CCW Quarterly Visit Verification

Form Instructions

This form shall be completed and signed for each quarterly visit in order to verify that the visit has occurred. Once completed, the form shall be uploaded in the Electronic Medicaid Waiver System (EMWS).

Participant: ____

Date of Visit: ____

Start Time: ______________________ **End Time:** ______________________

Participant/Legally Authorized Representative Signature:______________________________

Legally Authorized Representative Printed Name:________________ Date:____________
(If applicable)

Case Manager: ____

Agency: ____

Signature: ______________________________ Date:____________

Notes: