

## AGED AND DISABLED WAIVER RN MEMBER CONTACT FORM

<b>LAST NAME</b>		<b>FIRST NAME</b>		<b>Medicaid #</b>
<b>Date</b>	<b>Start Time:</b>	<b>Stop Time:</b>	<b>Total Time:</b>	

**REASON FOR HOME VISIT**

30 day home visit to assure service follows POC Needs/Condition Change Change in Plan of Care Post Hospital Attendance at PAS evaluation, at member request	Service Level Change Request Dual Service Request Home Visit for Incident Follow-up Service Plan Meeting (if initial at member request) PA/HM In Home Training Specific to Member
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**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 a material fact, may be prosecuted under Medicaid Fraud.*

\_\_\_\_\_  
**Member/Legal Representative Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**RN Signature**

\_\_\_\_\_  
**Date**