HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022102

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
83225010	09/15/2026	09/15/2026 - 11/13/2026	30254	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Karen Pinnock 7466E Furnace Branch Road Apt 301 GLEN BURNIE, MD 21060	Female	04/06/1954	240-401-7326
	Email		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI 1487113239		**Fax Number** 410-559-3002

Clinical Condition Requiring Homecare:

PT SOC/admission was completed, consents were obtained, and the patient is a 72-year-old female admitted to BWMC from 9/8/26 through 9/11/26 due to severe right hip, right knee, and right lower-extremity pain with associated difficulty ambulating. The patient reported, "I couldn't put my foot down, I couldn't walk." She stated that she initially developed right knee pain with buckling of the right knee and was unable to get out of bed. She contacted a KP nurse by telephone and subsequently presented to urgent care the week prior to hospitalization, where she underwent multiple tests and was prescribed a prednisone pack. The patient reported temporary improvement while taking steroids but continued to experience significant pain after completing the medication. She was subsequently hospitalized and later sent to rehabilitation. Hospital documentation indicates a history of intractable right hip and back pain, right-sided radicular pain radiating into the right leg, right leg and knee pain, anti-inflammatory arthritis, DVT, gout, and DM2. Past medical history also includes hypertension, hyperlipidemia, history of DVT not on anticoagulation, and history of gout. The patient reports no falls in several years. Prior to this episode, she was completely independent with ambulation without an assistive device and was able to ambulate community distances. She returned home via EMS and currently resides with her spouse, Ewan, who remains with her at all times to provide assistance. The patient lives in a senior apartment building with elevator access. Durable medical equipment available in the home includes a commode, shower tub, wheelchair, and rolling walker. Medication reconciliation was completed. The patient does not have Metformin in the home and reports that she has never taken Metformin. She has a scheduled telehealth appointment with Dr. Willis today and plans to discuss the medication discrepancy with the physician. Dr. Willis was notified that the admission has been completed. The patient and primary caregiver were educated regarding the PT plan of care and home safety. The patient handbook was provided and reviewed.

Physician Statement on Homebound Status:

Due to diagnosis of Gout unspecified, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device.

including home safety measures, fall-prevention strategies, and risk factors for falls. The patient was instructed regarding edema management, including positional strategies such as elevating the lower extremities above heart level during rest periods and using compression garments if recommended by the physician. The patient verbalized understanding of the instructions provided. The patient presents with right lower-extremity pain, decreased bilateral lower-extremity strength, decreased functional mobility, unsteady gait, difficulty with transfers, decreased balance, and increased risk for falls. Safe transfer training was performed using the walker, with instruction and verbal cues for proper hand and foot placement, forward weight shift, and reaching back for the chair before sitting. The patient required standby assistance (SBA) for safe transfers. Gait training was performed on level surfaces using the walker, with SBA required for safety and verbal cues provided for appropriate positioning within the walker, increased bilateral step height and step length, and overall gait safety. Tinetti and TUG gait assessments were performed. The patient was instructed to use the walker at all times for safe ambulation. She was also educated regarding the importance and benefits of daily ambulation, including promoting circulation and preventing complications associated with inactivity. A gradual walking program was recommended, beginning with short walks of approximately 1-2 minutes every 1-2 hours in the home, progressing from 3-5-minute walks as tolerated. The patient reported that pain is well controlled with current medications. Education was provided regarding effective pain management, including taking prescribed pain medication at the onset of pain, monitoring for dizziness and constipation as potential side effects, and contacting 911/EMS or the healthcare provider for chest pain, unrelieved pain, or shortness of breath. The patient was also instructed to take pain medication approximately one hour prior to PT sessions, as appropriate and according to prescribed instructions. The patient was instructed to apply ice to the right lower extremity for 20 minutes using an appropriate protective barrier and to perform skin assessments every five minutes during application. The patient and caregiver demonstrated understanding of the education provided. The patient is homebound due to right lower-extremity pain and functional limitations, requiring human assistance and use of an assistive device to safely leave the home. Leaving the home requires considerable and taxing effort and presents a safety risk. Skilled home health PT is medically necessary to address right lower-extremity pain, bilateral lower-extremity weakness, impaired balance, unsteady gait, transfer difficulties, decreased functional mobility, and increased fall risk. Without skilled PT intervention, the patient is at increased risk for falls, further functional decline, and loss of independence. The patient also presents with difficulty

