

Homemaker Personal Care

Ind.Name: _____ Address: _____ Medicaid _____ Span Date: _____
 Provider: _____ Provider Address: _____ Provider # _____

Month/Year _____

Outcome # 1

A. Action Steps:

How Often?

Support Considerations:

Date

Notes/Description

Staff int.

Date

Notes/Description

Staff int.

1.

2.

3.

4.

B. Action Steps:

How Often?

Support Considerations:

Date

Notes/Description

Staff
int.

1.

2.

3.			
IO Waiver/ Homemaker Personal Care			
Name _____ Address: _____ Medicaid _____ Span Date: _____			
Provider: Provider Address: _____ Provider # _____			
Additional Notes:			

Ind. Name: _____ Waiver Type _____ Address: _____ Medicaid _____ Span Date: _____

Provider: _____ Provider Address: _____ Provider # _____

Month/Year _____	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
Level of Support :																															
1.																															
2.																															
3.																															
4.																															
5.																															
6.																															

[illegible]

All services are provided in the home unless otherwise noted in the comments section on the back of this page. All Services provided at 1:1 ration unless otherwise noted.

4/20/2017

Also note problems with delivering services such as not at home, no contact, in hospital, or anything out of the ordinary on this document.

Additional Notes: