

### Self-Direct CFC/SDPAS SERVICES DELIVERY RECORD

Employee Name		Member Name		Medicaid ID (optional)						Pay Period (Mo/Day/Yr)- Mo/Day/Yr						
<b>Employees must complete all sections of the service delivery record in order to obtain payment.</b>		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>																
<b>HEALTH MAINTAINENCE ACTIVITIES (HMA)</b>																
Medication Administration																
Urinary System Management																
Bowel Program																
Wound Care																
<b>INSTRUMENTAL ACTIVITIES OF DAILY LIVING</b>																
Household Maintenance (HM)																
Correspondence Assistance (CA) - CFC Only																
<b>a) ADL, Household, Correspondence Daily Total</b>																
<b>b) Community Integration (CI)/Shopping -- Daily Total</b>																
<b>c) Skill Acquisition-CFC only- Daily Total</b>																

A. ADL ,HM and CA Total Time: \_\_\_ B. CI and Shopping Total Time: \_\_\_ C. Skill Acquisition Total Time: \_\_\_ Total AB Time: \_\_\_

<b>All services under HCBS/Medicaid Waiver must be <u>pre-approved</u> by the case management team.</b>	Date														
	Time In														
	Time Out														
	Total														
Social Supervision															
Homemaking															

Comments:

	Member/PR Signature	Date
	PCA Signature	Date
	Provider Representative Signature	Date