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 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 3 of
Service Period:	
Provider:	

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

Skill Development Codes
I-Independently A- Absent
V- Verbal
P-Physical
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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:
Medicaid #	Year:
Contract Provider #	Page 4 of
Service Period:	
Provider:	

Frequency/Duration:
_____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

SIGNATURE/ TITLE	INITIALS	SIGNATURE/ TITLE	INITIALS
Revised			

(My initials on the Document sheet and the corresponding signature/ title above signify that I have supported _____as outlined in _____ISP

Location: unless otherwise noted, all services were provided in the person's home.

Variations:
Date of Variation: _____
Type of Variation: (check all that apply) ___staff to individual ratio ___times of service delivery ___group size ___type of service
Reason(s) for variation: _____
Actual staff to individual ratio: ___:___ Time period of variation: _____

Date of Variation: _____
Type of Variation: (check all that apply) ___staff to individual ratio ___times of service delivery ___group size ___type of service
Reason(s) for variation: _____
Actual staff to individual ratio: ___:___ Time period of variation: _____

Date of Variation: _____
Type of Variation: (check all that apply) ___staff to individual ratio ___times of service delivery ___group size ___type of service
Reason(s) for variation: _____
Actual staff to individual ratio: ___:___ Time period of variation: _____