

Waiver Documentation for Ohio Shared Living (OSL)

Individual’s Name:											Address of Service:											Month/Year:		
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County:				Medicaid #:					Provider:								Contract #:			
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ISP Span Dates:																															
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Number of Units is 1 for each day service is provided

ISP Support & Frequency	DATE																															
	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	
Staff Initials																																

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Ratio of service is 1:1 unless otherwise noted below

Location of service is Address of Service unless otherwise noted below

Date	Location/Address	Start time	End time

Notes/Observations/Unusual occurrences/Progress notations

Date	Note	Initials

Signature _____ **Initials** _____ **Date** _____