

UNITED STATES DISTRICT COURT

for the

District of Columbia

United States of America

v.

Hope Falowo

Case No.

Defendant(s)

CRIMINAL COMPLAINT

I, the complainant in this case, state that the following is true to the best of my knowledge and belief.

On or about the date(s) of January 2013 through March 2017 in the county of _____ in the
_____ District of Columbia, the defendant(s) violated:*Code Section*

18 U.S.C. 1347

18 U.S.C. 1035

Offense Description

Health Care Fraud

False Statements

This criminal complaint is based on these facts:

Defendant Hope Falowo engaged in a scheme to bill D.C. Medicaid for Personal Care Aide ("PCA") services that were never provided to Medicaid beneficiaries and/or procured by kickbacks. (see attached affidavit)

☐ Continued on the attached sheet.

Complainant's signature

Adam Pool

Printed name and title

Sworn to before me and signed in my presence.

Date: 06/27/2018

Judge's signatureCity and state: Washington, DC

Robin M. Meriweather

Printed name and title

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA

v.

HOPE OMONE FALOWO

)
)
) MISC. NO. ____
)
)

Filed Under Seal

AFFIDAVIT IN SUPPORT OF CRIMINAL COMPLAINT AND ARREST WARRANT

I, Adam Pool being duly sworn, state:

1. I have been a Special Agent of the Federal Bureau of Investigation ("FBI") from 2005 to the present. I am an investigative or law enforcement officer of the United States within the meaning of 18 U.S.C. § 2510(7), in that I am empowered by law to conduct investigations and to make arrests for federal felony offenses.

2. I have received training in basic law enforcement investigation, complex investigations, interviewing, source handling and surveillance. I was previously assigned to work National Security investigations where, for the past thirteen years, I utilized advanced investigative techniques such as FISA warrants, utilized court process to submit subpoenas, participated in long-term human source operations and undercover operations, and conducted and participated in multiple arrests of individuals involved in National Security investigations in both the New York office of the FBI and Washington D.C office of the FBI.

3. For the past four months I have been assigned to a white-collar crime squad at the FBI's Washington Field Office in the District of Columbia (D.C.), specifically focused on the investigation of health care fraud and other health care crimes. My investigative focus during the past four months has been on fraud against government programs

I. OVERVIEW

4. As set forth in more detail below, in or about March 2018, the FBI, in partnership with the D.C. Medicaid Fraud Control Unit (“MFCU”) and the Department of Health and Human Services – Office of Inspector General (“HHS-OIG”) (collectively, the “investigative team”), opened an investigation into allegations that HOPE OMONE FALOWO, a personal care aide (“PCA”), defrauded D.C. Medicaid by submitting and causing to be submitted false claims between 2013 and 2017. The investigation confirmed those allegations, revealing that FALOWO submitted false claims falling into three categories: (1) claims purporting that FALOWO provided services in excess of 24 hours in a given day; (2) claims purporting that FALOWO provided services when she was in fact on international travel; and (3) claims purporting that FALOWO provided services to Medicaid beneficiaries to whom she provided no care at all. FALOWO’s false claims caused Medicaid to be billed for approximately \$399,165 for the claims that fell into at least one of these three categories.

5. This affidavit is made in support of a criminal complaint charging FALOWO with Health Care Fraud, in violation of 18 U.S.C. § 1347, and Health Care False Statements, in violation of 18 U.S.C. § 1035, arising from the false claims FALOWO submitted to D.C. Medicaid.

6. I have knowledge of the facts set forth in this Affidavit as a result of my participation in the investigation, including information provided to me by members of the investigative team and other law enforcement agencies, and analysis and review of documents, travel records, and Medicaid data, performed by me and others. I have personally interviewed witnesses, reviewed Medicaid billing claims and medical records associated with Medicaid recipients, reviewed other relevant documents, and obtained and

reviewed travel records. I have also obtained information from other members of the investigative team who have performed investigative tasks. This affidavit is not intended to include each and every fact and matter observed by me or known to the investigative team relating to the subject matter of this investigation. Instead, this affidavit contains only those facts which are necessary to establish that probable cause exists.

II. BACKGROUND

A. Hope Falowo

7. FALOWO was a Bowie, Maryland resident and was employed as a PCA from approximately January 2013 through March 2017.

8. FALOWO was employed as a PCA by seven Home Health Agencies (“HHAs”) during that time: HHA-1, HHA-2, HHA-3, HHA-4, HHA-5, HHA-6, and HHA-7 (collectively, the “Seven HHAs”).

B. The Medicaid Program and Personal Care Aides (“PCAs”)

9. Medicaid was a medical assistance program established by Congress under Title XIX of the Social Security Act of 1965 (the “Medicaid Act”). Medicaid was overseen and administered by the Centers for Medicare and Medicaid Services, an agency within the United States Department of Health and Human Services, and provided medical insurance coverage primarily to individuals (hereinafter referred to as “Medicaid beneficiaries”) whose incomes fell below a certain financial threshold as measured against the poverty line. Under the Medicaid Act, each state, and the District of Columbia, was required to promulgate and administer its own plan for medical assistance in accordance with federally established minimum requirements. In the District of Columbia, the Medicaid program was administered by the District of Columbia Department of Health Care Finance, located at 441

4th Street, N.W., Washington, D.C. (“DHCF”). Medicaid was jointly funded by the federal government and the District of Columbia, with the federal government paying approximately 70% of the costs of the Medicaid program.

10. Medicaid was a “health care benefit program” as defined in 18 U.S.C. § 24(b).

11. In Washington D.C., HHAs can provide certain services including skilled nursing, home health aide, and personal care services. Personal care services are intended to assist Medicaid beneficiaries in performing the activities of daily living, known as “ADLs.” ADLs include the ability to get in and out of bed, bathe, dress, eat out, take medication prescribed for self-administration, and engage in toileting.

12. To be eligible to participate in Medicaid, HHAs must agree to abide by all federal and local laws, regulations, and program manuals governing Medicaid reimbursements. To receive reimbursement from Medicaid, HHAs operating in D.C. are required to submit a claim, either electronically or in paper form, to DHCF. As part of the claim, an HHA must provide certain information, such as the name of the Medicaid beneficiary, the date of service, the type of service and corresponding billing code, the amount of time a service was provided, and the amount of money being claimed by the HHA as payment from Medicaid. Medicaid only pays for services that are medically reasonable and necessary, and that are actually provided as claimed.

13. HHAs employ and contract with PCAs to provide services to Medicaid beneficiaries. Under the Medicaid rules, a PCA must meet certain qualifications. Those qualification include: (a) being at least 18 years of age; (b) a citizen of the United States or an alien who is lawfully authorized to work in the United States; (c) completing a home health aide training program that involves at least seventy-five (75) hours of classroom training with

at least sixteen (16) hours devoted to supervised practical training; (d) passing a competency evaluation for the services which the PCA is required to perform consistent with the requirements set forth in 42 C.F.R. § 484.36; (e) obtaining certification in cardiopulmonary resuscitation and maintaining such certification annually; (f) demonstrating that the PCA is free from communicable disease as confirmed by an annual PPD Skin Test or documentation from a primary care physician stating that the person is free from communicable disease; and (g) passing a criminal background check.

14. PCAs are issued a unique 10-digit National Provider Identification number, the “NPI,” which the HHA uses to bill Medicaid for services rendered to a beneficiary based on timesheets submitted by the PCA.

15. To receive personal care services under Medicaid, a beneficiary must obtain a prescription from a doctor, informally known as an “intake.” Medicaid only pays for personal care services if the doctor determines, after a face-to-face physical examination, that the beneficiary has functional limitations in one or more ADLs. DHCF regulations that went into effect in November 2013, clarified that the doctor prescribing the intake must be the beneficiary’s primary care physician with whom the beneficiary had a pre-existing doctor-patient relationship.

16. A beneficiary takes the intake to a HHA that in turn arranges for a registered nurse to perform an initial assessment of the beneficiary’s functional status and needs. The nurse drafts a Plan of Care (“POC”) for the beneficiary based on the assessment. The POC is required to specify the frequency, duration, and expected outcome of the personal care services and is supposed to be tailored to address the individual needs of the beneficiary.

17. The HHA then assigns a PCA to provide the personal care services set forth in the POC to the beneficiary. Services are typically provided in the beneficiary's home and PCAs must document the provided care on a timesheet that is submitted to the HHA. The timesheet is supposed to accurately reflect the date the PCA provided services, the itemized services rendered, the amount of time spent providing each service, and the location at which the services were provided. Timesheets are supposed to be signed each day by both the PCA and the beneficiary. However, a single timesheet can contain a full week of services. HHAs use the timesheets to determine and justify the hours of services for which the HHA files a reimbursement claim with Medicaid.

18. As outlined in Section 6.3 Interrelationship of Providers, of the D.C. Medicaid MMIS Provider Billing Manual, "Providers are prohibited from referring or soliciting beneficiaries directly or indirectly to other providers for financial consideration. Providers are also prohibited from soliciting, receiving or offering kickbacks; payments, gifts, bribes, or rebates for purchasing; leasing, ordering, arranging for, recommending purchasing, leasing; ordering for goods, facilities, or items for which payment is made through the D.C. Medicaid Program."

III. **FACTS SUPPORTING PROBABLE CAUSE**

19. On September 28, 2017, DHCF issued a Report of Investigation to the FBI identifying FALOWO as a PCA who billed for services not rendered and who billed more than 20 hours in a single day across multiple D.C. Medicaid beneficiaries.

20. In March 2018, the investigative team opened an investigation into FALOWO based on these fraud allegations. That investigation, which included the review and analysis of Medicaid billing data and witness interviews, revealed that FALOWO submitted

fraudulent claims to Medicaid for PCA services she did not provide. As noted above, these false claims fall into three categories, which sometimes overlap: (1) time sheets in which FALOWO purported to work more than 20 hours in a given day; (2) time sheets in which FALOWO purported to render services when she was in fact on international travel; and (3) time sheets in which FALOWO purported to render services to Beneficiaries she did not care for or visit. Moreover, witness interviews revealed that FALOWO paid kickbacks to some Beneficiaries in return for introducing her to Beneficiaries for whom FALOWO then submitted false Medicaid claims.

