DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH CARE NEEDS
HEALTHY CHILDREN AND YOUTH (HCY)

PROVIDER MONITORING LOG

Comment Key:
1 - Hospitalization (Date(s))
2 - Family Refused Substitute Staff (Date(s))
3 - Family Cancelled Services (Date(s))
4 - Family Available to Provide Care (Date(s))
5 - Doctor's Appointment (Date(s))
6 - Inclement Weather (Date(s))

Identify dates of under-utilization and appropriate reasons for the authorized services. (Example: #6, #4, date(s)/hour(s) identifying the difference between authorized and delivered services)

NAME OF PROVIDER AGENCY	MONTH/YEAR LOG PERTAINS TO	PROVIDER SIGNATURE	DATE SIGNED BY PROVIDER	
			PRIVATE DUTY NURSING SERVICES	

SERVICE COORDINATOR INITIALS/DATE	**PARTICIPANT'S NAME** Name of HCY Private Duty Nursing Participant(s) receiving services during this calendar month.	**PARTICIPANT'S DCN** Medicaid number for each of the HCY Participant(s) receiving services during this calendar month.	**AUTHORIZED UNITS** Amount of Private Duty Nursing units authorized by SHCN.	**DELIVERED UNITS** Amount of Private Duty Nursing units actually delivered.	**COMMENTS**
					This space is provided for the Provider Agency to explain any discrepancies between the authorized and delivered amounts and document other relevant information. ***A comment must be entered if the amount authorized is different than the amount delivered.***
MONTHLY GRAND TOTALS		**Total Units for All Participants**			The Provider Monitoring Log *must* be completed within 30 days from the end of the calendar month services were provided. Submit a copy of the Provider Monitoring Log (mail or fax) to the appropriate SHCN office. Maintain the original monitoring log in your provider file.

SERVICE COORDINATOR SIGNATURE	SERVICE COORDINATOR SIGNATURE	SERVICE COORDINATOR SIGNATURE