**SHARED LIVING DOCUMENTATION**

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| Month: | Year: |  | **SERVICE CODES**  If you cannot deliver a service, write in the code below & explain at the bottom or on an attached sheet.  **A** – Absent (Individual was gone)  **O** – Other (Alternate location, etc.)  **R –** Individual Refused |  | **INSTRUCTIONS:** Write in all services, skill developments, frequencies, & durations for all items assigned to you in the ISP. Document according to the frequency. Sign and initial then initial each time you deliver each service. Document if services provided anywhere but individual’s home. Document medications and mileage elsewhere. |
| Individual: | Medicaid # |
| Provider: | Provider # |
| Group Size:1:1 Place of service: | All services delivered at home unless otherwise noted |

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| **SUPPORT AREA – FREQUENCY** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Outcome #1 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**EXPLANATION FOR “A” “R” OR “O” ABOVE / ALL SERVICES DELIVERED IN THE HOME UNLESS INDICATED BELOW**

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| **Provider** | **INITIALS** | **SIGNATURE** | **TITLE** |
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**NOTES** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Staff initials** | **Time in** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Time out** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Enter number of units for each date** | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |