Waiver Documentation for Homemaker Personal Care Services

Individual's name:		**Address of Service:**		**Month/Year:**	
County:		**Medicaid #:**		**Provider:**		**Provider #:**	
Date of ISP					

	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
Services Type:																															
Number of Units:																															
Services Type:																															
Number of Units:																															

Services are routine HPC unless otherwise indicated as On-Site/On-Call or Level One Emergency

ISP Supports/Activities	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

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Staff Coverage		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
Staff Initials:	Time In																															
	Time Out																															
Staff Initials:	Time In																															
	Time Out																															
Staff Initials:	Time In																															
	Time Out																															
Staff Initials:	Time In																															
	Time Out																															
Ratio of service is 1:1_unless otherwise specified below																																

Dates and location of services not provided at <u>(list home address):</u>

Date:	Location/Address:	Start time:	End time:

Notes/Observations/Unusual occurrences/Progress notations

Date:	Note:	Initial

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Signature:	Initial	Signature:	Initial	Signature:	Initial

Individual's signature: _____