A. FALOWO's False Claims in Excess of 20 Hours

21. An analysis of the D.C. Medicaid claims data shows that from January 8, 2014 through August 28, 2015, FALOWO submitted claims indicating she worked the following hours per day. The total submitted for all days with more than 20 hours billed is \$136,448:

	Number of Days
Days over 20 hours	303 days
Days over 24 hours	231 days
Days over 28 hours	80 days

22. For example, on November 4, 2014, FALOWO caused D.C. Medicaid to be billed for 28 hours of PCA services for four beneficiaries associated with four HHAs. On this date, FALOWO alleged to have provided eight hours of PCA services to Beneficiaries K.W., B.S., and S.R, and four hours of services to Beneficiary B.B. These hours do not include travel time between these four locations.

23. Additionally, a review of the time sheets submitted by FALOWO show that she signed multiple time sheets for overlapping hours on the same day for multiple beneficiaries.

24. For example, the following is a summary of the time sheets submitted by FALOWO on July 13, 2015, totaling 25 hours of service. These time sheets can be found in Exhibit 1 attached to this complaint:

- a. 6 hours (8 AM to 2 PM) to HHA-1 for Beneficiary B.S. (Exhibit 1A),
- b. 8 hours (7 AM to 3 PM) to HHA-6 for Beneficiary M.C. (Exhibit 1B),
- c. 3 hours (9 AM to noon) to HHA-2 for Beneficiary P.J. (Exhibit 1C), and
- d. 8 hours (7 AM to 3 PM) to HHA-3 for Beneficiary S.R. (Exhibit 1D).

25. Additionally, as discussed below, beneficiaries B.S. and M.C. were interviewed by agents and they confirmed they never received services from FALOWO.

B. FALOWO's False Claims While on International Travel

26. A review of the travel records show that FALOWO continued to bill D.C. Medicaid for services to beneficiaries while she was out of the country. The below is a chart showing her out of country travel and the number of beneficiaries she purported to provide services to during this time.

Departure U.S.	Return U.S.	Destination	# of Beneficiaries	Billed Amount
03/09/2014	03/17/2014	London, UK	3	\$2,154
10/11/2014	10/20/2014	London, UK	4	\$4,454
01/07/2015	01/23/2015	Dubai, UAE	3	\$4,002
03/06/2015	03/10/2015	Dubai, UAE	4	\$2,548
04/01/2015	04/13/2015	London, UK	4	\$6,310
10/18/2015	10/25/2015	London, UK	4	\$2,102

04/25/2016	05/01/2016	London, UK	4	\$4,136
07/04/2016	07/11/2016	London, UK	2	\$1,526

27. For example, on April 1, 2015, FALOWO traveled to London aboard British Airways flight 216, which departed Dulles Airport at 6:30 PM. On that same day, she claimed to have provided 27 hours of PCA services to 4 separate beneficiaries. FALOWO continued to bill for services during the duration of her trip outside the country, totaling more than \$6,300 in claims submitted to Medicaid for 4 beneficiaries.

28. The document support that FALOWO was purporting to provide services while she was out of the country. For example, Exhibit 2 is a timesheet from HHA-1, showing days allegedly worked by FALOWO from October 19-25, 2015, during which time she was out of the country. As seen in the chart above, FALOWO left for London, UK on October 18, 2015, and returned on October 25, 2015.

29. In addition, as discussed below, B.S., whose time sheet is in Exhibit 2, told agents that she never received services from FALOWO.

C. FALOWO's False Claims For Services Not Provided

30. Beneficiary B.S. was interviewed by agents in June 2018. A review of the Medicaid data shows that FALOWO billed \$89,700 worth of services to B.S. B.S. told agents that s/he never received any services from FALOWO despite these billings. B.S. said s/he met FALOWO and gave FALOWO his/her Medicaid number, but did not recall why s/he was asked to do so. B.S. recognized FALOWO from a photo and told agents that FALOWO approached him/her and gave him/her \$50 to introduce her to people in the building who needed PCA services. B.S. referred FALOWO to her neighbor, G.S., but told

agents s/he thought G.S. stopped seeing FALOWO because FALOWO never showed up to provide services.

31. Beneficiary G.S. was interviewed by agents in June 2018. A review of the Medicaid data shows that FALOWO billed more than \$25,000 worth of services to G.S. G.S. told agents that his/her neighbor, B.S., referred FALOWO to him/her. G.S. told agents that FALOWO paid him/her \$200 every two weeks to sign time sheets saying she was there, although she did not provide any services. If G.S. did need services, s/he would call FALOWO but FALOWO would say she was too busy. FALOWO told G.S. that if anyone from the HHA called, s/he should say she had been there. G.S. identified FALOWO by photo.

