Home Visit and Service Observation Form

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: ________________________________
Case Management Agency: ___________________________ N/A □
Case Manager Signature: ___________________________ Date: ________________

Monthly Home Visit Verification

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>End Time</th>
</tr>
</thead>
</table>

The participant, legally authorized representative, or provider representative shall select the topics discussed during the home visit. Case managers are not required to address every topic at each home visit.

- Questions and concerns
- Participant rights (including current restrictions and possible violations)
- Health and welfare
- Choice of providers and services (including the need for new or additional)
- Satisfaction with services
- Satisfaction with providers

Participant/Legally Authorized Representative Name: ___________________________ Date: ________________
Participant/Legally Authorized Representative Signature: ___________________________

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: ___________________________
Provider/Provider Staff Signature: ___________________________ Date: ________________

Notes (Attach additional pages if more space is needed)
Use Service Observation Verification fields below as required. Attach additional pages if more space is needed.

### Service Observation Verification

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>End Time</th>
<th>Service Observed</th>
<th>Provider</th>
</tr>
</thead>
</table>

The provider representative shall select the topics discussed during the service observation.

- [ ] Training objective/goal progress
- [ ] Potential changes to the IPC
- [ ] Level of support

Provider/Provider Staff Printed Name: ____________________________

Provider/Provider Staff Signature: __________________ Date: ______________

Case Manager Signature: __________________ Date: ______________

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The provider representative shall select the topics discussed during the service observation.

- [ ] Training objective/goal progress
- [ ] Potential changes to the IPC
- [ ] Level of support

Provider/Provider Staff Printed Name: ____________________________

Provider/Provider Staff Signature: __________________ Date: ______________

Case Manager Signature: __________________ Date: ______________

**Notes** *(Attach additional pages if more space is needed)*