



DEPARTMENT OF HEALTH AND SENIOR SERVICES
 SPECIAL HEALTH CARE NEEDS
 MEDICALLY FRAGILE ADULT WAIVER (MFAW)
PROVIDER MONITORING LOG

Comment Key:

1 - Hospitalization (Date(s))	4 - Family Available to Provide Care (Date(s))
2 - Family Refused Substitute Staff (Date(s))	5 - Doctor's Appointment (Date(s))
3 - Family Cancelled Services (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 AGENCY'S SIGNATURE						DATE SIGNED BY PROVIDER	
REGIONAL COORDINATOR SIGNATURE			DATE SIGNED BY REGIONAL COORDINATOR						MFAW PROGRAM MANAGER SIGNATURE						DATE SIGNED BY MFAW PROGRAM MANAGER	
A- Authorized Units: Amount of units authorized by SHCN for calendar month per participant D- Delivered Units: Amount of units delivered by provider agency for calendar month per participant			UNITS AUTHORIZED-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. <i>A comment must be entered if the amount authorized is different than the amount delivered.</i>	
			STATE PLAN ADULT SERVICES						WAIVER SERVICES							
Basic Personal Care (T1019)		Advanced Personal Care (T1019 TF)		Authorized Nursing Visits (T1001)		Waiver Attendant Care (S5125 U5)		Private Duty Nursing (T1000 U5)		Specialized Medical Supplies (T2028 U5 NU)						
Service Coordinator initials/Date	Participant's Name	DCN (8-digit)	A	D	A	D	A	D	A	D	A	D	A	D		
MONTHLY GRAND TOTALS																
			Total Units for All Participants													
SERVICE COORDINATOR SIGNATURE					SERVICE COORDINATOR SIGNATURE					SERVICE COORDINATOR SIGNATURE						

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.