performing BADLs due to right lower-extremity pain and decreased standing tolerance; therefore, skilled OT intervention is indicated to improve standing tolerance, functional mobility, safety, and independence with BADLs. The patient and caregiver participated in development of the PT plan of care and are in agreement with the plan. Home PT is scheduled to begin 9/15/26 at a frequency of 2W2, followed by 1W6, with visits initially planned for Tuesday/Wednesday and subsequently on Wednesday. The patient will continue to follow up with Dr. Willis regarding her current condition and medication concerns, and the plan of care will focus on progressive strengthening, transfer training, gait training, balance activities, fall prevention, safety awareness, functional mobility, and restoration of the patient's prior level of independence.

Date of Order
09/15/2026
Orders
Physician Face-to-Face Date: 09/11/2026
Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat OT-eval & treat due to Gout unspecified
Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home

1 - SOC - PT Notes: soc
OT Eval Notes:

Physician
Waddleton Willis, Felecia

ICD-10 CM Principal Diagnosis: M10.9. Gout unspecified

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
M25.551	Pain in right hip	EMERGEN-C IMMUNE PO 1 tablet by mouth daily CAPSAICIN CREAM 0.025 % / Apply 1 Application to the skin topical twice a day Commonly known as: ZOSTRIX Diclofenac Sodium - Diclofenac Sodium 1 % Gel / Apply 4 g to the skin topical 2 times daily Commonly known as: VOLTAREN ATORVASTATIN Take 20 MG Tablet by mouth nightly Commonly known as: LIPITOR CHOLECALCIFEROL 25 MCG (1000 UT) Tablet / Take 1,000 Units by mouth once a day Commonly known as: VITAMIN D Co Q 10 - Coenzyme Q10 Take 1 capsule by mouth daily LISINOPRIL Take 10 MG Tablet by mouth daily Commonly known as: ZESTRIL MELOXICAM Take 15 MG Tablet by mouth daily Commonly known as: MOBIC Extra Strength Tylenol - Acetaminophen 1-2 tabs by mouth every 6 hours 2 tabs every 6 hours as needed for mild to moderate pain, not to exceed 6 tabs in 24 hours OXYCODONE 0 Immediate Release 5 MG / 1 Tablet by mouth every 4 hours as needed For diagnoses: Pain of right hip, Ambulatory dysfunction. Commonly known as: ROXICODONE decreased to 1/2 tab daily starting on 9/16/26 as per MD Willis. ASPIRIN 81 MG Tablet by mouth daily Decreased to 1 tab per day by MD Wilis on 9/15/26 Senna S - Senna 50 mg by mouth in the evening 1 tab daily
M47.819	Spondylosis without myelopathy or radiculopathy site unsp	
I10.	Essential (primary) hypertension	
E11.9	Type 2 diabetes mellitus without complications	
E78.00	Pure hypercholesterolemia unspecified	
Z79.84	Long term (current) use of oral hypoglycemic drugs	
Z79.82	Long term (current) use of aspirin	
Z86.718	Personal history of other venous thrombosis and embolism	
Z87.891	Personal history of nicotine dependence	

Prognosis
good

Mental and Psychosocial Status
COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No

Functional Limitations	Activities Permitted
Endurance, Ambulation	Cane, Walker, Exercises Prescribed, Wheelchair, Transfer bed/Chair, Up As Tolerated
DME & Supplies	**Safety Measures**
wheelchair, rolling walker, hand held shower, bath bench, commode, cane	transfer with assist, fall precautions, diabetic precautions, bleeding precautions, avoid temperature extremes, ambulates with device, wheelchair precautions, standard precautions, , ambulates with assistance, , walker precautions, smoke detectors , bathroom safety, activity supervision
Nutrition	**Allergies**
regular	Pcn [Penicillins]

Advance Directives	Caregiver Status
No Advance Directive	2. Non-agency caregiver(s) need training/supportive services to provide assistance
Rehabilitation Potential	**DISCHARGE PLAN:**
SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.	PT: patient will be responsible for managing treatment OT: family/caregiver will be responsible for managing treatment

Orders for Discipline and Treatment:

1 - SOC - PT

OT Eval

OT CAREPLAN

OT frequency WK1: 1 (09/15/26-09/19/26),WK2: 1 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26),WK6: 1 (10/18/26-10/24/26),WK7: 1 (10/25/26-10/31/26)