32. Beneficiary M.C. was interviewed by agents in June 2018. A review of the Medicaid data shows that FALOWO billed \$21,749 worth of services to M.C. M.C. identified FALOWO by photo. M.C. told agents that FALOWO approached him/her and offered to pay him/her \$100.00 in exchange for signing fraudulent timesheets purporting that FALOWO provided PCA services. FALOWO then paid M.C. \$15.00 to sign papers for a doctor's office visit/consultation. According to M.C., FALOWO told him/her that if s/he took the \$100.00 payment, they could both get in trouble and go to jail. FALOWO told M.C. to tell anyone that asks that FALOWO was providing services from 8:00am to 3:30pm every day.

33. M.C. stated that s/he was on probation and afraid s/he would go to jail and therefore did not sign any timesheets. M.C. told agents s/he never received home health services from FALOWO.

V. CONCLUSION

34. Based on the information detailed above, which includes statements from beneficiaries, D.C. Medicaid claims data, travel records, and other documents, there is probable cause to believe, and I do believe, that HOPE FALOWO caused Medicaid to be billed for PCA services she did not provide during the period of on or about January 21, 2013 through on or about March 3, 2017, in violation of 18 U.S.C. § 1347 (Criminal Health Care Fraud), and 18 U.S.C. § 1035 (Health Care False Statements). As a result of this fraud, FALOWO caused the D.C. Medicaid program to be billed for approximately \$399,165.

35. As such, your affiant respectfully requests that an arrest warrant be issued for HOPE FALOWO.

Special Agent Adam Pool
Federal Bureau of Investigation

Sworn to and subscribed before me on this ____th day of June 2018.

HONORABLE ROBIN M. MERIWEATHER

EXHIBIT 1

HOME HEALTH/HOME CARE

HOME HEALTH CARE AGENCY

AIDE WEEKLY VISIT RECORD

CLIENT NAME: [REDACTED]

NPI #: [REDACTED]

EMPLOYEE NAME: Hope Fedorov

CLIENT ID#: [REDACTED]

EMPLOYEE ID#: [REDACTED]

When completing, be sure to follow the Aide Assignment Sheet (from 3574/3) codes

WEEKLY TIME SHEET		MON	TUE	WED	THU	FRI	SAT	SUN	
DATE		7/13	7/14	7/15	7/16	7/17	7/18	7/19	H. Fedorov
TIME IN AM/PM		8am	8am	8am	8am	8am	8am	8am	SIGNATURE OF AIDE:
TIME OUT AM/PM		2pm	2pm	2pm	2pm	2pm	1pm	1pm	[REDACTED]
TOTAL HOURS		6hrs	6hrs	6hrs	6hrs	6hrs	5hrs	5hrs	SIGNATURE OF CLIENT:
ACTIVITIES		MON	TUE	WED	THU	FRI	SAT	SUN	INSTRUCTION: PLEASE DATE AND HAVE CLIENT SIGN ALL THE DATES OF SERVICE AS APPROPRIATE
		RECORD THE TIME YOU SPEND IN MINUTES/EXAMPLE MEALS 30minX3=90MINUTES							
BATH	Bed- Tub/Shower	30m	20m	25m	30m	35m	25m	30m	MONDAY
	Bed Bath- partial/complete								M. 7 D. 13 YR. 15
	Assist Bath- Chair								[REDACTED]
	Personal care								
HYGIENE/GROOMING	Dress	20m	15m	20m	30m	25m	15m	10m	TUESDAY
	Hair Care-								M. 7 D. 14 YR. 15
	Brush/Shampoo/Other	20m	20m	20m	25m	20m	20m	20m	CLIENT SIGNATURE
	Skin Care	20m	15m	15m	15m	10m	10m	10m	[REDACTED]
	Check Pressure Areas								
	Shave/Groom/Deodorant	30m	30m	30m	20m	20m	30m	20m	WEDNESDAY
	Nail Hygiene-Clean/File/Report								M. 7 D. 15 YR. 15
	Oral care-Brush/Swab/Dentures	10m	10m	20m	20m	20m	20m	30m	[REDACTED]
	Elimination Assist/Incontinent Care								
	Change and time								
PROCEDURES	Catheter Care								THURSDAY
	Ostomy Care								M. 7 D. 16 YR. 15
	Prepare/Nap time/Bed time	30m	20m	25m	20m	30m	20m	10m	CLIENT SIGNATURE
	Medication Reminders	10m	10m	15m	20m	20m	20m	10m	[REDACTED]
VS	TPR/BP								
	Ambulation Assist- WC/Walker/Cane/Crutches/SBA	30m	30m	20m	30m	20m	25m	20m	FRIDAY
	Assist/Walk Pt.								M. 7 D. 17 YR. 15
	ROM- Active/Passive	20m	30m	30m	20m	25m	20m	30m	CLIENT SIGNATURE
	Ambulation Positioning-Encourage/Assist								[REDACTED]
	To turn q 2 Hrs:								SATURDAY
	8AM, 10AM, 12AM, 2PM, 4PM, 6PM, 8PM, 10PM, 12PM								M. 7 D. 18 YR. 15
	Exercise- Per PT/OT/SLP Care Plan								CLIENT SIGNATURE
									[REDACTED]
	Meal Preparation								SUNDAY
	Set up/ Feed	20m	20m	25m	20m	20m	20m	15m	M. 7 D. 19 YR. 15
	Breakfast	45m	20m	35m	20m	30m	30m	20m	CLIENT SIGNATURE
	Lunch	45m	20m	30m	20m	20m	20m	20m	[REDACTED]
	Dinner								
	Snack								
	Medical Appointment								
	Grocery Shopping/Medication Pick up		30m	30m			20m	20m	
	Laundry	60m			60m		60m		
	Light Housekeeping								
	Bedroom/Bath/Room/Kitchen-Change Bed Linen	30m	20m	30m		30m	20m	30m	
OTHER	OTHER (specify)								
	TOTAL HOURS	6hrs	6hrs	6hrs	6hrs	6hrs	5hrs	5hrs	4hrs

