Order Number:
1111111

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
	1/10/2022	1/10/2022 to 3/10/2022	123456789	44444444

Patient's Name and Address:
MINNIE MOUSE (123) 456-7890
1234 MAIN ST
ANY CITY, USA 12345

Provider's Name, Address and Telephone Number:
HOME HEALTH AGENCY F: (123)867-5309
4567 MAIN ST
ANY CITY, USA 12345 P: (123)456-7899

Physician's Name & Address: P: (386)409-6839 F: (386)409-6916

JOHN DOE, MD
8910 MAIN ST
ANY CITY USA 12345

Patient's Date of Birth: 1/1/44
Patient's Gender: FEMALE
Order Date: 1/10/2022 1:56 PM
Verbal Order: Y
Verbal Date: 1/10/2022
Verbal Time: 4:55 PM

Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature) THERAPY THERAPIST PT / NANCY NURSE RN 1/10/2022

Date HHA Received Signed POC

Patient's Expressed Goals:
TO GET STRONGER AND IMPROVE ENDURANCE

ICD-10
Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	I95.1	ORTHOSTATIC HYPOTENSION	ONSET	01/04/2022
2	R65.21	SEVERE SEPSIS WITH SEPTIC SHOCK	EXACERBATION	12/29/2021
3	I82.403	ACUTE EMBOLISM AND THOMBOS UNSP DEEP VEINS OF LOW EXTRM, BI	ONSET	01/04/2022

Frequency/Duration of Visits:
PT 2WK3,1WK3
OT 1WK1

Orders of Discipline and Treatments:
PHYSICAL THERAPY TO EVALUATE/ASSESS AND DEVELOP PHYSICAL THERAPY PLAN OF CARE TO BE SIGNED BY THE PHYSICIAN.

PHYSICAL THERAPY TO PROVIDE SKILLED TEACHING TO MINIMIZE AND MANAGE IDENTIFIED RISKS OF HOSPITALIZATION AND/OR ED VISIT LISTED IN SUPPORTING DOCUMENTATION FOR RISK OF HOSPITAL READMISSION SECTION OF THE PLAN OF CARE.

PHYSICAL THERAPY TO PROVIDE FALL PREVENTION STRATEGIES TO REDUCE FALL RISK.

PHYSICAL THERAPY TO PROVIDE THERAPEUTIC ACTIVITY AND EXERCISE TO IMPROVE FUNCTIONAL STRENGTH AND POWER.

PHYSICAL THERAPY TO PROVIDE GAIT TRAINING TO IMPROVE AMBULATION AND SAFETY WITH/WITHOUT ASSISTIVE DEVICE.

PHYSICAL THERAPY TO PROVIDE NEUROMUSCULAR RE-ED AND BALANCE RETRAINING.

PHYSICAL THERAPY TO ESTABLISH/PROGRESS HOME EXERCISE PROGRAM.

PHYSICAL THERAPY TO PROVIDE INSTRUCTION IN ENERGY CONSERVATION TECHNIQUES DESIGNED TO MAXIMIZE PATIENT'S PRODUCTIVITY WITH FUNCTIONAL ACTIVITIES.

LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FALLING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS. TEMP<95>101 PULSE<60>100 RESP<12>24 SYSTOLICBP<90>150 DIASTOLICBP<50>90 PAIN>7 O2SAT<90

Goals/Rehabilitation Potential/Discharge Plans:
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/CAREGIVER VERBALIZES/DEMONSTRATES ABILITY TO MANAGE THE RISK OF HOSPITALIZATION OR ED VISITS AS EVIDENCED BY NO HOSPITALIZATION OR ED VISITS DURING CARE.
POC GOAL: PATIENT WILL IMPROVE AWARENESS OF FALL RISK FACTORS AND DEMONSTRATE APPROPRIATE ACTIONS TO REDUCE RISK FACTORS AS EVIDENCED BY NO FALLS BY 1/28/22
PATIENT WILL IMPROVE FUNCTIONAL STRENGTH AND POWER AS EVIDENCED BY POSITIVE CHANGE WITH IMPROVED ABILITY TO PERFORM SIT TO STAND TRANSFERS WITHOUT USING UES TO PUSH UP BY 2/18/22
PATIENT WILL IMPROVE GAIT AND AMBULATION AS EVIDENCED BY IMPROVED TUG SCORE BY 2/18/22
PATIENT WILL IMPROVE STATIC AND DYNAMIC, FUNCTIONAL BALANCE AS EVIDENCED BY IMPROVED STANDARDIZED BALANCE TEST SCORE BY 2/18/22

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.

