AGED AND DISABLED WAIVER
CASE MANAGEMENT MONTHLY CONTACT

Participant name: Person spoken to: Note in comments section below reasons why the Participant was not available.	Medicaid Number:	_____ Face to Face Contact _____ Telephone Contact

	Yes	No	Comments
Did you get all the services you were supposed to get last month? If not, which services?			
Have you had any disagreements or problems with the people who come into your home to provide you services? If yes, who is the person and what types of problems are you having?			
Are there times when you needed help and didn't get it? If yes, what happened?			
Have your needs for assistance changed since we last talked? If so, How?			
Have you visited a physician, hospital or nursing home as a patient since we last talked? If so, what was the reason for the visit?			
Do you need help in making any appointments? If yes, with who and when?			
Do you need any additional medical equipment services or resources? If yes, what?			
Are you having any problems paying for or getting food, housing, utilities or medications?			
Have there been any changes in your life that affect your need for service (death, loss, divorce, etc.)?			
If anything happens, do you know how to report problems (services or abuse, neglect or exploitation)?			
Is there anything that I can help you with?			
Did you receive information about your Medicaid this month?			

Comments:

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.

_______________________________ _______________ _______________
Case Manager Signature Date Time