**Reporting Period:** **(select date) to (select date)**

|  |  |
| --- | --- |
| **Provider Agency Name:** | **Region:** |

|  |  |  |  |  |  |  |  |  |
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| **Service**  **Name** | **Certification Type** | **# of Individuals** | **# of Current Authorized Providers** | **Average Hours per Month** | **Total # of Doses Administered** | **# of 1201 Deficiencies**  **(specify deficiency type)** | **# of Medically Frail Individuals** | **# of Individuals on ≥4 Psych meds\*** |
|  |  | in Region |  |  |  |  |  |  |
|  |  | in Total |  |  |  |  |  |  |
|  |  | in Region |  |  |  |  |  |  |
|  |  | in Total |  |  |  |  |  |  |
|  |  | in Region |  |  |  |  |  |  |
|  |  | in Total |  |  |  |  |  |  |
|  |  | in Region |  |  |  |  |  |  |
|  |  | in Total |  |  |  |  |  |  |
|  |  | in Region |  |  |  |  |  |  |
|  |  | in Total |  |  |  |  |  |  |
|  |  | in Region |  |  |  |  |  |  |
|  |  | in Total |  |  |  |  |  |  |
|  |  | in Region |  |  |  |  |  |  |
|  |  | in Total |  |  |  |  |  |  |
|  |  | in Region |  |  |  |  |  |  |
|  |  | in Total |  |  |  |  |  |  |
|  |  | in Region |  |  |  |  |  |  |
|  |  | in Total |  |  |  |  |  |  |

* For individuals on ≥4 psychotropic medications, please consider psychiatric provider involvement.

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| **Areas of Concern and/or Additional Information**: |

|  |  |
| --- | --- |
| **Nurse Trainer Name:** | **Contact Phone Number:** |
| **Signature or Electronic Signature:** | **Date:** |