SHARED LIVING (ASP) – Daily Rate WAIVER SERVICE DELIVERY DOCUMENTATION – Cuyahoga County

CONSUMER NAME: _____ PROVIDER: _____

ADDRESS of SERVICE: _____

_____ PROVIDER #: _____

MEDICAID #: _____ SERVICE MONTH: _____ YEAR: _____

DATE of Service	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																															

ALL SERVICES ARE PROVIDED IN THE PERSON'S HOME UNLESS OTHERWISE NOTED. R = refused service ND = Not Delivered

DATE COMMENT: Progress toward Goal, Service locations if other than home, problems delivering services, refusal, unusual incidents & reasons, etc.

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

Updated by AG 110217