(Rev. 02/2015)

CFC/PAS Agency Based Service Delivery Record

Employee Name	Member Name	Medicaid ID *(optional)*	Pay Period (Mo/Day/Yr - Mo/Day/Yr)

		Su	M	T	W	Th	F	S	Su	M	T	W	Th	F	S
Employees must complete all sections of the service delivery record in order to obtain payment.	**Date**														
	Time In														
	Time Out														
	Total (A+B+C)														
ACTIVITIES OF DAILY LIVING (ADL)															
Bathing															
Personal Hygiene															
Meal Preparation & Eating															
Exercise															
Medication Reminder															
Other: *(approved by MPQH)*															
Other: *(approved by MPQH)*															
INSTRUMENTAL ACTIVITIES OF DAILY LIVING															
Household Maintenance (HM)															
Correspondence Assistance (CA) - CFC only															
A	ADL/HM/CA - Daily Total														
B	Community Integration (CI)/Shopping Daily Total														
C	Skill Acquisition – Daily Total – CFC only														

A. ADL/HM/CA Total Time: ____ B. CI/Shopping Total Time: ____ C. Skill Acquisition Total Time: _____ Total A+B+C Time:____ _____

All services under HCBS/Medicaid Waiver must be <u>pre-approved</u> by the case management team.	**Date**														
	Time In														
	Time Out														
	Total														
Social Supervision															
Homemaker															

Comments:

This is to certify that I worked the hours recorded and completed the work tasks assigned.

This is to certify that the employee has worked the hours recorded, completed the tasks assigned. **Misrepresentation constitutes fraud.**

Member Signature	**Date**
PCA Signature	**Date**
Provider Representative Signature	**Date**