09/17/2026 Problems : Pain Effect on Sleep
Pain Interference with ADLs
M1400 - Dyspnea
GG0130B1 - Oral Hygiene
GG0130C1 - Toileting Hygiene
GG0130E1 - Shower/Bathe Self
GG0130G1 - Lower Body Dressing
GG0130H1 - Don/Doff Footwear
GG0130A1 - Eating
GG0130F1 - Upper Body Dressing

PROCEDURES: cough/deep breathing exercises, incentive spirometer, home exercise program: Deep breaths, functional ambulation ue strengthening, equipment training, work simplification/energy conservation

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT NARRATIVE

Pt is a 72 y.o. female, HD #0 with PMH of HTN, hyperlipidemia, history of DVT not any

anticoagulation, history of gout presented with intractable right hip and back pain, R sided radicular pain radiating to R leg and DM2. According to the Pt her R knne pain started and she had buckling of R knee, could not get up from her bed. Pt waited but the pain did not subside and was taken to urgent care following a telephone consultation with KP nurse. Pt was put on steriods but that help till she was on it. Pt was taken to ER hospitalized and sent to rehab. given steroid, diagnosed as right leg and knee pain, anti inflammatory arthritis, DVT, gout. Pt has a commode, shower tub, wheelchair, RW. Pt complain of pain in R LE, pain while doing BADLs. OT skilled intervention is reqruied to gain I in BADLs and improves standing toelrance.

OT GOALS

PATIENT-STATED GOAL: To return to plof, ambulate without a walker

GOALS
patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

PT CAREPLAN	PT NARRATIVE
PT frequency WK1: 2 (09/15/26-09/19/26),WK2: 2 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26),WK6: 1 (10/18/26-10/24/26),WK7: 1 (10/25/26-10/31/26),WK8: 1 (11/01/26-11/07/26)	PT SOC/admission completed, obtained consents. Pt is a 72 yo female who was admited to BWMC from 9/8 to 9/11/26 due to severe pain in R hip top knee, I couldnt put my foot down, I couldnt walk" Pt reports that she went to urgent care the week before that, she was on a prednisone pack, she had multipe tests done, but still she does not know the reason she had so much pain. Pt has not had a fall in several years. PLOF pt was a completely independent ambulator with no AD community distances. Pt returned home via EMS. Pts spouse Ewan is with her at all times to provide assistance. Pt lives in a senior apt building, uses elevator.
PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5	
CAREGIVER: 1. Non-agency caregiver(s) currently provide assistance	
HOSPITALIZATION RISKS: 7. Currently taking 5 or more medications	Performed medication reconciliation, pt does not have her Metformin, she has never been on Metformin, she has a telehealth appt with Dr Willis today and she plans to discuss this med with the MD on that phone call today. Performed
STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.	pt and home safety assessment, provided and reviewed pt handbook, discussed and develeoped PT POC.
Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.	
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale	Pt presents with the following deficits, R LE pain, decreased strength in bilateral LEs, decreased functional mobility, unsteady gait, difficulty with transfers, decreased balance, increased risk for falls. Pt will benefit from home PT services to improve strength, functional mobility, transfers, safety with ambulation, steps, balance, and safety awareness to restore independent function at home. Without skilled PT pt is at a risk for falls, further functional decline, and loss of independence.
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.	Discussed and developed PT POC with pt/PCG, each in agreement with PT POC. Pt to be seen for home PT with frequency beginning 9/15/26 2w2, (tue/wed) then 1w6 (wed). Please assign all to Carl L starting next week, will f/u with Dr Willis today.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.	
Provide education content at patient's level of health literacy.	
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.	MD Willis made aware admission has been completed.
Assess: Musculoskeletal status.	
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device	Instructed pt/PCG on what causes edema, and positional strategies to decrease edema, to include elevating LEs above heart during rest periods and use of compression garments if recomended by MD. Pt verbalized understanding of instructions provided.
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.	
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques	
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.	
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training	From pg 32-33 of the pt handbook instructed pt in home safety, preventing falls, risk factors for falls, and home safety measures to decrease the risk for falls.
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.	
; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds	Pt instructed in safe transfers using walker, cues for proper hand/foot placement and fwd wt shift, also for reach back to chair prior to sitting down, pt requiring SBA to safely transfer.
Advance Directive:No Advance Directive	
09/15/2026 Problems : GG0170G1 - Car Transfer GG0170E1 - Chair to Bed to Chair GG0170P1 - Picking Up Object GG0170O1 - 12 Steps GG0170N1 - 4 Steps GG0170M1 - 1 - Step (curb) GG0170L1 - Walk 10 ft on Uneven Surface GG0170K1 - Walk 150 Feet	Pt instructed in safe ambulation skills on level surfaces with walker, pt required sba to safely walk with walker, provided cues for position in walker, increased bilateral step height and length and for safety. Performed Tinetti and TUG gait assessments. Recomended that pt walk with walker at all times.
GG0170J1 - Walk 50 ft with 2 Turns GG0170I1 - Walk 10 Feet GG0170F1 - Toilet Transfer GG0170D1 - Sit to Stand Pain Effect on Sleep Pain Interference with Therapy activities Pain Interference with ADLs M1400 - Dyspnea	Pt educated on importance and benefits of daily ambulation, including improved blood circulation and prevention of complications due to inactivity. Instructed to start a walking program with short walks every 1-2 hours in the home, 1-2x, long walks to start 3-5 min then slowly progress as tolerated.
M2020 - Oral Med Management muscle weakness M2102d - Caregiver Performs Treatment	Pt instructed to apply ice to R LE x 20 minutes with necessary barrier and skin assessments q 5 minutes.
PROCEDURES: train caregiver(s) to perform medical/rehabilitation treatments: Sciatic stretches if indicated, train caregiver(s) to perform medical/rehabilitation treatments: Piriformis stretches if indicated, home exercise program: Supine- ankle pump, quad set, gluteal set, heel slide, SLR, bridging.	Pain well controlled with current meds. Pt instructed on effective pain management, to take pain meds at start of pain, watch for dizzyness and constipation as s/e of pain meds, call 911/EMS or provider for chest pain, unrelieved pain or SOB. Also recomended pt take pain medications 1 hour prior to all PT .
Seated-LAQ hip flex, hip abd, pillow squeeze.	

