Homemaker/Personal Care Documentation Sheet

OAC 5123:2-9-30

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| **Name of provider** **:** | **Name of Individual receiving service** **:** |
| **DODD Contract Number:** | **Medicaid number of individual** **:** |
| **Signature of Provider** **:** | |
| **My signature on this documentation sheet signifies that I have supported the individual as identified in the Individual Service Plan (ISP) and the time in/out and services provided are accurate.** | |

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| **Type of Service (HPC or HPC/OSOC)** |  |  |  |  |  |  |  |
| **Date of Service** |  |  |  |  |  |  |  |
| **Place of Service** |  |  |  |  |  |  |  |
| **Description of service as specified in the ISP** |  |  |  |  |  |  |  |
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| **Outcomes:**  **Start date:**  **Expected completion date:** |  |  |  |  |  |  |  |
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| **Group Size** |  |  |  |  |  |  |  |
| **Time in (Begin Time)** |  |  |  |  |  |  |  |
| **Time out (End Time)** |  |  |  |  |  |  |  |
| **Number of units of service** |  |  |  |  |  |  |  |

**Notes:** (*please include updates on individual’s progress toward outcomes, as applicable*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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