PERSONAL CARE

RN Member Contact Form

Last Name:				**First Name:**		**Medicaid ID:**
Date:		**Start Time:**		**Stop Time:**		**Total Time:**
REASON FOR HOME VISIT						
	Needs/condition Change			Dual Services Meeting		
	Change in Plan of Care			Home Visit for Incident Follow-up		
	Post Hospital			PA In-Home Training Specific to Member		
	IDD/PC IDT meeting					
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.

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PC Member/Legal Representative Signature **Date**

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RN Signature **Date**