PROVIDER NAME / WAIVER TYPE / WAIVER SERVICE (HPC/ADULT DAY/ETC.)

Name: _____ Address: _____ Medicaid #: _____ Span Date: _____

Provider Name: _____ Provider Address: _____ Provider #: _____

Month/Year: _____

Outcome #: 1 Henry will do some recreational activities he enjoys so that his anxiety remains low and assists his overall health.

Action Step/How Often	Date:	Action Notes/Description/How Addressed	Staff Int.
Henry will obtain a membership to the YMCA. / One time only			
Henry will go to the YMCA for an activity of his choice. / At least 1x per week.			
Henry will go to the YMCA for an activity of his choice. / At least 1x per month.			

Outcome #: 2 Henry will explore/plan a possible vacation so that he has an opportunity to take a break from everyday life and relax.

Action Step/How Often	Date:	Action Notes/Description/How Addressed	Staff Int.
Henry will explore possible places to take a vacation based on his current income. / As often as needed until a couple of options are established.			
Henry will communicate with his family, friends, and provider to inquire if anyone is able to go on the trip with him. / Ongoing until Henry establishes who is able to go with him.			

PROVIDER NAME / WAIVER TYPE / WAIVER SERVICE (HPC/ADULT DAY/ETC.)

Name: _____ Address: _____ Medicaid #: _____ Span Date: _____

Provider Name: _____ Provider Address: _____ Provider #: _____

Additional Notes:

PROVIDER NAME / WAIVER TYPE / WAIVER SERVICE (HPC/ADULT DAY/ETC.)

Name: _____ Address: _____ Medicaid #: _____ Span Date: _____

Provider Name: _____ 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
Support Considerations:																															
1. Meal preparation How Often: Daily																															
2. Home Maintenance How Often: Daily																															
3. Personal Hygiene How Often: Daily																															
4. Mobility How Often: Daily																															
5. Laundry How Often: Weekly																															
6. Shopping How Often: Weekly																															
7. Social Inclusion/Interpersonal Relationships How Often: Monthly																															
8. Money Management How Often: As needed/requested																															

All services are provided in the home unless otherwise noted in the comments section.

Other codes to be used to indicate when a service was not provided (staff will need to provide an explanation): A= Absent H=Hospital R=Refused

Staff Comments: Please note service (specific locations) other than the home (IE: Kroger's, Rite Aid, Office, etc.)

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

Staff Signature/initials: _____

_____

_____

Additional Notes: