Shared Living – Daily Rate - SERVICE DELIVERY DOCUMENTATION

CONSUMER NAME: ______________________________ PROVIDER: ______________________________

ADDRESS: ______________________________ ADDRESS: ______________________________

______________________________ ______________________________

MEDICAID #: ______________________________ PROVIDER #: ______________________________

SERVICE PERIOD: ____/____/____ to ____/____/____

Day/Date	SUN /	MON /	TUE /	WED /	THU /	FRI /	SAT /		SUN /	MON /	TUE /	WED /	THU /	FRI /	SAT /
ASP SERVICE Duration/Frequency															

*ALL SERVICES ARE PROVIDED IN THE PERSON'S HOME UNLESS OTHERWISE NOTED IN THE COMMENTS SECTION BELOW.

R = Refused service **ND = Not Delivered**

STAFF COMMENTS (Unusual staffing & reasons, service locations if other than home, problems delivering services, etc.)

SIGNATURE: ______________________________ **INITIALS:** __________

DATE: ______________

Prepared by AG 10/12/17