Order Number: 127946

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
3FV5J29AF99	5/12/2025	9/9/2025 to 11/7/2025	1FW00003714301	458178

Patient's Name and Address:
JAMIE HATFIELD (682) 429-0572
2151 GREEN OAKS RD, #4510
FORT WORTH, TX 76116-

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: 9/8/2025 8:00 AM
Verbal Order: Y
Verbal Date: 9/8/2025
Verbal Time: 8:00 AM

Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature)
TIMOTHY BARLOW, RN / AMBER VICE RN 9/8/2025

Date HHA Received Signed POC

Patient's Expressed Goals:
TO GET STRONGER, TO TAKE MY MEDICATION LIKE IM SUPPOSE TO

ICD-10 Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	M17.0	BILATERAL PRIMARY OSTEOARTHRITIS OF KNEE	EXACERBATION	05/12/2025
2	M16.0	BILATERAL PRIMARY OSTEOARTHRITIS OF HIP	EXACERBATION	05/12/2025
3	F41.9	ANXIETY DISORDER, UNSPECIFIED	EXACERBATION	05/12/2025
4	G62.9	POLYNEUROPATHY, UNSPECIFIED	EXACERBATION	05/12/2025
5	M10.9	GOUT, UNSPECIFIED	EXACERBATION	05/12/2025
6	I10	ESSENTIAL (PRIMARY) HYPERTENSION	EXACERBATION	05/12/2025
7	M47.819	SPONDYLOSIS WITHOUT MYELOPATHY OR RADICULOPATHY, SITE UNSP	EXACERBATION	05/12/2025
8	M41.9	SCOLIOSIS, UNSPECIFIED	EXACERBATION	05/12/2025
9	G47.00	INSOMNIA, UNSPECIFIED	EXACERBATION	05/12/2025
10	M85.80	OTH DISRD OF BONE DENSITY AND STRUCTURE, UNSPECIFIED SITE	EXACERBATION	05/12/2025
11	Z79.83	LONG TERM (CURRENT) USE OF BISPHOSPHONATES	EXACERBATION	09/08/2025
12	Z55.6	Problems related to health literacy	EXACERBATION	05/12/2025
13	Z91.81	HISTORY OF FALLING	EXACERBATION	05/12/2025

Frequency/Duration of Visits:
SN EFFECTIVE 09/21/2025 1WK1,1EVERY2WK6

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 BILATERAL KNEE OSTEOARTHRITIS 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 PROVIDE/INSTRUCT REGARDING INTERVENTION(S) TO MONITOR AND MITIGATE PAIN.

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

SKILLED NURSE TO OBSERVE AND ASSESS CARDIOVASCULAR SYSTEM TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED CARDIOVASCULAR STATUS INCLUDING PATHOPHYSIOLOGY, NUTRITION, MEDICATION REGIMEN, AND PERMITTED ACTIVITIES. MAY PERFORM O2 SATURATION LEVELS PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS.

SKILLED NURSE TO REVIEW MEDICATION PROFILE AND RECONCILE MEDICATIONS AS NEEDED. SKILLED NURSE MAY INSTRUCT AND REINFORCE MEDICATION TEACHING RELATED TO USE OF MEDICATIONS TO TREAT DISEASE PROCESSES. SKILLED NURSE MAY FILL MEDI-PLANNER PER CURRENT MEDICATION ORDERS/PROFILE EVERY OTHER WEEK AND PRN.

THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS ON THIS POC ATTESTS THAT THE PHYSICIAN'S ORDERS WERE RECEIVED ON 9/8/2025.

I recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. 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

Electronically Signed by Dr. Snellings, Mary B. on 09/14/2025

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.

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
3FV5J29AF99	5/12/2025	9/9/2025 to 11/7/2025	1FW00003714301	458178

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

Orders of Discipline and Treatments:

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:

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 11/7.
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 11/7
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 11/7.
CARDIOVASCULAR EXACERBATIONS WILL BE IDENTIFIED PROMPTLY AND INTERVENTIONS INITIATED TO MINIMIZE RISKS.
PATIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE AN ABILITY TO MANAGE CARDIOVASCULAR DISEASE AS EVIDENCED BY NO UNPLANNED HOSPITALIZATIONS BY 11/7. ABNORMAL O2 SATURATION LEVELS WILL BE REPORTED TO PHYSICIAN.
PATIENT WILL DEMONSTRATE COMPLIANCE WITH MEDICATIONS AS PRESCRIBED. PATIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE UNDERSTANDING OF MEDICATION SCHEDULE, PURPOSE, SIDE EFFECTS AND AND ANY SPECIAL PRECAUTIONS RELATED TO MEDICATION REGIMEN BY 11/7.

Rehab Potential:

FAIR TO ACHIEVE GOALS AS STATED BY 11/7

DC Plans:

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

DME and Supplies:

ALCOHOL; DME-WALKER-ROLLING ; ELEVATED/RAISED TOILET SEAT; GAUZE; GLOVES ; GRAB BARS; THERMOMETER SHEATH

Prognosis:

FAIR

Functional Limitations:

BOWEL/BLADDER (INCONTINENCE); HEARING; ENDURANCE; AMBULATION; ASSISTIVE DEVICE TO AMBULATE; DYSPNEA WITH MODERATE EXERTION; PAIN; POOR BALANCE/COORDINATION; DECREASED BLANCE/COORDINATION; EASILY FATIGUES; DIZZINESS AT TIMES; FORGETFUL; ANXIETY ; ASSISTANCE NEEDED WITH MEDICATIONS ; ADVANCED AGE; POOR SAFETY AWARENESS AND IMPULSIVITY; DECREASED VISION

Safety Measures:

ADEQUATE LIGHTING, AS TOLERATED, CLEAN TECHNIQUE, CLEAR PATHWAYS, DISPOSAL OF MEDICAL WASTE, EMERGENCY PLAN, MED PRECAUTIONS, REMOVAL OF THROW RUGS, REMOVE CLUTTER, UNIVERSAL PRECAUTIONS

Activities Permitted:

UP AS TOLERATED; WALKER; ASSIST MOBILITY; ASSIST TO LEAVE HOME; FREQUENT REST PERIODS; FALL PRECAUTIONS; FREQUENT FALLS

Nutritional Requirements:

REGULAR DIET

Advance Directives:

NONE

Mental Statuses:

ORIENTED; FORGETFUL

Supporting Documentation for Cognitive Status:

INDICATE BEHAVIORAL ASSESSMENT FINDINGS (MARK ALL THAT APPLY):
INABILITY TO RECALL EVENTS OF PAST 24 HOURS || INABILITY TO APPROPRIATELY STOP ACTIVITIES || JEOPARDIZES SAFETY THROUGH ACTIONS

Supporting Documentation for Psychosocial Status:

PSYCHOSOCIAL ISSUES THAT COULD POTENTIALLY IMPACT THE PLAN OF CARE (MARK ALL THAT APPLY):
INADEQUATE SOCIAL/FAMILY SUPPORT || STRESSFUL ENVIRONMENT

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) || 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

Signature of Physician	Date
Electronically Signed by Dr. Snellings, Mary B. on 09/14/2025	
Optional Name/Signature Of TIMOTHY BARLOW, RN / AMBER VICE RN	Date 9/8/2025

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
3FV5J29AF99	5/12/2025	9/9/2025 to 11/7/2025	1FW00003714301	458178

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

Allergies:

NKA

Medications:

Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
ALENDRONATE 70 MG TABLET		ORAL			
1 tablet	*WEEKLY*				
Reason: BONE HEALTH					
Instructions:					
ALLOPURINOL 100 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: GOUT					
Instructions:					
D3-5000 125 MCG (5,000 UNIT) CAPSULE		ORAL			
1 capsule	*DAILY*				
Reason: BONE HEALTH					
Instructions:					
MIRTAZAPINE 15 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: APPETITE STIMULANT					
Instructions:					
MONTELUKAST 10 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: ALLERGIES					
Instructions:					
OMEPRAZOLE 20 MG CAPSULE,DELAYED RELEASE		ORAL			
1 capsule	*DAILY*				
Reason: GERD					
Instructions:					
PRAVASTATIN 20 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: CHOLESTEROL					
Instructions:					
PREGABALIN 75 MG CAPSULE		ORAL			
1 capsule	*DAILY*				
Reason: PAIN					
Instructions:					
SERTRALINE 50 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: DEPRESSION					
Instructions:					
VALSARTAN 80 MG-HYDROCHLOROTHIAZIDE 12.5 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: BP					
Instructions:					

Signature of Physician	Date
Electronically Signed by Dr. Snellings, Mary B. on 09/14/2025	
Optional Name/Signature Of TIMOTHY BARLOW, RN / AMBER VICE RN	Date 9/8/2025

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
3FV5J29AF99	5/12/2025	9/9/2025 to 11/7/2025	1FW00003714301	458178

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

Supporting Documentation for Home Health Eligibility:

IMPAIRED BODY FUNCTIONS THAT EITHER REQUIRE HOME HEALTH INTERVENTION OR WILL IMPACT THE PLAN OF CARE:
CARDIOVASCULAR FUNCTIONS, DIGESTIVE FUNCTIONS, EYES OR HEARING IMPAIRMENT, GENITOURINARY FUNCTIONS, MENTAL FUNCTIONS, NEUROMUSCULOSKELETAL AND MOVEMENT RELATED FUNCTIONS, PAIN, RESPIRATORY FUNCTIONS, SENSORY FUNCTIONS

ACTIVITY LIMITATIONS AND PARTICIPATION RESTRICTIONS:
COMMUNICATION, DOMESTIC LIFE/IADLS, LEARNING AND APPLYING KNOWLEDGE, MEDICATION MANAGEMENT, MOBILITY, SELF CARE/ADLS, SELF MANAGEMENT OF HEALTH CONDITIONS, WELLNESS AND EXERCISE

THE PATIENT IS HOMEBOUND BECAUSE OF THESE ENVIRONMENTAL AND/OR PHYSICAL CONDITIONS:
FALL RISK, IMPAIRED GAIT, IMPAIRED MENTAL PROCESSING, IMPAIRED VISUAL ACUITY, ONLY ABLE TO AMBULATE A FEW FEET, POOR BALANCE, REQUIRES ASSISTIVE DEVICE FOR SAFE AMBULATION, REQUIRES HUMAN AND DEVICE ASSISTANCE FOR TRANSFERS, RISK FOR INFECTION, WEAKNESS

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

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

Signature of Physician	Date
Electronically Signed by Dr. Snellings, Mary B. on 09/14/2025	
Optional Name/Signature Of TIMOTHY BARLOW, RN / AMBER VICE RN	Date 9/8/2025