AIDE WEEKLY VISIT RECORD

EXHIBIT 1A

EXHIBIT 1B

Check in number [REDACTED]

Sick call number [REDACTED]

VMT HOME HEALTH AIDES- EMPLOYEE TIME SHEET

Only 1 client per time sheet additional client need to be on a separate time sheet

NPI Number [REDACTED]

Client Name [REDACTED]

Employee Name: Hope Falowo

Enter Date	Date	Client Signature	Employee Signature	Time In	Time Out	Hours Worked
Sunday	7/12/15	[REDACTED]	H. Falowo	9am	12noon	3hrs
Monday	7/13/15	[REDACTED]	H. Falowo	9am	12noon	3hrs
Tuesday	7/14/15	[REDACTED]	H. Falowo	9am	12noon	3hrs
Wednesday	7/15/15	[REDACTED]	H. Falowo	9am	12noon	3hrs
Thursday	7/16/15	[REDACTED]	H. Falowo	9am	12noon	3hrs
Friday	7/17/15	[REDACTED]	H. Falowo	9am	12noon	3hrs
Saturday	7/18/15	[REDACTED]	H. Falowo	9am	12noon	3hrs

ck 1

Care Provided:	SUN	MON	TUE	WED	THU	FRI	SAT
NOTE: Reference the Care Plan to provide services. CIRCLE YOUR ANSWER							
Changes reported to VMT (medications, falls, new pain issues, Changes in health) immediately. Y (yes) NA (No changes)	Y or NA	Y or NA	Y or NA	Y or NA	Y or NA	Y or NA	Y or NA
Behavior: (N) normal (A) abnormal- If abnormal notify VMT immediately	N or A	N or A	N or A	N or A	N or A	N or A	N or A
Appearance: (N) normal (A) abnormal- If abnormal notify VMT immediately	N or A	N or A	N or A	N or A	N or A	N or A	N or A
Bathing: (T) Tub (SH) Shower (SP) Sponge Including Perineal care	T SH SP	T SH SP	T SH SP	T SH SP	T SH SP	T SH SP	T SH SP
(SC) Shampoo/Condition (CB) Comb/Brush Hair	SC CB	SC CB	SC CB	SC CB	SC CB	SC CB	SC CB
(O) Oral/dental care (D) Clean dentures (S) Shave	O D S	O D S	O D S	O D S	O D S	O D S	O D S
ck pressure areas/ reposition every 2 hours- Notify VMT of any skin changes (redness, dark areas, drainage, abrasions, cuts immediately).	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N
(D) Dressing (G) Grooming (L) Lay out clothing	D G L	D G L	D G L	D G L	D G L	D G L	D G L
(S) Skin Care (F) Foot Care (N) nail care (Do not cut nails)	S F N	S F N	S F N	S F N	S F N	S F N	S F N
Toileting: (B) Bathroom/Commode (U) Urinal (BP) Bedpan (I) incontinence care	B U B P I	B U B P I	B U B P I	B U B P I	B U B P I	B U B P I	B U B P I
Bowel Movement - record (Please write time)	Time	Time	Time	Time	Time	Time	Time
Catheter Care / Empty Catheter Bag N (no) Y (yes) NA (no catheter)	N Y NA	N Y NA	N Y NA	N Y NA	N Y NA	N Y NA	N Y NA
Ambulation (A) Assist (S) Supervise	A or S	A or S	A or S	A or S	A or S	A or S	A or S
Check Equipment-Cleanliness, safety N (no) Y (yes) NA (no equipment)	N Y NA	N Y NA	N Y NA	N Y NA	N Y NA	N Y NA	N Y NA
(ROM) active/passive (EX) exercise per PT/OT Care Plan Y (yes) R (client refused) Notify VMT if client refuses	Y or R	Y or R	Y or R	Y or R	Y or R	Y or R	Y or R
Transfers (CH) Chair (WC) Wheelchair (CM) Commode (H) Hoyer lift	CH WC CM H	CH WC CM H	CH WC CM H	CH WC CM H	CH WC CM H	CH WC CM H	CH WC CM H
(P) Prepare Meals/Snacks (A) Assist with Feeding (FS) Food Shopping	P A FS	P A FS	P A FS	P A FS	P A FS	P A FS	P A FS
What is the client's diet restrictions Are you following it? Example - low sugar, low salt, low fat, no dairy, low cholesterol, low carbohydrates	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N	Y or N
Remind to take Medications Y (yes) R (client refused) If client refuses, notify VMT immediately	Y or R	Y or R	Y or R	Y or R	Y or R	Y or R	Y or R
Shopping/Errands-ONLY UP TO 3 TIMES A WEEK E(errand) NA (no errands)	E NA	E NA	E NA	E NA	E NA	E NA	E NA
(L) Do laundry (D) pick up dry cleaning (O) Organize closets, drawers	L D O	L D O	L D O	L D O	L D O	L D O	L D O
Clean: (BA) Bathroom (K) Kitchen (BD) Bedroom (LA) Living Areas	BA K BD LA	BA K BD LA	BA K BD LA	BA K BD LA	BA K BD LA	BA K BD LA	BA K BD LA
Reinforce Dressings Y (yes) NA (no wounds) if yes notify VMT immediately	Y or NA	Y or NA	Y or NA	Y or NA	Y or NA	Y or NA	Y or NA
(A) Socialization (C) Conversation (PG) Play games (AC) Assist with Correspondence	A C PG AC	A C PG AC	A C PG AC	A C PG AC	A C PG AC	A C PG AC	A C PG AC
Accompany to MD/other N (no) Y (yes) NA (no appointments)	N Y NA	N Y NA	N Y NA	N Y NA	N Y NA	N Y NA	N Y NA
Ensure Home Safety, Secure Home Y (yes) ALWAYS SECURE THE HOME	Y	Y	Y	Y	Y	Y	Y
Precautions: (F) Falls (S) Standard (B) Bleeding (D) Diabetic	F S B D	F S B D	F S B D	F S B D	F S B D	F S B D	F S B D
Practice Infection Control-At all times-using gloves/ hand washing/keeping client clean	Y	Y	Y	Y	Y	Y	Y

