE: 2/6/2026	TARGET DATE: 2/27/2026

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