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 cooridnation, 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 S. Ketha 11/12/14

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.

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 heatlhy 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:
S. Kelly 11/12/14	
11. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Monica Todd RN	12. Date 10/23/2014

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

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.
510161715A	10/06/2014	From: 10/06/2014 To: 12/04/2014	IHHC-123	747682

6. Patient's Name and Address

Guenther, Maxine
1330 N ROGERS
Irving, TX 75061
(972) 259-9601

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 10/29/1920 **9. Sex** ☐ M ☒ F

11. ICD-9-CM	Principal Diagnosis		Date
733.97	Stress fx shaft femur	E	
12. ICD-9-CM	**Surgical Procedure**		**Date**
13. ICD-9-CM	**Other Pertinent Diagnoses**		**Date**
781.2	Abnormality of gait	E	
715.90	Osteoarthros NOS-unspec	E	
799.3	Debility NOS	E	
338.11	Acute pain due to trauma	E	

10. Medications: Dose/Frequency/Route (N)ew (C)hanged (U)nchanged

CITALOPRAM 20 MG TAB 1 ONCE A DAY By mouth (PO) C
DHEA 25 MG SR TAB 1 ONCE A DAY By mouth (PO) C
B1-EAST(80/20) 1.25 MG SR TAB 1 ONCE A DAY By mouth (PO) U
ARMOUR THYROID 60 MG TAB 1 EVERY MORNING By mouth (PO) C
COLACE 100 MG TAB 1 ONCE A DAY By mouth (PO) U
HYDROCODONE/APAP (10/325) 1TAB 4- TIMES A DAY AS NEEDED FOR PAIN By mouth (PO) U
PROGESTERONE SR 75 MG 1 TAB ONCE A DAY AT BED TIME By mouth (PO) U

14. DME and Supplies

Walker, Alcohol Pads, Exam Gloves, Probe Covers

15. Safety Measures:

Emergency Plan Developed, Fall Precautions, Keep Pathway Clear,

16. Nutritional Req. Regular.

17. Allergies: sulfa

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 ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☒ 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 ☒ Oriented 2 ☐ Comatose 3 ☒ Forgetful 4 ☒ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☒ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

SN Frequency: 1W9. PT Frequency: EVAL &TREAT. OT Frequency: EVAL&TREAT. HHA Frequency: 1W1 2W8.
SN to notify MD of: Temperature greater than (>) 100.5 or less than (<) 95. Pulse greater than (>) 120 or less than (<) 60. Respirations greater than (>) 28 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 R/A. Weight Gain/Loss (lbs/7 days) Greater than 5lbs in 1 wk.
Homebound Status: Exhibits considerable & taxing effort to leave home; Unable to safely leave home unassisted; SN to develop individualized emergency plan with patient. SN to in[illegible]ruct patient on nonpharmacologic pain relief measures, including relaxation techniques, SN to assess skin for breakdown every visit. SN to assess O2 saturation on room air [illegible]e patient the following symptoms could be signs of a heart attack: chest discomfort, [illegible]ach, shortness of breath, cold sweat, nausea, or dizziness. Instruct patient on signs and [illegible]on establishing bladder regimen. SN to perform a neurological assessment each visit. [illegible]evaluate. SN to assess/instruct on pain management, proper body mechanics and safety [illegible]opriate activity levels. SN to instruct patient to wear proper footwear when ambulating. [illegible]e when ambulating. SN to instruct patient to change positions slowly. SN to instruct the [illegible] such as clothes, books, shoes, electrical cords, or other items that may cause patient to [illegible]ency to report any fall with or without minor injury and to call 911 for fall resulting in [illegible] to assist with ADL's & IADL's per HHA care plan. SN to assess patient

Sign, date
Between 10-6-14 & 11-5-14

[illegible]sode. Patient will have absence or control of pain as evidenced by optimal mobility and [illegible] by the end of the episode. Patient skin integrity will remain intact during this episode. [illegible]atory distress during the episode. The Patient/Caregiver will verbalize understanding of [illegible]11 by . The Patient/Caregiver will verbalize and demonstrate edema-relieving measures

[illegible]able:
4

25. Date HHA Received Signed POT

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.

2925 Skyway Cir N
Irving TX 75038
Phone: (972) 247-3060 | Fax: (888) 841-3651

27. Attending Physician's Signature and Date Signed S. Kelle 11/12/14

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.

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.
510161715A	10/06/2014	From: 10/06/2014 To: 12/04/2014	IHHC-123	747682

6. Patient's Name:	7. Providers Name
Guenther, Maxine	Integris Home Health Care, LLC

10. Medications
CYANOCOBALAMIN 1,000 MCG ONCE A WEEK Intramuscular (IM) C

13. Diagnoses
728.87 / Muscle weakness-general (E) /
285.9 / Anemia NOS (E) /
244.9 / Hypothyroidism NOS /
599.0 / Urin tract infection NOS (E) /
477.9 / Allergic rhinitis NOS (E) /
V15.88 / Personal history of fall (E) /

15. Safety Measures
Safety in ADLs, Slow Position Change, Use of Assistive Devices, Instructed on mobility safety, Instructed on safety measures

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
filling medication box to determine if patient is preparing correctly. SN to assess if the Patient/Caregiver can verbalize an understanding of the indication for each medication. SN to assess the Patient/Caregiver administering injectable medications to determine if proper technique is utilized. SN to instruct the Patient/Caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, sedative hypnotics, narcotics, antiarrhythmics, antineoplastics, skeletal muscle relaxants. Physical therapist to evaluate and submit plan of treatment. Occupational therapist to evaluate and submit plan of treatment.

22. Goals/Rehabilitation Potential/Discharge Plans
by . Patient will be without signs/symptoms of UTI (pain, foul odor, cloudy or blood-tinged urine and fever) during this episode. Patient will be free from signs and symptoms of constipation during the episode. Neuro status will be within normal limits and free of S&S of complications or further deterioration. Patient will have increased mobility, self care, endurance, ROM and decreased pain by the end of the episode. The patient will be free from falls during the episode. Patient will remain free of adverse medication reactions during the episode. Rehab Potential: Fair for stated goals.Discharge when goals met.

9. Signature of Physician:	10. Date: 11/12/14
11. Optional Name / Signature of Nurse / Therapist Electronically Signed by: Anna Abraham RN	12. Date 10/9/2014

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