SUPERVISORY MONITORING LOG-HIV/AIDS CASE MANAGEMENT

Name of Provider Agency				**Month and Year**		**Supervisor Signature**					
Client Name				**DCN**		**Aide Name**					
SPPC						**WAIVER**					
Basic Personal Care Units		**SPPC Licensed Nurse Visit**		**Advanced Personal Care Units**		**Waiver Personal Care Units**		**Private Duty Nursing**		**Attendant Care Days**	
A	**D**	**A**	**D**	**A**	**D**	**A**	**D**	**A**	**D**	**A**	**D**

A=Authorized D=Delivered

COMMENTS: THIS MUST BE COMPLETED IF THERE ARE ANY MISSED SHIFTS AND REASONS FOR UNDELIVERED SERVICES.

CLIENT CONDITION: PLEASE NOTE ANY CHANGES IN CLIENT'S CONDITION, ABILITY TO REMAIN IN THEIR HOME, OR DIFFICULTIES WITH MEDICATION ADHERENCE.

THIS FORM MUST BE FAXED OR MAILED TO THE CASE MANAGER LISTED BELOW BY THE TENTH OF EACH MONTH
FAILURE TO PROVIDE THIS DOCUMENTATION OF CARE PROVIDED COULD RESULT IN REMOVAL OF CLIENT FROM AGENCY

CASE MANAGER_____ AGENCY_____

ADDRESS_____

FAX NUMBER_____ PHONE NUMBER_____

Revised 9/28/2018