Department of Health and Human Services Centers for Medicare & Medicaid Services — Form Approved OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
448607490C2	10/23/2014	From: 10/23/2014 To: 12/21/2014	IHHC-127	747682

6. Patient's Name and Address
Alsip, Jeromy
3831 MEHALIA DR.
Dallas, TX 75241
(469) 233-1544

7. Provider's Name, Address and Telephone Number
Integris Home Health Care, LLC
2735 VILLA CREEK PARKWAY, STE 142,
Dallas, TX 75234
Phone: (972) 249-4999 | Fax: (972) 468-6991
Email: sraju@integrishhc.com

8. Date of Birth 10/19/1983 — 9. Sex [X] M [ ] F

11. ICD-9-CM	Principal Diagnosis	Date
333.99	Extrapyramidal dis NEC	10/23/2014

12. ICD-9-CM	Surgical Procedure	Date

13. ICD-9-CM	Other Pertinent Diagnoses	Date
724.3	Sciatica	10/23/2014
401.9	Hypertension NOS	10/23/2014
V58.69	Long-term use meds NEC	10/23/2014
300.00	Anxiety state NOS	10/23/2014

10. Medications: Dose/Frequency/Route (N)ew (C)hanged (U)nchanged
HALOPERIDOL 10 MG ORAL TABLET 1 tab QID By mouth (PO) U
DEPAKOTE 500 MG ORAL DELAYED RELEASE TABLET 1 tab morning
2 tabs night By mouth (PO) U
DIPHENHYDRAMINE 50 MG ORAL CAPSULE 1 tab twice daily By mouth (PO) U
TRAZODONE 100 MG ORAL TABLET 1 tab at bedtime prn By mouth (PO) U
LORAZEPAM 2 MG ORAL TABLET 1 tab every 6 hours By mouth (PO) N

14. DME and Supplies
, Alcohol Pads, Exam Gloves, Probe Covers, Tape, blood pressure

15. Safety Measures:
Emergency Plan Developed, Safety in ADLs, Slow Position Change,

16. Nutritional Req. Heart Healthy.

17. Allergies: NKA (Food/Drugs/Latex/Environment)

18.A. Functional Limitations
1 [ ] Amputation; 2 [ ] Bowel/Bladder (Incontinence); 3 [ ] Contracture; 4 [ ] Hearing; 5 [ ] Paralysis; 6 [ ] Endurance; 7 [ ] Ambulation; 8 [ ] Speech; 9 [ ] Legally Blind; A [ ] Dyspnea With Minimal Exertion; B [X] Other (Specify): social functioning, concentration

18.B. Activities Permitted
1 [ ] Complete Bedrest; 2 [ ] Bedrest BRP; 3 [X] Up As Tolerated; 4 [ ] Transfer Bed/Chair; 5 [ ] Exercises Prescribed; 6 [ ] Partial Weight Bearing; 7 [ ] Independent At Home; 8 [ ] Crutches; 9 [ ] Cane; A [ ] Wheelchair; B [ ] Walker; C [ ] No Restrictions; D [ ] Other (Specify)

19. Mental Status: 1 [X] Oriented; 2 [ ] Comatose; 3 [X] Forgetful; 4 [X] Depressed; 5 [ ] Disoriented; 6 [ ] Lethargic; 7 [ ] Agitated; 8 [ ] Other

