



HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.		2. Start Of Care Date 05/01/2025		3. Certification Period From: 10/28/2025 To: 04/25/2026		4. Medical Record No.		5. Provider No.			
6. Patient's Name and Address Jane doe 101 Bedford Ave, Brooklyn, NY 11211, USA					7. Provider's Name, Address and Telephone Number						
8. Date of Birth 02/22/1954			9. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		10. Medications: Dose/Frequency/Route (N)ew (C)hanged						
11. ICD M62.81		Principal Diagnosis Muscle weakness (generalized)			Date						
12. ICD Z90.10		Surgical Procedure Acquired absence of unspecified breast an			Date						
13. ICD R27.9 R26.81 Z97.3		Other Pertinent Diagnoses Unspecified lack of coordination Unsteadiness on feet Presence of spectacles and contact			Date						
14. DME and Supplies Rollator, Grab Bars, Shower Rails, Shower Chair					15. Safety Measures Fall Precautions, Skin/Pressure Prevention, Emergency Plan, Environment,						
16. Nutritional Req. Soft					17. Allergies Medication Allergies: NKDA. (See Addendum)						
18.A. Functional Limitations					18.B. Activities Permitted						
1 <input type="checkbox"/> Amputation		5 <input type="checkbox"/> Paralysis		9 <input type="checkbox"/> Legally Blind			1 <input type="checkbox"/> Complete Bedrest		6 <input type="checkbox"/> Partial Weight Bearing		A <input type="checkbox"/> Wheelchair
2 <input type="checkbox"/> Bowel/Bladder (Incontinance)		6 <input type="checkbox"/> Endurance		A <input type="checkbox"/> Dyspnea With Minimal Exertion			2 <input type="checkbox"/> Bedrest BRP		7 <input type="checkbox"/> Independent At Home		B <input type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture		7 <input checked="" type="checkbox"/> Ambulation		B <input type="checkbox"/> Other (Specify)			3 <input type="checkbox"/> Up As Tolerated		8 <input type="checkbox"/> Crutches		C <input checked="" type="checkbox"/> No Restrictions
4 <input checked="" type="checkbox"/> Hearing		8 <input type="checkbox"/> Speech					4 <input type="checkbox"/> Transfer Bed/Chair		9 <input type="checkbox"/> Cane		D <input type="checkbox"/> Other (Specify)
5 <input type="checkbox"/> Exercises Prescribed								5 <input type="checkbox"/> Disoriented		7 <input type="checkbox"/> Agitated	
19. Mental Status		1 <input checked="" type="checkbox"/> Oriented		3 <input type="checkbox"/> Forgetful			6 <input type="checkbox"/> Lethargic		8 <input checked="" type="checkbox"/> Other Alert		
		2 <input type="checkbox"/> Comatose		4 <input checked="" type="checkbox"/> Depressed							
20. Prognosis		1 <input checked="" type="checkbox"/> Poor		2 <input type="checkbox"/> Guarded			3 <input type="checkbox"/> Fair		4 <input type="checkbox"/> Good		5 <input type="checkbox"/> Excellent
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) ORDERS: SN to Assess Patient Needs and Appropriateness of Plan of Care.											
Update Plan of Care As Indicated by Patient Needs, SN for Assessment of: Safety, Personal Care Needs, Medication Regimen and Supervision of HHA/PCA. Assess CV, CP, GI, GU, Endo, Neuro, MS, PV, Skin, Cognitive and Mental Status, Nutrition and Hydration Status, Assess / Instruct On Health Status / Maintenance, Activities Permitted, Safety Measures, And Management. SN to notify MD if heart rate is below 50 or above 120bpm or if blood pressure is less than 90/50 or above (See Addendum)											
22. Goals/Rehabilitation Potential/Discharge Plans GOALS: Patient Demonstrates Improvement in the Following: (See Addendum)											
23. Nurse's Signature and Date of Verbal SOC Where Applicable: 02/09/2026 						25. Date of HHA Received Signed POT 02/09/2026					
24. Physician's Name and Address Dr. Jane Doe 101 Bedford Ave, Brooklyn, NY 11211, USA						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 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.					

ADDENDUM TO HOME CARE



ADDENDUM TO:



PLAN OF TREATMENT



MEDICAL UPDATE

1. Patient's HI Claim No.	2. SOC 05/01/2025	3. Certification Period From: 10/28/2025 To: 04/25/2026	4. Medical Record No.	5. Provider No.
6. Patient's Name Jane Doe			7. Provider Name Home care agency name	
8. Item No.				
12	Z90.10 - Acquired absence of unspecified breast and nipple -			
13	H52.7 - Unspecified disorder of refraction - H91.90 - Unspecified hearing loss, unspecified ear - K08.409 - Partial loss of teeth, unspecified cause, unspecified class - R27.0 - Ataxia, unspecified - F32.A - Depression, unspecified - C50 - Malignant neoplasm of breast - S32 - Fracture of lumbar spine and pelvis -			
15	Fall Precautions, Skin/Pressure Prevention, Emergency Plan, Environment, Aspiration Precautions, DME/Transfer Safety			
17	Food Allergies: NKA. Substance/Environmental Allergies: NKA.			
21	Safety, Personal Care Needs, Medication Regimen and Supervision of HHA/PCA. Assess CV, CP, GI, GU, Endo, Neuro, MS, PV, Skin, Cognitive and Mental Status, Nutrition and Hydration Status, Assess / Instruct On Health Status / Maintenance, Activities Permitted, Safety Measures, And Management. SN to notify MD if heart rate is below 50 or above 120bpm or if blood pressure is less than 90/50 or above 170/100 and if patient reports pain level above 7 with no relief. Notify MD if blood glucose level is below 55mg/DL or above 240mg/DL. Aide Will Perform Personal Care and ADLs As Specified In Plan Of Care. Service Type: PCA. aide frequency: 7 days x 3 hours			
22	Adequate Personal Care, Adequate ADLs, Maintaining Patient Safely in the Home, Will Comply With All Fall Prevention Duties and Safety Precautions, Demonstrates Safety In Mobility, Use Of Adaptive Devices, Understanding Disease Process, Limitations And Medication Regimen, Maintains Optimal Nutrition/Hydration Status, Demonstrates Appropriate Disease Process Management, Demonstrates Safety In Mobility, Use Of Adaptive Devices, Understanding Disease Process, Limitations And Medication Regimen. Aide Demonstrates Improvement in the Following:			
9. Signature of Physician 			10. Date	
11. Optional Name/Signature of Nurse/Therapist  Jane Doe			12. Date 02/09/2026	