Check in number [REDACTED]

Sick call number [REDACTED]

EXHIBIT 1C

HOME HEALTH/PERSONAL CARE AIDE WEEKLY LOG								
STAFFING AGENCY NAME: [REDACTED]					CLIENT NAME: [REDACTED]			
STAFFING AGENCY PROVIDER ID: [REDACTED]					CLIENT ID: [REDACTED]		PRE-AUTHORIZATION NUMBER: [REDACTED]	
ADDRESS: [REDACTED]					EMPLOYEE NAME: Hope Falowo			
TELEPHONE NO.: [REDACTED]					EMPLOYEE NPI: [REDACTED]			
FAX NO.: [REDACTED]					EMPLOYEE PHONE NUMBER: [REDACTED]			
WEEKLY TIME SHEET		MON	TUE	WED	THU	FRI	SAT	SUN
DATE		7/13	7/14	7/15	7/16	7/17		
TIME IN AM/PM		7am	7am	7am	7am	7am		
TIME OUT AM/PM		3pm	3pm	3pm	3pm	3pm		
TOTAL HOURS		8hrs	8hrs	8hrs	8hrs	8hrs		
ACTIVITIES		MON	TUE	WED	THU	FRI	SAT	SUN
Record the time you spend in minutes. E.g. Meals 30 minutesx3=90 minutes								
Bath	Bed-Tub/shower	4am	4am	6am	5am	4am		
	Bed bath - partial/complete							
	Assist bath - chair/sink							
Hygiene/Grooming	Personal care	3am	4am	6am	4am	3am		
	Dress	4am	2am	4am	4am	4am		
	Hair care - brush, shampoo, other	6am	4am	4am	3am	4am		
	Skincare	3am	4am	3am	4am	2am		
	Check pressure areas							
	Shave/groom/deodorant	2am	3am	2am	2am	2am		
	Nail hygiene - clean/file/report							
	Oral care-brush/swab/dentures	2am	2am	2am	3am	2am		
Procedures	Elimination assist./ Incontinence care change and dress							
	Catheter care							
	Ostomy care							
	Prepare/nap time/bed time	3am	4am	2am	3am	4am		
VS	Medication reminders	1am	1am	1am	1am	1am		
	TPR/BP							
Activity	Ambulation assist - WC/walker/crutch/crutches/SBA	3am	2am	4am	3am	3am		
	Assist/walk pt.							
	ROM - active/passive	3am	2am	2am	2am	2am		
	Ambulation positioning -							
	Encourage/Assist to Turn 2 hours:							
Nutrition	8AM, 10 AM, 12 PM, 2PM, 4 PM, 6 PM, 8 PM, 10 PM, 12 AM							
	Exercise - per PT/OT/SLP care, plan							
	Meal preparation	2am	2am	2am	3am	2am		
	Setup/feed	3am	6am	3am	4am	4am		
	Breakfast	4am	6am	3am	2am	3am		
	Lunch							
	Dinner							
	Snack							
	Medical appointment							
	Grocery shopping/medication pick up		2am			2am		
Other	Laundry	7am		7am		7am		
	Light housekeeping - bedroom/bathroom/kitchen/change bed linen	2am	2am	3am	2am	3am		
	Other (specify)							
Total Hours		8hrs	8hrs	8hrs	8hrs	8hrs		

