Homemaker/Personal Care Documentation

Individual		Medicaid #		Month/Year	
Provider Name		Provider Billing #			

*All services are provided in the consumer's home unless otherwise specified on the reverse side of this document (indicate date/time). **Duration is for the length of time the activity normally takes to occur unless otherwise specified. All service are routine unless otherwise specified. ALWAYS USE INK – do not use pencil. If you make an error, cross out and initial error, then insert correct information. Whiteout cannot be used.

Services	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
Start time																															
End time																															
Total # units																															
Group size																															

initials ______ staff signature ______________________ initials ______ staff signature ______________________

initials ______ staff signature ______________________ initials ______ staff signature ______________________

Response to services:

Homemaker/Personal Care Docum[obscured by callout]

Type of Service:
Could be OSOC, Routine, Level One Emergency

Individual		Medicaid #		Month/Year	
Provider Name		Provider Billing #			

Recipient's Name

Provider's Name

Recipient's Medicaid #

Provider's Billing #

Date of Service

Place of Service

*All services are provided in the consumer's home unless otherwise specified on the reverse side of this document (indicate date/time). **Duration is for the length of time the activity normally takes to occur unless otherwise specified. All service are routine unless otherwise specified. ALWAYS USE INK – do not use pencil. If you make an error, cross out and initial error, then insert correct information. Whiteout cannot be used.

Date of Service

Services	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
Use these boxes to document description and details of services delivered from the ISP																															
Start time																															
End time																															
Total # units																															
Group size																															

initials ______ staff signature ______ initials ______ staff signature ______

initials ______ staff signature ______ initials ______ staff signature ______

Signatures & Initials of Providers

Response to services:

Monthly notation of the individual's response to services