Waiver Documentation for HOMEMAKER/PERSONAL CARE SERVICES- Shared Living 5123:2-9-33

Waiver Recipient:	Provider Name:	Service Location:
Medicaid #:	Provider #:	County: Summit
*Staffing ratio is 1:1 (staff to recipient) unless otherwise noted	*All services provided in the home (service location) unless otherwise noted	
Month/Year:		

Initial boxes when services are provided or write: A-Absent, S-Sick, R-Refused

ISP Services Description Identify Frequency and Duration	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Monitor if any incident reports were written and enter them on UI Log.																															

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Billing Daily Rate

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Daily																														

Codes- 1-Billable day (unit), NB-Non billable because received HPC services from another provider, NSP-No Services Provided-Non billable day because person was away for full 24 hours.

Observations/Comments/Unusual Occurrences-UIR/MUI written/Service Refusals/Absences/Location changes/Ratio Changes/Use of On Site-On Call or Emergency Level One Services

DATE	Initials	Entry:

I certify that I provided the services as noted in this record in accordance with this waiver recipient's ISP. Signature: _____