Geauga County Routine Adult Family Living Documentation Sheet

Name:	Month:
Medicaid #	Year:
Contract Provider #	Page 1 of
Service Period:	
Provider:	

Frequency/Duration:
Up to 96 Units Daily
Units Weekly
Units Monthly
Units Yearly

Skill Development Codes I-Independently A- Absent V- Verbal P-Physical HOH- hand over hand assistance R- Chose not to participate

SUPPORT AREA FREQUENCY	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
DAILY (eg. 1x, 2x, 3x)																															
																															

Geauga County Adult Family Living Documentation Sheet

Name:	Month:
Medicaid #	Year:
Contract Provider #	Page 2 of
Service Period:	
Provider:	

Frequency/Duration:
Units Daily
Units Weekly
Units Monthly
Units Yearly

Skill Develop	ment Codes
I-Independently	A- Absent
V- Verbal	
P-Physical	
HOH- hand over h	and assistance
R- Chose not to pa	articipate

SUPPORT AREA FREQUENCY	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
DAILY (eg.1x,2x,3x)																															
																															\square

Geauga County Adult Family Living Documentation Sheet

Name:	Month:
Medicaid #	Year:
Contract Provider #	Page 3 of
Service Period:	
Provider:	

Frequency/Duration:
Units Daily
Units Weekly
Units Monthly
Units Yearly

Skill Develop	ment Codes
I-Independently	A- Absent
V- Verbal	
V- Verbal P-Physical	
HOH- hand over h	and assistance
R- Chose not to pa	articipate

SUPPORT AREA FREQUENCY	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
WEEKLY (eg.1x,2x,3x)																															
Monthly (eg.1x,2x,3x)																															
Quarterly																															
RATIO (if other than 1:1)																															
UNITS PROVIDED:																															

Geauga Adult Family Living Documentation Sheet

Name:	Month:	F	requency/Duration:	Skill Development C		
Medicaid # Contract Provider #	Year: Page 4 of	-	Units Daily Units Weekly	I-Independently A- A V- Verbal	Absent	
Service Period:		-	Units Weekly	P-Physical		
Provider:		_	Units Yearly	HOH- hand over hand as	ssistance	
				R- Chose not to participation	ate	
SIGNATURE/ TITI	LE	INITIALS	SIGNAT	TURE/ TITLE	INITIALS	
Revised						
(My initials on the Document sheet an	d the corresponding	g signature/ tit	le above signify that I hav	ve supported	_as outlined in	ISP
Location: unless otherwise noted, all	services were provi	ided in the per	son's home.			
Variations: Date of Variation: Type of Variation: (check all that app Reason(s) for variation:	ly)staff to indiv	vidual ratio	_times of service delivery	group sizetype of se	ervice	
Actual staff to individual ratio::	Time period of	variation:				
Date of Variation: Type of Variation: (check all that app Reason(s) for variation: Actual staff to individual ratio::				group sizetype of se	ervice	
Date of Variation: Type of Variation: (check all that app Reason(s) for variation: Actual staff to individual ratio::	-		-	group sizetype of se	ervice	