HCDDS HOMEMAKER PERSONAL CARE DOCUMENTATION / PAGE 1 OF 2

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 – Individual Refused

INSTRUCTIONS: Write in all services & frequency for all items assigned to you in the "My Plan". Document according to the frequency. Sign and initial, and then initial each time you deliver each service. Document if services provided anywhere but individual's home. Document medications & 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" "R" OR "O" ABOVE / ALL SERVICES DELIVERED IN THE HOME UNLESS INDICATED BELOW

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

HCDDS HOMEMAKER PERSONAL CARE DOCUMENTATION / PAGE 2 OF 2

Month	Year		**SERVICE TYPE**	**INSTRUCTIONS**
Individual	Medicaid #		☐ Routine	This documentation form is required for all services provided per Ohio Administrative Code 5123: 2-9-05.
Provider	Provider #		☐ On Site / On call	
			☐ Level 1 Emergency	

Day of the Month:	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																															
Number of 15 min units																															
Group size																															

PRINTED NAME	INITIALS	SIGNATURE	TITLE