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

Waiver Documentation for Homemaker Personal Care Services

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 (list home address):

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

Notes/Observations/Unusual occurrences/Progress notations

Date:	Note:	Initial

Waiver Documentation for Homemaker Personal Care Services

Signature:	Initial	Signature:	Initial	Signature:	Initial

Individual's signature: ____