20. Prognosis: 1 [ ] Poor; 2 [ ] Guarded; 3 [X] Fair; 4 [ ] Good; 5 [ ] Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
SN Frequency: 1W9. PT Frequency: evaluate and treat. OT Frequency: evaluate and treat. MSW Frequency: evaluate for community resources.
SN to notify MD of: Temperature greater than (>) 100.5 or less than (<) 96.0. Pulse greater than (>) 100 or less than (<) 60. Respirations greater than (>) 24 or less than (<) 12. Systolic BP greater than (>) 160 or less than (<) 90. Diastolic BP greater than (>) 90 or less than (<) 60. O2 Sat (percent) less than (<) 90. Weight Gain/Loss (lbs/7 days) Greater than 5.
Homebound Status: Unable to safely leave home unassisted; Unsafe to leave home due to cognitive or psychiatric impairments; SN to determine (and educate) if the patient/caregiver is able to identify the correct dose, route, desired effect, precautions, and frequency of each medication. MSW to assess psychosocial needs, environment and assist with community referrals and resources. SN to develop individualized emergency plan with patient. SN to assess pain level and effectiveness of nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and hot/cold packs, and to report to physician if patient experienes pain level not acceptable to patient level not acceptable to patient, or pain level greater 5/10. SN to assess for burning pain, sensitivity to touch, lack of coordination, and numbness or tingling in feet, hands, legs, and arms. SN to instruct the patient the following symptoms could be signs of a heart attack: chest discomfort, discomfort in one or both arms, back, neck, jaw, stomach, shortness of breath, cold sweat, nausea, or dizziness. Instruct patient on signs and symptoms that necessitate calling 911. SN to instruct Patient/Caregiver on Heart Healthy diet and assess patient/caregiver for diet compliance. SN to notify physician this patient was screened for depression using the PHQ-2 scale and meets criteria for further evaluation for depression. MSW: visits, every 60 days for provider services. SN to assess/instruct on pain

22. Goals/Rehabilitation Potential/Discharge Plans
Patient will remain free of adverse medication reactions during the episode. The Patient/Caregiver will verbalize understanding of medication regimen, dose, route, frequency, indications, and side effects by 12/22/2014. The patient will have no hospitalizations during the episode. The Patient/Caregiver will verbalize understanding of individualized emergency plan by the end of the episode. Patient will have absence or control of pain as evidenced by optimal mobility and activity necessary for functioning and performing ADLs by the end of the episode.

23. Nurse's Signature and Date of Verbal SOC Where Applicable:
Electronically Signed by: Monica Todd RN 10/23/2014

25. Date HHA Received Signed POT

24. Physician's Name and Address
Ketha, Sumana MD NPI: 1962447805
2925 Skyway Cir N
Irving TX 75038
Phone: (972) 247-3060 | Fax: (888) 841-3651

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed

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

FAXED FAXED

Department of Health and Human Services
Centers for Medicare Medicaid Services

Form Approved
OMB No. 0938-0357

ADDENDUM TO: PLAN OF TREATMENT

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
448607490C2	10/23/2014	From: 10/23/2014 To: 12/21/2014	IHHC-127	747682

6. Patient's Name:	7. Providers Name
Alsip, Jeromy	Integris Home Health Care, LLC

10. Medications
INVEGA SUSTENNA 234 MG/1.5 ML INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE prn Intramuscular (IM) U

13. Diagnoses
296.82 / Atypical depressive dis / 10/23/2014

14. DME and Supplies
monitor

15. Safety Measures
Standard Precautions/Infection Control, Instructed on disaster/emergency plan

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
management, proper body mechanics and safety measures. SN to instruct patient to wear proper footwear when ambulating. SN to instruct patient to change positions slowly. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility. Physical therapist to evaluate and submit plan of treatment.

22. Goals/Rehabilitation Potential/Discharge Plans
Patient/Caregiver will demonstrate/verbalize knowledge regarding daily skin and foot exams (areas affected by neuropathy) by the end of the episode. The Patient/Caregiver will verbalize understanding of symptoms of cardiac complications and when to call 911 by 12/15/2014. Patient will maintain 75% diet compliance and verbalize knowledge and examples of the heart healthy nutritional plan. Patient will have optimal cognitive functioning within parameters established for the stage of disease by the end of the episode. Patient's community resource needs will be met with assistance of social worker. The patient will be free from falls during the episode. The patient will be free from injury during the episode. eye and dentalRehab Potential: Fair for stated goals.

9. Signature of Physician:	10. Date:
X	
11. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Monica Todd RN	12. Date 10/23/2014

Form CMS-487 (U4)(4-87)