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
MINNIE MOUSE	HOME HEALTH AGENCY

Goals/Rehabilitation Potential/Discharge Plans:

PATIENT WILL ADOPT AND INTEGRATE HOME EXERCISE PROGRAM INTO DAILY ROUTINE AS EVIDENCED BY PROGRESSION OF ACTIVITIES AND/OR CONDITION SPECIFIC PROTOCOL BY 1/28/22
PATIENT/CAREGIVER TO DEMONSTRATE UNDERSTANDING OF AND COMPLIANCE WITH ENERGY CONSERVATION MEASURES, AS EVIDENCED BY DYSPNEA RATING OF 4/10 FUNCTIONAL ACTIVITIES BY 2/18/22

Rehab Potential:

GOOD/MARKED IMPROVEMENT IN FUNCTIONAL STATUS IS EXPECTED

DC Plans:

DC TO SELF CARE UNDER SUPERVISION OF MD WHEN GOALS ARE MET

DME and Supplies:

NONE

Prognosis:

GOOD

Functional Limitations:

ENDURANCE; AMBULATION; BALANCE

Safety Measures:

COVID-19 PRECAUTIONS, EMERGENCY PLAN, FALL PRECAUTIONS

Activities Permitted:

EXERCISES PRESCRIBED; WALKER

Nutritional Requirements:

HEART HEALTHY DIET, LOW SODIUM DIET

Advance Directives:

LIVING WILL

Mental Statuses:

ORIENTED

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:
0 - NEVER
(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?
06 - AROUND THE CLOCK
PSYCHOSOCIAL ISSUES THAT COULD POTENTIALLY IMPACT THE PLAN OF CARE (MARK ALL THAT APPLY):
NONE AT THIS TIME

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.)
3 - MULTIPLE HOSPITALIZATIONS (2 OR MORE) IN THE PAST 6 MONTHS || 4 - MULTIPLE EMERGENCY DEPARTMENT VISITS (2 OR MORE) IN THE PAST 6 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:

COW MILK; MIRIPIN

Signature of Physician	Date
Optional Name/Signature Of THERAPY THERAPIST, PT / NANCY NURSE, RN	Date 1/10/2022

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Patient's Name	Provider's Name
MINNIE MOUSE	HOME HEALTH AGENCY

Medications:

Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
BETHANECHOL CHLORIDE 10 MG TABLET		ORAL	01/10/2022		
1 tablet	*3 TIMES DAILY*				
Reason: BLADDER Instructions:					
BIOTIN 1 MG CAPSULE		ORAL	01/10/2022		
1 capsule	*DAILY*				
Reason: SUPPLEMENT Instructions:					
IRBESARTAN 150 MG TABLET		ORAL	01/10/2022		
0.5 tablet	*DAILY*				
Reason: BLOOD PRESSURE Instructions:					
LABETALOL 100 MG TABLET		ORAL	01/10/2022		
1 tablet	*3 TIMES DAILY*				
Reason: BLOOD PRESSURE Instructions:					
MIRTAZAPINE 15 MG TABLET		ORAL	01/10/2022		
1 tablet	*DAILY*				
Reason: DEPRESSION Instructions:					
OXYCODONE-ACETAMINOPHEN 5 MG-325 MG TABLET		ORAL	01/10/2022		
1 tablet	*AS NEEDED EVERY 4 HOURS/PRN*				
Reason: PAIN AS NEEDED, NOT TO EXCEED 3 GM PER DAY Instructions:					
SPIRONOLACTONE 25 MG TABLET		ORAL	01/10/2022		
1 tablet	*2 TIMES DAILY*				
Reason: BLOOD PRESSURE Instructions:					
VITAMIN D3 25 MCG (1,000 UNIT) CAPSULE		ORAL	01/10/2022		
1 capsule	*DAILY*				
Reason: SUPPLEMENT Instructions:					

Signature of Physician	Date
Optional Name/Signature Of THERAPY THERAPIST, PT / NANCY NURSE, RN	Date 1/10/2022

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Patient's Name	Provider's Name
MINNIE MOUSE	HOME HEALTH AGENCY

Supporting Documentation for Home Health Eligibility:

FOCUS OF CARE (SUPPORTING CLINICAL INFORMATION, PERTINENT MEDICAL HISTORY, ADDITIONAL DIAGNOSIS, LAST REHOSPITALIZATION, ER, OR URGENCY CARE VISIT):

PT REFERRED TO HOME S/P HOSPITALIZATION DUE TO HEADACHE, NECK PAIN, FOUND TO HAVE CNS INFECTION BACTERIAL MENINGITIS, SEPSIS, HAD SHUNT PLACED IN HEAD AND ALSO DVT BILATERAL LES AND HAD FILTER PLACED. DIAGNOSED WITH DEPRESSION. PT HAS HX OF HTN. PT HAS PITTING EDEMA BILATERAL LES AND WEARS COMPRESSION STOCKINGS. PT IS CURRENTLY USING 2WW TO AMBULATE, HAS DECREASED GAIT SPEED. PT IS MOD I WITH SIT TO STAND TRASNFERS. PT FATIGUES EASILY WITH ACTIVITY AND REQUIRES REST BREAKS TO RECOVER. TODAY, PT SCORED 19.3" TUG, 8/12 SPPB AND 31/56 BEG, INDICATING THAT SHE IS A FALL RISK. PT LIVES IN 2 STORY HOME, BUT HER BEDROOM/KTICHEN/BATHROOM ARE ALL ON MAIN LEVEL, SO PT DOES NOT NEED TO ASCEND/DESCEND STAIRS ON A DAILY BASIS. 2 STEPS TO ENTER HOME THROUGH GARAGE.
PLOF: IND WITH ALL ACTIVITIES/ADLS AND AMBULATION, WOULD TAKE DOG ON WALK OUTSIDE FOR 45 MINUTES
PT GOAL: TO RETURN TO FULL INDEPENDENCE
PT WILL FOCUS ON: LE STRENGTHENING, GAIT TRAINING, BALANCE TRAINING
PT FREQ: 2W3, 1W3
PT PCP IS DR JOHN DOE FOLLOW UP ON FRIDAY
HAD FOLLOW UP WITH NEPHROLOGIST, DR PICKLES, TODAY IS 10 POUNDS LIGHTER THAN HER LAST VISIT, BUT STILL HAS PITTING EDEMA BILATERAL LES. DR PICKLES CALLED IN PRESCRIPTION FOR BUMEX, WAITING ON PHARMACY.

THE PATIENT IS CONSIDERED HOMEBOUND/CONFINED TO HOME BECAUSE: (MARK ALL THAT APPLY)
BECAUSE OF ILLNESS OR INJURY, PATIENT NEEDS AID OF SUPPORTIVE DEVICES - WALKER - LEVEL 1

DOCUMENT PATIENT'S CONDITION AND LIMITATIONS AS IT RELATES TO THEIR HOMEBOUND STATUS
FATIGUE WITH AMBULATION > 100FT USING 2WW AND REQUIRES SEATED REST BREAK TO RECOVER

DOES THE PATIENT MEET LEVEL 2 CRITERIA - NORMAL INABILITY TO LEAVE THE HOME EXISTS AND LEAVING HOME REQUIRES A CONSIDERABLE AND TAXING EFFORT?
WHERE A PHYSICIAN HAS DETERMINED THAT IT IS MEDICALLY CONTRAINDICATED FOR A BENEFICIARY TO LEAVE THE HOME BECAUSE THE PATIENT HAS A CONDITION THAT MAY MAKE THE PATIENT MORE SUSCEPTIBLE TO CONTRACTING COVID-19

Therapy Short Term/Long Term Goals:

Discipline: PT

BALANCE AND FUNCTIONAL CAPACITY (PT)

BERG BALANCE SCALE (BBS) (SUM SCORE)

STG: 40	LTG: 45
TARGET DATE: 1/28/2022	TARGET DATE: 2/18/2022

GAIT (ASSISTANCE)

LEVEL SURFACE ASSISTANCE (ORTHO)

STG: SETUP OR CLEAN-UP ASSISTANCE	LTG: INDEPENDENT
TARGET DATE: 1/28/2022	TARGET DATE: 2/18/2022

UNLEVEL SURFACE ASSISTANCE (ORTHO)

STG: SUPERVISION OR TOUCHING ASSISTANCE	LTG: SETUP OR CLEAN-UP ASSISTANCE
TARGET DATE: 1/28/2022	TARGET DATE: 2/18/2022

STAIRS ASSISTANCE (ORTHO)

STG: SUPERVISION OR TOUCHING ASSISTANCE	LTG: SETUP OR CLEAN-UP ASSISTANCE
TARGET DATE: 1/28/2022	TARGET DATE: 2/18/2022

Signature of Physician	Date
Optional Name/Signature Of THERAPY THERAPIST, PT / NANCY NURSE, RN	Date 1/10/2022