

Type of Service:Adult Day Support

INDIVIDUAL'S NAME: _____

INDIVIDUAL'S MEDICAID #: _____

PLACE OF SERVICE (ADDRESS): _____

PROVIDER NAME: _____

PROVIDER CONTRACT #: _____

MONTH/YEAR: _____ **ISP SPAN:** _____

Date of Service	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
Time Service Started																															
Time Service Stopped																															
Number of Units																															
Group size is recognized as being fluid within a facility-based program. Group size for services provided outside a facility-based location as well as when billing the 'small group in an integrated community setting' rate must be documented via grid below.																															
Description and Details of Services Delivered that Directly Relate to Services Specified in the approved ISP as Services to be Provided																															

Key (staff initials = support delivered R = refused support Blank = Not Delivered)

Date	Location of Services if Different from Address Above	Total group size of individuals served by the provider at this location	Was the small group rate billed? (Y/N)

Outcome Documentation (if applicable) to be maintained on separate Outcome Documentation sheet

Printed Name: _____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name: _____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name: _____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name: _____ Signature: _____ INITIALS: _____ DATE: _____

Printed Name: _____ Signature: _____ INITIALS: _____ DATE: _____