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| **Individual’s Name:** | |  | | | **County:** |  | | | | | **Month/Year:** | | |  | | |
| **Individual’s Address:** | |  | | | | | | **Medicaid #:** |  | | | **Span Period:** | | |  | |
| **Provider:** |  | | **Provider #:** |  | | | **Provider Address:** | | |  | | | **Provider Phone:** | | |  |

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| ISP Supports Provided | 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 |
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| Satisfaction of Services |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *Note: All services are routine HPC services provided in the home unless otherwise noted in the comment section on last page. Ratio 1:1 unless otherwise stated.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **Outcome Documentation:** | | | |
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| **Outcome Documentation:** | | | |
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| **Provider Coverage** | | | | | | | | | | | |
| Date | In | Out | In | Out | In | Out | Total Units | Service Type | Mileage | Place of Visit | Purpose of Visit |
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| **Provider Notes** | | |
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