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| **Service Types:** |  | **Month/Year** of Service | |  | | **Type of Home** (place a check next to one): | | | |
| **PC** = Personal Care |  | AFC **\_\_\_\_** | | Budgeted **\_\_\_\_\_\_\_\_\_** | Other **\_\_\_\_\_\_** |
| **CL** =Community Living Support |  | | | | | | | | |
|  |  | **Home** |  | | | **Provider** |  | | |
| **Daily Codes:**  **X** = in home @ 11:59 PM |  | Address |  | | | Address |  | | |
| **LOA** = Leave of Absence |  | City/State |  | | | City/State |  | | |
| **H** = Hospitalized |  |  | | | | | | | |
| **Complete One:** | | Federal ID# | | | **or** | Provider Social Security # | | | |

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| **Identifying Information** | | | | |  | **Service Charges Billed to CMH** | | | | | | |
| Case# | Initials | Check ONE  MI DD | | Medicaid  Yes or No | Days of PC | | PC Rate | PC Charges | Days of CL | CL Rate | CL Charges | Total PC & CLS  Charges |
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|  | **Days of Month – NOTE: Place a daily code in each date for each person (Please use Daily Codes ABOVE)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Case # | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | Days in Home |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**Certification and Signatures** Page \_\_\_\_\_ of \_\_\_\_\_

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| --- | --- |
| I hereby certify that the above represents the true number of individuals & days of service provided for the period stated as specified in their Individual Plan(s) of Service |  |
| **Provider /Provider Designee Signature & Date** | CMH USE Initials & Date |