Homemaker Personal Care (HPC) – WAIVER SERVICE DELIVERY DOCUMENTATION

CONSUMER NAME: ______________________________ PROVIDER: ______________________________

ADDRESS of SERVICE: ______________________________

______________________________ PROVIDER #: ______________________________

MEDICAID #: ______________________________

SERVICE MONTH: ____________________ YEAR: ____________

SERVICES ARE ROUTINE HPC UNLESS OTHERWISE INDICATED AS ON-SITE/ON CALL OR LEVEL ONE EMERGENCY

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
Time In																															
Time out																															
# of Units																															
# OF INDIVIDUALS SHARING SUPPORTS , if other than 1:1.																															
Supports in Plan Duration / Frequency																															
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*ALL SERVICES ARE PROVIDED IN THE PERSON'S HOME UNLESS OTHERWISE NOTED BELOW. R indicates consumer refused service.

DATE Service locations if other than home, problems delivering services, refusal, unusual incidents & reasons, etc.

SIGNATURE: _____ **INITIALS:** _____ **DATE:** _____