HCDDS ADULT SHARED LIVING DOCUMENTATION / PAGE 1 OF 2

Revised 4-4-08

Month	Year
Individual	Medicaid #
Provider	Provider #
Signature	Initials
Signature	Initials
My Plan Span Dates	

SERVICE CODES

If you cannot deliver a service, write in the code below & explain at the bottom or on an attached sheet.

A – Absent (Individual was gone)
O – Other (Alternate location, etc.)
R - Refused

INSTRUCTIONS: Write in all services & skill developments & frequency for all items assigned to you in the "My Plan". Document according to the frequency. Sign and initial then initial each time you deliver each service. Write a methodology for each skill development & track the progress each time you teach the skill. Document if services provided anywhere but individual's home. Document medications, time & units, & mileage elsewhere.

SUPPORT AREA & FREQUENCY	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

EXPLANATION FOR "A", "O" OR "R" ABOVE / ALL SERVICES DELIVERED IN THE HOME UNLESS INDICATED BELOW

Date	Explanation	Date	Explanation
Date	Explanation	Date	Explanation
Date	Explanation	Date	Explanation

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Revised 1-29-08

Month	Year		**SERVICE TYPE**		**INSTRUCTIONS**
Individual	Medicaid #		Adult Foster Care		This documentation form is required for all services provided per Ohio Administrative Code 5123: 2-9-05, and 5123:2-13-06. This form should be completed in addition to the AFC documentation form that identifies the services and frequencies.
Provider	Provider #				
Group size					

PRINTED NAME	INITIALS	SIGNATURE	TITLE