HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 1195954

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
118871438	08/01/2026	08/01/2026 - 09/29/2026	863	239350

Patient's Name and Address	Gender	Date of Birth	Phone Number
Barbara Snider 831 W Sheldon, St Apt 302 Gaylord, MI 49735	Female	02/04/1960	(989) 858-6823
	Email		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
Evergreen Home Health	403 W Main Street Suite A1 Gaylord, MI 49735	989-214-1114
NPI: 1184225021		Fax Number: 866-410-7843

Clinical Condition Requiring Homecare:
- Referral order states the patient may discharge home with home health services for PT, OT, and skilled nursing. - The packet documents a recent acute-care stay at McLaren Northern Michigan from 06/30/2026 through 07/01/2026, followed by admission to Medilodge of Gaylord on 07/01/2026. Diagnoses listed during the facility stay include right hip osteoarthritis, presence of right artificial hip joint, type 2 diabetes with hyperglycemia, mixed hyperlipidemia, epilepsy, hypertension, and COVID-19 exposure. The packet also contains right hip incision wound-care orders and orthopedic follow-up instructions.

Physician Statement on Homebound Status:
patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home, medical condition could get worse if patient leaves home

ICD-10 CM Principal Diagnosis: M16.11. Unilateral primary osteoarthritis right hip

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
Z96.641	Presence of right artificial hip joint	Lisinopril - Lisinopril 20 mg 1 tab by mouth once a day Lamictal - Lamotrigine 100 mg 1 tab by mouth every 12 hours Atorvastatin - Atorvastatin Calcium 1 20mg tablet by mouth once a day Acetaminophen - Acetaminophen 650 mg 1 tab by mouth every 8 hours Trulicity - Dulaglutide 1.5mg subcutaneous once a week
E11.65	Type 2 diabetes mellitus with hyperglycemia	
G40.909	Epilepsy unsp not intractable without status epilepticus	
I10.	Essential (primary) hypertension	

Prognosis	Mental and Psychosocial Status
good	COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No
Functional Limitations Endurance, Ambulation	**Activities Permitted** Up As Tolerated, Walker, Wheelchair
DME & Supplies grab bars, bath bench, wheelchair, 4 wheeled walker	**Safety Measures** walker precautions, restricted ROM, medication safety, fall precautions, diabetic precautions, ambulates with device, hip precautions, wheelchair precautions, seizure precautions, bathroom safety
Nutrition regular	**Allergies** dilantin

Advance Directives
No Advance Directive

Caregiver Status
0. No assistance needed - patient is independent or does not have needs in this area; 0. No assistance needed - patient is independent or does not have needs in this area

Rehabilitation Potential
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.

DISCHARGE PLAN:
patient will be responsible for managing treatment
patient will be responsible for managing treatment
patient will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

PT Eval

OT Eval

SN CAREPLAN

SN frequency WK1: 1 (08/01/26-08/01/26),WK2: 1 (08/02/26-08/08/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 94 > 101.0, heart rate < 50 > 100, respiratory rate < 12 > 20, blood pressure systolic < 90 > 150, blood pressure diastolic < 60 > 100, O2 saturation < 90 > 100, pain < 0 > 7

CAREGIVER: 0. No assistance needed - patient is independent or does not have needs in this area

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls – or any fall with an injury – in the past 12 months), 7. Currently taking 5 or more medications

STANDING ORDERS: Home Health Clinician to provide ongoing patient and caregiver education regarding prevention of skin breakdown and pressure injuries during the home health episode as clinically indicated.; Home Health Clinician to assess fall risk and provide ongoing patient and caregiver education regarding fall prevention and home safety measures throughout the home health episode as clinically indicated.; Home Health Clinician to assess, monitor, educate, and implement non-pharmacological pain management interventions as clinically indicated throughout the home health episode. Notify physician/authorized provider of uncontrolled pain, significant changes in pain status, or adverse medication effects.; Home Health Clinician to assess, monitor, and provide patient/caregiver education regarding mood status, signs and symptoms of depression, and coping strategies throughout the home health episode. Notify physician/authorized provider of significant mood changes, safety concerns, or worsening depressive symptoms.; Home Health Clinician to implement standard and transmission-based infection control precautions as indicated and provide ongoing patient/caregiver education regarding infection prevention throughout the home health episode. Notify physician/authorized provider of suspected or confirmed infection or clinical deterioration.; Home Health Clinician to assess, review, and reinforce patient/caregiver emergency preparedness plan throughout the home health episode, recertifications and resumptions of care.; Home Health Clinician to assess patient advance directive status and provide education regarding advance care planning throughout the home health episode. Assist with identification, completion, or updating of advance directive documents as appropriate and within scope of practice.
Advance Directive:No Advance Directive

08/01/2026 Problems : M1400 - Dyspnea
M2020 - Oral Med Management
dependent edema
seizures
balance deficit
limited strength
limited range of motion
limited endurance

PROCEDURES: cough/deep breathing exercises, incentive spirometer, physician-ordered wound care, wound vacuum

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 optimize mental status with cognition therapy home safety optimize mobility with active and passive range of motion therapeutic exercises diet and fluids to optimize peripheral circulation, related medication(s) purpose, schedule, * how to manage inflammatory process optimize mobility with active and passive range of motion exercises fluid and diet intake to promote healing prevent constipation home safety, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule

SN NARRATIVE

RN was let into building by patient's next door neighbor who was waiting at front door. RN knocked and entered patient's apartment. She is sitting in wheelchair in living room. She transferred to recliner using walker. Admission documents reviewed and signed. Head to toe assessment completed and vitals obtained. Vitals stable. Patient got into car accident in 1989 and shattered her left hip. She states she has "no hip" there now because they did not know how to put an artificial hip in then. Her left leg is therefore shorter and she is required to use a lift shoe. Her incision to her right hip is newly epithelialized since surgery was several weeks ago. Patient denies any pain. She is agreeable with POC. Denied further questions or conerns at conclusion of visit.

