

COMPLETION OF THE HCY PROVIDER MONITORING LOG

NAME OF PROVIDER: NAME OF AGENCY.

FOR MONTH/YEAR: MONTH AND YEAR THIS LOG PERTAINS TO.

PROVIDER'S SIGNATURE: SIGNATURE OF PERSON COMPLETING THIS FORM.

DATE SIGNED: DATE FORM WAS COMPLETED AND SIGNED.

NAME OF SERVICE COORDINATOR: LEAVE BLANK (COMPLETED BY BSHCN).

DATE SIGNED: LEAVE BLANK (COMPLETED BY BSHCN).

RECIPIENT'S NAME: NAME OF HCY PRIVATE DUTY NURSING RECIPIENT(S) RECEIVING SERVICES DURING THIS CALENDAR MONTH.

RECIPIENT'S DCN: MEDICAID NUMBER FOR EACH OF THE HCY RECIPIENT(S) RECEIVING PRIVATE DUTY NURSING SERVICES DURING THIS CALENDAR MONTH.

AUTHORIZED UNITS: AMOUNT OF PRIVATE DUTY NURSING UNITS AUTHORIZED BY BSHCN FOR THIS CALENDAR MONTH PER RECIPIENT.

DELIVERED UNITS: AMOUNT OF PRIVATE DUTY NURSING UNITS ACTUALLY DELIVERED PER RECIPIENT FOR THIS CALENDAR MONTH.

COMMENTS: THIS SPACE IS PROVIDED SO THE PROVIDER AGENCY MAY BE ABLE TO EXPLAIN ANY DISCREPANCIES BETWEEN THE AUTHORIZED AND DELIVERED UNITS OR DOCUMENT OTHER RELEVANT INFORMATION.

MONTHLY GRAND TOTAL: TOTAL AUTHORIZED UNITS FOR THIS CALENDAR MONTH AND THE TOTAL DELIVERED UNITS FOR THIS CALENDAR MONTH FOR ALL RECIPIENTS LISTED.