Shared Living (Daily Rate) – WAIVER SERVICE DELIVERY DOCUMENTATION – Fulton County

CONSUMER NAME: PROVIDER:
ADDRESS OF SERVICE: PROVIDER #:

MEDICAID #: SERVICE MONTH: YEAR: _

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
Supports in Plan Duration / Frequency																															

DESIRED OUTCOME:

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

# OF INDIVIDUALS SHARING SUPPORTS , if other than 1:1.																															

KEY: Initials = Service Provided R= Refused

*ALL SERVICES ARE PROVIDED IN THE PERSON'S HOME UNLESS OTHERWISE NOTED IN THE COMMENTS SECTION BELOW.

DATE **Service location, if other than home, problems delivering services, refusal, unusual incidents & reasons, etc.**

PROVIDER SIGNATURE: _____ **INITIALS:** _____ **DATE:** _____