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

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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.

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

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