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.:
6565675678A	01/10/2015	01/29/2016 - 03/28/2016	DS000911	652323

6. Patient's Name and Address
SAMSON, DANIAL
125,mailage road
Dallas TX 56589-6552
Phone No:

7. Provider's Name, Address and Telephone Number
Excellent Home Health Care NPI: 1497739544
12200,Ford Road
STE 355
DALLAS TN 37203-1245
Phone No: 928-445-1112 Fax: 584-112-2111

8. Date of Birth: 01/03/1950 **9. Sex:** ◉ 1 - Male ○ 2 - Female

10. Medications: Dose/Frequency/Route/New/Changed

11. ICD-10-CM: **Principal Diagnosis:** **Date:**
A32.12 E

12. ICD-10-CM: **Surgical Procedure:** **Date:**

13. ICD-10-CM: **Other Pertinent Diagnoses:** **Date:**

*** See description at the end of the page**

14. DME and Supplies

15. Safety Measures

16. Nutritional Req

17. Allergies No Known Allergy

18.A. Functional Limitations

18.B. Activities Permitted

Up as tolerated

19. Mental Status
Disoriented;

20. Prognosis ○ Guarded ○ Poor ○ Fair ◉ Good ○ Excellent

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

SN visit frequency : 1w2
SN to Assess VS & all body systems knowledge of disease process and its associated care and treatment, med regimen knowledge, and s/s complications necessitating medical attention.
Spiritual grieving & coping methods : P

S/S of impending death : P

Notification procedures for death at home : P

S/S of complications of diabetes : P

22. Goals/Rehabilitation Potential/Discharge Plans

kl

23. Nurse's Signature and Date of Verbal SOC
Digitally Signed by odhc, administrator, RT on 08/23/16 at 00:00 hrs.
Date of Verbal SOC: 08/02/2016

25. Date HHA Received Signed POT: Array

24. Physician's Name and Address
KLOPMAN, MATTHEW NPI: 1104000116
1364 CLIFTON RD NE
DEPARTMENT OF ANESTHESIOLOGY
ATLANTA, GA 303221059
Phone No: 404-778-3900 Fax: 91-40-23557796

26. 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. 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.

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: 6565675678A	**2. Start of Care Date:** 01/10/2015	**3. Certification Period:** 01/29/2016 - 03/28/2016	**4. Medical Record No.:** DS000911	**5. Provider No.:** 652323
6. Patient's Name: SAMSON, DANIAL	**7. Provider's Name :** Excellent Home Health Care			

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

Mental Status : Disoriented

ADL/IADLs (continued):

Fall Risk Assessment:

Care Management :

Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed

ICD-10-CM Codes	Description
A32.12	Listerial meningoencephalitis

9. Signature of Physician	10. Date
11. Optional Name / Signature of Nurse / Therapist Digitally Signed by odhc, administrator, RT	**12. Date** 08/23/2016 00:00