

# Homemaker Personal Care (HPC) – SERVICE DELIVERY DOCUMENTATION FORM –

County \_\_\_\_\_

INDIVIDUAL'S NAME: \_\_\_\_\_

PROVIDER NAME: \_\_\_\_\_

PLACE OF SERVICE (Address): \_\_\_\_\_

PROVIDER #: \_\_\_\_\_

INDIVIDUAL'S MEDICAID #: \_\_\_\_\_

SERVICE MONTH: \_\_\_\_\_ YEAR: \_\_\_\_\_ ISP Span: \_\_\_\_\_

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																																					
Time In																																					
Time out																																					
# of Units																																					
Ratio of service if other than 1:1																																					
Supports in Plan Duration / Frequency																																					

Sample Key (staff initials = service delivered R = refused service ND = Not Delivered)

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SERVICE MONTH: \_\_\_\_\_ YEAR: \_\_\_\_\_ ISP Span: \_\_\_\_\_

Date	Location of Services is Address of Service, unless otherwise noted below	Start Time	End time

Notes/Observations:

Date	Note	Initials

*Outcome Documentation (if applicable) to be maintained on separate Outcome Documentation sheet*

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ INITIALS: \_\_\_\_\_ DATE: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ INITIALS: \_\_\_\_\_ DATE: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ INITIALS: \_\_\_\_\_ DATE: \_\_\_\_\_

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