H. Falowo
Signature of Aide

Instructions: Please date and have client

sign all the dates of service as approval

MONDAY
MM: 7 DD: 13 YY: 15

Client Signature: [REDACTED]

TUESDAY
MM: 7 DD: 14 YY: 15

Client Signature: [REDACTED]

WEDNESDAY
MM: 7 DD: 15 YY: 15

Client Signature: [REDACTED]

THURSDAY
MM: 7 DD: 16 YY: 15

Client Signature: [REDACTED]

FRIDAY
MM: 7 DD: 17 YY: 15

Client Signature: [REDACTED]

SATURDAY
MM: DD: YY:

Client Signature: [REDACTED]

SUNDAY
MM: DD: YY:

Client Signature: [REDACTED]

NOTES:

EXHIBIT 1D

HOME HEALTH/HOME CARE

ALLIANCE HOME HEALTH CARE AGENCY

AIDE WEEKLY VISIT RECORD

CLIENT NAME: [REDACTED]

NPI #: [REDACTED]

EMPLOYEE NAME: Hope Falowo

CLIENT ID#: [REDACTED]

EMPLOYEE ID#: [REDACTED]

When completing, be sure to follow the Aide Assignment Sheet (from 3574/3) codes

WEEKLY TIME SHEET		MON	TUE	WED	THU	FRI	SAT	SUN	
DATE		10/19	10/20	10/21	10/22	10/23	10/24	10/25	H. Falowo
TIME IN AM/PM		8am	8am	8am	8am	8am	8am	8am	[REDACTED]
TIME OUT AM/PM		2pm	2pm	2pm	2pm	2pm	1pm	1pm	[REDACTED]
TOTAL HOURS		6hrs	6hrs	6hrs	6hrs	6hrs	5hrs	5hrs	SIGNATURE OF CLIENT:
ACTIVITIES		MON	TUE	WED	THU	FRI	SAT	SUN	INSTRUCTION: PLEASE DATE AND HAVE CLIENT SIGN ALL THE DATES OF SERVICE AS APPROPRIATE
		RECORD THE TIME YOU SPEND IN MINUTES/EXAMPLE MEALS 30minX3=90MINUTES							
BATH	Bed- Tub/Shower	30m	25m	20m	30m	30m	25m	30m	MONDAY
	Bed Bath- partial/complete								M. 10 D. 19 YR. 15
	Assist Bath- Chair								[REDACTED]
HYGIENE/GROOMING	Personal care	[REDACTED]							[REDACTED]
	Dress	20m	15m	20m	30m	20m	15m	10m	TUESDAY
	Hair Care-								M. 10 D. 20 YR. 15
	Brush/Shampoo/Other	20m	20m	20m	25m	20m	20m	20m	CLIENT SIGNATURE
	Skin Care	20m	15m	10m	15m	10m	10m	10m	[REDACTED]
	Check Pressure Areas								WEDNESDAY
	Shave/Groom/Deodorant	30m	30m	30m	20m	20m	20m	20m	M. 10 D. 21 YR. 15
	Nail Hygiene-Clean/File/Report								[REDACTED]
	Oral care-Brush/Swab/Dentures	10m	15m	20m	20m	30m	30m	20m	THURSDAY
PROCEDURES	Elimination Assist/Incontinent Care								M. 10 D. 22 YR. 15
	Change and time								[REDACTED]
	Catheter Care	[REDACTED]							[REDACTED]
VS	Ostomy Care	[REDACTED]							[REDACTED]
	Prepare/Nap time/Bed time	30m	20m	25m	20m	30m	20m	10m	FRIDAY
	Medication Reminders	10m	10m	15m	20m	20m	20m	10m	M. 10 D. 23 YR. 15
ACTIVITY	TPR/BP								[REDACTED]
	Ambulation Assist- WC/Walker/ Cane/Crutches/SBA	30m	30m	20m	30m	20m	25m	20m	FRIDAY
	Assist/Walk Pt.								M. 10 D. 23 YR. 15
	ROM- Active/Passive	20m	30m	30m	30m	20m	25m	20m	[REDACTED]
	Ambulation Positioning- Encourage/Assist								SATURDAY
	To turn q 2 Hrs:								M. 10 D. 24 YR. 15
	8AM, 10AM, 12AM, 2PM, 4PM, 6PM, 8PM, 10PM, 12PM								CLIENT SIGNATURE
NUTRITION	Exercise- Per PT/OT/SLP Care Plan								[REDACTED]
	Meal Preparation	[REDACTED]							SUNDAY
	Set up/ Feed	20m		20m	20m	20m	20m	20m	M. 10 D. 25 YR. 15
	Breakfast	45m	20m	40m	20m	45m	30m	20m	CLIENT SIGNATURE
	Lunch	45m	20m	30m	20m	45m	20m	20m	X
	Dinner								
	Snack								
	Medical Appointment								
	Grocery Shopping/Medication Pick up		30m	20m	20m			20m	
	Laundry		60m		60m		60m		
OTHER	Light Housekeeping Bedroom/Bath/Room/Kitchen- Change Bed Linen	30m	20m	30m		30m	20m	30m	
	OTHER (specify)								
TOTAL HOURS		6hrs	6hrs	6hrs	6hrs	6hrs	5hrs	5hrs	40hrs

AIDE WEEKLY VISIT RECORD

EXHIBIT 2

HomeSolutions Net®

PCA Intervention

Patient's Name: [REDACTED]

PH 9-126-827

Visit Date		Staff ID	Patient ID	Drive Time (24 Hr Clock)		Mileage	Visit Time (24 Hr Clock)	
Day	Month/Day/Year			Departure	Arrival	Miles to Visit	Start	Finish
Jan	01/13/15	[REDACTED]	[REDACTED]				7:00	15:00
Feb	02/13/15	[REDACTED]	[REDACTED]					
Mar	03/13/15	[REDACTED]	[REDACTED]					
Apr	04/13/15	[REDACTED]	[REDACTED]					
May	05/13/15	[REDACTED]	[REDACTED]					
Jun	06/13/15	[REDACTED]	[REDACTED]					
Jul	07/13/15	[REDACTED]	[REDACTED]					
Aug	08/13/15	[REDACTED]	[REDACTED]					
Sep	09/13/15	[REDACTED]	[REDACTED]					
Oct	10/13/15	[REDACTED]	[REDACTED]					
Nov	11/13/15	[REDACTED]	[REDACTED]					
Dec	12/13/15	[REDACTED]	[REDACTED]					

☐ Not a table visit
 ☐ First visit today
 ☐ Round trip drive
 Differential: ☐ Chronic
☐ Acute
☐ Applicable
☐ Surgical
☐ Staff
☐ Holiday

VITAL SIGNS

Temp.	Pulse	Resp.	Weight	Blood Sugar	Blood Pressure
		Rate		mg/dl	Systolic / Diastolic
<input type="checkbox"/> Fahrenheit <input type="checkbox"/> Celsius Site: <input type="checkbox"/> Oral <input type="checkbox"/> Axillary <input type="checkbox"/> Tympanic <input type="checkbox"/> Rectal <input type="checkbox"/> Temporal <input type="checkbox"/> Skin Temp: <input type="checkbox"/> Hot <input type="checkbox"/> Cold	<input type="checkbox"/> Radial <input type="checkbox"/> Apical <input type="checkbox"/> Femoral <input type="checkbox"/> Irregular <input type="checkbox"/> Weak <input type="checkbox"/> Bounding <input type="checkbox"/> Perior Pulses <input type="checkbox"/> Limb cool <input type="checkbox"/> R. on-de p	<input type="checkbox"/> Labored <input type="checkbox"/> Shallow <input type="checkbox"/> Irregular	<input type="checkbox"/> lbs <input type="checkbox"/> kg (Select One) <input type="checkbox"/> Reported <input type="checkbox"/> Actual	<input type="checkbox"/> FBS <input type="checkbox"/> Random	<input type="checkbox"/> Systolic <input type="checkbox"/> Diastolic Arm: <input type="checkbox"/> Left <input type="checkbox"/> Right

CARE PLAN ACTIVITIES (Mark activities completed this visit)

Special Procedures	Bathing
<input type="checkbox"/> Dressing changed (if applicable) <input type="checkbox"/> Reminded to take/assisted with medications <input type="checkbox"/> Acc. vitals appt. cc removed <input type="checkbox"/> Support hose applied/removed <input type="checkbox"/> Incentive spirometer (describe) <input type="checkbox"/> Advanced w/ (describe below)	<input type="checkbox"/> Shower <input type="checkbox"/> Tub bath <input type="checkbox"/> Part of sponge bath <input type="checkbox"/> Complete sponge bath <input type="checkbox"/> Shampoo hair <input type="checkbox"/> Other (describe)
Notes: _____	Notes: _____
Bowel Care	Skin Care
<input type="checkbox"/> Assisted to empty bedpan <input type="checkbox"/> Assisted to empty commode <input type="checkbox"/> Emptying urinary appliance <input type="checkbox"/> Performed per rectal care <input type="checkbox"/> Tumor dressing (describe) <input type="checkbox"/> Other (describe)	<input type="checkbox"/> Lot oint (describe) <input type="checkbox"/> Massage (describe) <input type="checkbox"/> Soaked (describe) <input type="checkbox"/> Non-diabetic fingernails trimmed <input type="checkbox"/> Non-diabetic toenails trimmed <input type="checkbox"/> Incontinence skin care <input type="checkbox"/> Other (describe)
Notes: _____	Notes: _____

Date

Staff Signature

Date

