Form Instructions
This form shall be completed and signed for each home visit and service observation visit. Record notes in the section provided during home visits and service observations, and provide detailed documentation of the home visit/service observation in the Electronic Medicaid Waiver System (EMWS). This form shall be uploaded in EMWS to provide verification that a home visit/service observation occurred.

Participant Name: ____________________________

Case Manager Name: ____________________________

Monthly Home Visit Verification

Start Time | End Time
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Participant/Legally Authorized Representative Name: ____________________________

Participant/Parent/Guardian Signature: ____________________________  Date: __________

If the participant or legally authorized representative is not able to sign, the provider/provider staff shall sign off on the home visit.

Provider/Provider Staff Printed Name: ____________________________  Date: __________

Provider/Provider Staff Signature: ____________________________  Date: __________

Service Observation Verification

Start Time | End Time | Service Observed
-----------|-----------|-------------------

Provider/Provider Staff Printed Name: ____________________________  Date: __________

Provider/Provider Staff Signature: ____________________________  Date: __________

Notes
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Case Manager Signature: ____________________________  Date: __________