Standing-Mini squat, heel/toe raise, hip flex, hip abd, hip ext, leg curls., therapeutic modalities: Apply ice to R LE x 20 minutes with necessary barrier and skin assessments q 5 minutes., equipment training: Walker, cane, w/c, dynamic standing balance exercises: Dynamic balance activity to be performed on firm surface with no hands on device, weight shifting L-R with wide BOS, and forward backward with separated stance., gait training on uneven surfaces, gait training/stair training, transfers training, assist with fall prevention: Teach falls risk reduction strategies

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver performs medical/rehabilitation treatments with adequate competence, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 05. Setup or clean-up assistance, Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance, Walk 150 Feet - 05. Setup or clean-up assistance, Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance, 1 - Step (curb) - 05. Setup or clean-up assistance, 4 Steps - 05. Setup or clean-up assistance, 12 Steps - 05. Setup or clean-up assistance, Picking Up Object - 05. Setup or clean-up assistance, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 06. Independent, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

Homebound status- Due to diagnosis of R LE pain pt is unable to leave the house w/o human assistance and the use of an AD. Leaving the house causes such a taking effort that regular trips outside of the home pose a danger to the pts safety. Pt requires human assistance and the use of a walker to leave the home.

PT GOALS
PATIENT-STATED GOAL: I want to be able to walk again without any AD

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Walk 10 ft on Uneven Surface - 05. Setup or clean-up assistance

1 - Step (curb) - 05. Setup or clean-up assistance

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

caregiver performs medical/rehabilitation treatments with adequate competence

Sit to Stand - 06. Independent

Car Transfer - 06. Independent

Walk 10 Feet - 05. Setup or clean-up assistance

Walk 50 ft with 2 Turns - 05. Setup or clean-up assistance

Walk 150 Feet - 05. Setup or clean-up assistance

4 Steps - 05. Setup or clean-up assistance

12 Steps - 05. Setup or clean-up assistance

Picking Up Object - 05. Setup or clean-up assistance

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Shower/Bathe Self - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/15/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.
F2F date: 09/11/2026

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.

Certifying Physician or Allowed Practitioner Name and Address **Felecia Waddleton Willis** 7070 Samuel Morse Dr Columbia, MD 21046 NPI 1366673097	**Phone Number** **Fax Number**

Physician's Signature and Date Signed

X

Felecia Waddleton Willis
09/11/2026: Date of physician last face-to-face

Pinnock, Karen | Cert Period 09/15/26 - 11/13/26