GEAUGA COUNTY HOMEMAKER PERSONAL CARE
SKILL DEVELOPMENT

Name:	
Medicaid #	
Contract Provider #	
Service Period:	
Provider:	

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

Goal: _____

_____

Current Status: _____

_____

Methodology: _____

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Documentation: Document by using staff initials and individual's level of participation by using the skill development codes listed on the Documentation sheet.

(Note: If individual did not participate in Skill Development Program make a brief comment related to reason).

QUARTERLY REVIEW

1st Quarter:

Reviewed By: Date:

2nd Quarter:

Reviewed By: Date:

3rd Quarter:

Reviewed By: Date:

4th Quarter:

Reviewed By: Date: