

Agency Based-CFC/ABPAS SERVICES DELIVERY RECORD

| Employee Name | Member Name | Medicaid ID (optional) | Pay Period (Mo/Day/Yr)- Mo/Day/Yr | | | | | | | | | | | | |
|--|----------------------|--|-----------------------------------|---|---|----|---|---|-------------|---|---|---|----|---|---|
| Employees must complete all sections of the service delivery record in order to obtain payment. | Date | Su | M | T | W | Th | F | S | Su | M | T | W | Th | F | S |
| | Time In | | | | | | | | | | | | | | |
| | Time Out | | | | | | | | | | | | | | |
| | Total (a+b+c) | | | | | | | | | | | | | | |
| ACTIVITIES OF DAILY LIVING (ADL) | | | | | | | | | | | | | | | |
| Bathing | | | | | | | | | | | | | | | |
| Personal Hygiene | | | | | | | | | | | | | | | |
| Meal Preparation & Eating | | | | | | | | | | | | | | | |
| Exercise | | | | | | | | | | | | | | | |
| Medication Reminder | | | | | | | | | | | | | | | |
| Other: <i>(approved by MPQH)</i> | | | | | | | | | | | | | | | |
| Other: <i>(approved by MPQH)</i> | | | | | | | | | | | | | | | |
| Other: <i>(approved by MPQH)</i> | | | | | | | | | | | | | | | |
| INSTRUMENTAL ACTIVITIES OF DAILY LIVING | | | | | | | | | | | | | | | |
| Household Maintenance (HM) | | | | | | | | | | | | | | | |
| Correspondence Assistance (CA) - CFC Only | | | | | | | | | | | | | | | |
| a) ADL, Household, Correspondence Total | | | | | | | | | | | | | | | |
| b) Community Integration (CI) /Shopping -- Daily Time | | | | | | | | | | | | | | | |
| c) Skill Acquisition –CFC only-Time | | | | | | | | | | | | | | | |
| A. ADL, HM and CA Total Time: ___ B. CI and Shopping Total Time: ___ C. Skill Acquisition Total Time: ___ Total A+B+C Time: ___ | | | | | | | | | | | | | | | |
| All services under HCBS/Medicaid Waiver must be pre-approved by the case management team. | Date | | | | | | | | | | | | | | |
| | Time In | | | | | | | | | | | | | | |
| | Time Out | | | | | | | | | | | | | | |
| | Total | | | | | | | | | | | | | | |
| Social Supervision | | | | | | | | | | | | | | | |
| Homemaking | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | |
| This is to certify that I worked the hours recorded and completed the work tasks assigned. This is to certify that to the employee has worked the hours recorded, completed the tasks assigned. Misrepresentation constitutes fraud | | Member Signature | | | | | | | Date | | | | | | |
| | | PCA Signature | | | | | | | Date | | | | | | |
| | | Provider Representative Signature | | | | | | | Date | | | | | | |