



OFFICE USE ONLY

Supervisors' approval initials: _____ Date: _____
 Hours Approved: pay _____ bill _____ EVV Verified: _____

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AWC In Home and Community Supports

Staff Name: _____ Date of Service: _____
 Hours of Service: _____ AM/PM - _____ AM/PM Total Hours: _____
 Consumer's Name: _____ Location of services: home or community (circle one)

Time skill started: _____ am/pm Ended: _____ am/pm **ISP Outcome:** _____

What is the skill the consumer is working on: _____

What did the consumer work on to support the skill/outcome? _____

How did staff support the consumer in learning or maintaining this skill? _____

Describe consumer progress or lack of progress to ISP goal: _____

Time skill started: _____ am/pm Ended: _____ am/pm **ISP Outcome:** _____

What is the skill the consumer is working on: _____

What did the consumer work on to support the skill/outcome? _____

How did staff support the consumer in learning or maintaining this skill? _____

Describe consumer progress or lack of progress to ISP goal: _____

My signature below verifies that I received/provided a service on the dates and times listed above or documented corrections below. Further, all of the information in the entirety of this document is true and factual. I understand that payment for these services are from Federal and State funds, and that any false claims, statements, documents, or concealment of material facts may be prosecuted under Federal and State Laws.

Emergency Contact: _____ **Phone Number:** _____

Signature of Employee: _____ **Date:** _____

Signature of Consumer/Guardian: _____ **Date:** _____

EVV notes _____