AGED AND DISABLED WAIVER- RN CONTACT FORM

Last Name:	**First Name:**	**Medicaid ID:**

Date:	**Start Time:**	**Stop Time:**	**Total Time:**

REASON FOR HOME VISIT			
	30 Day Home Visit to Ensure Services Follow Plan		Monthly medication box refill (if ordered)
	Needs/condition Change		PA In-Home Training Specific to ADW Participant
	Change in Service Plan (Personal Attendant Log)		Attendance at PAS Evaluation (at member's request)
	Post Hospital		Home visit for incident follow-up
	Service Plan Meeting		Other (Justify reason below.)

REQUIRED SUPPORTIVE DOCUMENTATION FOR HOME VISIT

By signing, I certify that the reported information is complete and accurate. I understand that payment for the services certified on this form will be from federal and state funds, and that any false claims, statements, or documents or concealment of material fact, may be prosecuted under Medicaid fraud.

_____ _____

ADW Member/Legal Representative Signature **Date**

_____ _____

RN Signature **Date**