Homemaker/Personal Care Documentation Sheet

OAC 5123:2-9-30

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.	

Type of Service (HPC or HPC/OSOC)							
Date of Service							
Place of Service							
Outcomes: **Start date:** **Expected completion date:**							
Description of service as specified in the ISP							
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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