SN GOALS

PATIENT-STATED GOAL: regain independence

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

patient/caregiver recalls
* how to manage inflammatory process
* optimize mobility with active and passive range of motion exercises
* fluid and diet intake to promote healing
* prevent constipation
* home safety
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to optimize mental status with cognition therapy
* home safety
* optimize mobility with active and passive range of motion therapeutic exercises
* diet and fluids to optimize peripheral circulation
* recalls related medication(s) purpose, schedule

OT CAREPLAN
OT frequency WK2: 2 (08/02/26-08/08/26),WK4: 1 (08/16/26-08/22/26),WK5: 1 (08/23/26-08/29/26)

08/27/2026 Problems : GG0170I1 - Walk 10 Feet
M1400 - Dyspnea
Pain Interference with ADLs
Pain Interference with Therapy activities
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
GG0170J1 - Walk 50 ft with 2 Turns
GG0130B1 - Oral Hygiene
GG0170G1 - Car Transfer
GG0170E1 - Chair to Bed to Chair
GG0170D1 - Sit to Stand
GG0170F1 - Toilet Transfer
GG0130A1 - Eating
GG0130C1 - Toileting Hygiene
GG0130E1 - Shower/Bathe Self
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130F1 - Upper Body Dressing

PROCEDURES: cough/deep breathing exercises, 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, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 04. Supervision or touching assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Upper Body Dressing - 06. Independent

OT NARRATIVE
PT participated in OT EVAL and home assessment. PT requires CGA for dressing LB but is just using gowns right now, has a toilet riser that seems too high but performed decently with it. Lower seat riser would increase safety and performance. She is currently sponge bathing as she does not have the proper set up yet. There is a shower chair but is small and OT does not feel it is safe. OT added a bar to the side of bed as someone from COA dropped it off. PT reports she was using WC full time as she was afraid to walk on her own all the time. OT edu on using wc in kitchen only as there are a lot of dynamic movements and PT has a dysfunctional gait pattern. OT also placed a mirror at the end of her hall for feedback for her on form during gait using 2ww. PT was given resources and edu on bathroom safety equ and would like to work on LB dressing skills. PT is agreeable to be assisted to find suitable AE from multiple sources and be trained on it. 3 times in cert period for increasing ability to dress, shower, prep small meals

OT GOALS
PATIENT-STATED GOAL: Showering;Dressing

GOALS
Toileting Hygiene - 06. Independent

Upper Body Dressing - 06. Independent

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

Don/Doff Footwear - 06. Independent

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

Shower/Bathe Self - 04. Supervision or touching assistance

Lower Body Dressing - 06. Independent

PT CAREPLAN

PT frequency WK2: 2 (08/02/26-08/08/26),WK3: 2 (08/09/26-08/15/26),WK4: 2 (08/16/26-08/22/26),WK5: 1 (08/23/26-08/29/26),WK6: 1 (08/30/26-09/05/26)

PROCEDURES: Home Exercise Program: Instruct and progress HEP to include B LE strengthening, balance training exercises, and post surgical HEP, home exercise program, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT NARRATIVE

S/P right THA 6/30/26. PMH: right hip osteoarthritis, presence of right artificial hip joint, type 2 diabetes with hyperglycemia, mixed hyperlipidemia, epilepsy, hypertension, and COVID-19 exposure.
Patient went to rehab following surgery, Reporting she didn't walk for the first 2 weeks following surgery as she kept declining visits. She reports she was walking good before returning home but came home with a wheelchair and has been mostly using the wheelchair due to fear of falling, she reports pain has been minimal to none. Patient has a history of MVA in the 80's and has a shattered left hip with multiple surgeries and is now left without a hip joint and significant leg length discrepancy, she also broke both ankle and had a closed head injury during the MVA. Patient presents with abnormal gait, and significant left sided hip weakness and toe walking on the left which led to Right sided hip and knee OA and pain. Patient needs further skilled PT interventions to train balance, ambulation with walker, and strengthening. Patient needs to progress endurance and walking distance to be able to safely leave the apartment complex to walk out to her vehicle in the parking lot.

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PT GOALS

Chair to Bed to Chair - 06. Independent

1 - Step (curb) - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Car Transfer - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Walk 150 Feet - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

Sit to Stand - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: SAMANTHA LUBELAN RN SN on 08/01/2026

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.

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 **DAVID DARGIS**
109 S 13 HARRINGTON ST
ALPENA, MI 49707-1609
NPI 1457490609

Phone Number (989) 356-2400

Fax Number 19893542606

Physician's Signature and Date Signed

X

DAVID DARGIS, DO

: Date of physician last face-to-face

Snider, Barbara | Cert Period 08/01/26 - 09/29/26