Shared Living – WAIVER SERVICE DELIVERY DOCUMENTATION

CONSUMER NAME: ____

ADDRESS of SERVICE: ____

____

MEDICAID #: ____

SERVICE MONTH: ______________________ YEAR: ______________

PROVIDER: ____

PROVIDER #: ____

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
Supports in Plan Duration / Frequency																															
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# OF INDIVIDUALS SHARING SUPPORTS , if other than 1:1.																															

R= Refused ND = Not Delivered

*ALL SERVICES ARE PROVIDED IN THE PERSON'S HOME UNLESS OTHERWISE NOTED IN THE COMMENTS SECTION BELOW.

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

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