MEDICAID RESIDENTIAL ATTENDANCE RECORD

Evergreen Service Providers

Provider: _____ Month Ending: _____

This form is DUE to ESP no later than the 1st day of each MONTH in order to receive payment!

(You can fax to 303 4224985 or email to (deanne.evergreen@comcast.net)

	1	2	3	4		15	7	B	9	10	11	12	13	14	15	16	17	18	19	20	21	22	123	124	25	26	27	128	29	30	31	Absent
Notes:																																
Notes:																																
Notes:																																

Attendance Certified By: _____ _____ _____

Name (Signature): Title: Date:

SPEOAL CODES:

E = Enrollment/Admission Date
H = Hospital Day/Nursing Home/ICFMR
T = Termination/Discharge Date
V = Visit to Family, Friends or Special Program

Provider Initials in Service = Client in Residence
J = Incarceration
X = Vacant Days due to Termination
I = Ineligible Days