Ohio ISP SERVICE DELIVERY DOCUMENTATION- Homemaker Personal Care

Month __February____	Year 2024____
Individual: xxx CID009	Medicaid # 123456789
Provider: **Sunshine, LLC**	Provider # **8302492**
Type of Service: HPC Tom Wanfen EID999	Service Location: abc road Mason OH 45040
Span Date:**11/29/23- 11/28/24** Group size (# of individuals: # of DSPs): 1:1	

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
V- Verbal Prompt
P –Physical Assistance
HDH – Hand over Hand Assistance

INSTRUCTIONS: Detail all outcomes, experiences, services, supports, & frequencies for all services assigned to you/your agency in the ISP. Initial each time you deliver each service. All DSPs will print name, sign, and initial final page. Review DODD rule specific to type of service to ensure documentation remains compliant when rule changes occur.

20 hours/week

Outcome # 1	Details to know
XXXX	XX is active in church and receives services to help her attend different church activities as well.

Experience # 1	What needs to happen	How it should happen	When/How often
	To continue to meet new people at church and in the community	Being able to attend through her provider or mother.	Weekly

Date	1	2	3	4	4	5	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	25	25	26	27	28	29	30	31
Initials		SD		SD	SD	SD		SD	SD	SD	SD	SD			SD	SD	SD	SD				SD	SD	SD	SD	SD			SD		

Experience # 2	What needs to happen	How it should happen	When/How often
	To participate in groups and activities at my church, such as Bible study, prayer group, and choir	Being able to go to these activities through her provider or mother.	as requested

Date	1	2	3	4	4	5	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	25	25	26	27	28	29	30	31
Initials		SD		SD	SD	SD		SD	SD	SD	SD	SD			SD	SD	SD	SD				SD	SD	SD	SD	SD			SD		

Notes: Optional

Date	Out/Exp # or Ser/Sup #	**Summary of Progress**: Share accomplishments and progress as they occur. (What happened? What was learned? What worked well/did not work well? What did the person like/dislike?)	Initials
1/3/24	#1	This is optional area.	
		You can write big progress or major issue to allow SSA to know.	

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Services and Supports

SUPPORT AREA – FREQUENCY	1	2	3	4	4	5	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	25	25	26	27	28	29	30	31
XXX community that she chooses. Weekly		V		V	V	V		V	V	V	V	V			V	V	V	V				V	V	V	V	V			V		
XXX will receive transportation to and from requested activities. up to 300 miles/month		V		V	V	V		V	V	V	V	V			V	V	V	V				V	V	V	V	V			V		

Day of the Month:	1	2	3	4	4	5	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	25	25	26	27	28	29	30	31
Time In		9:26 am		7:25 am	6:25 pm	6:30 pm		9:36 am	9:24 am	1:14 pm	7:29 am	6:24 pm			6:35 pm	9:32 am	5:50 pm	7:28 am				6:27 pm	9:19 am	7:45 am	2:00 pm	7:00 pm			6:24 pm		
Time Out		12:20 pm		11:24 am	9:08 pm	9:07 pm		11:54am	12:09pm	5:42 pm	11:42am	9:18 pm			8:44 pm	12:15pm	8:45 pm	11:56am				9:20 pm	12:12pm	11:31am	4:07 pm	9:11 pm			9:26 pm		
Number of 15 min units (8 minutes round up)		12		16	10	10		9	11	18	17	12			9	11	12	18				12	12	15	8	9			12		
Group size		1:1		1:1	1:1	1:1		1:1	1:1	1:1	1:1	1:1			1:1	1:1	1:1	1:1				1:1	1:1	1:1	1:1	1:1			1:1		

Printed name	Initials	Signature	Title
ABC DFE	AD	__Please sign here___	**Provider**