

MFP Self-directed Waiver Services

P.O BOX 2130, Amherst, MA 01004-2130

Tel: (413) 256-6692, (800) 442-1185

Fax: (888) 773-4281, (413) 256-3849

From Sunday / / To Saturday / /

(Last 4 Digits Only)

Employer Name _____ Employer Number

DCW Name _____ DCW SSN

EMPLOYER CHECK ONLY IF NEW ADDRESS, TELEPHONE, OR E-MAIL AND ATTACH CHANGE FORM

DCW CHECK ONLY IF NEW ADDRESS, TELEPHONE, OR E-MAIL AND ATTACH CHANGE FORM

27967

Service Codes: 1 - Adult Companion 2 - Chore Service 3 - Homemaker 4 - Indiv Support & Community Habilitation 5 - Personal Care 6 - Peer Support

	Svc Code	Time In			Time Out		Total			Svc Code	Time In			Time Out		Total			
S U N	<input type="text"/>	<input type="text"/>	<input type="text"/>	AM <input type="radio"/>	<input type="text"/>	<input type="text"/>	AM <input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	AM <input type="radio"/>	<input type="text"/>	<input type="text"/>	AM <input type="radio"/>	<input type="text"/>	<input type="text"/>	
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Total Week 1 :

Total Week 2 :

By signing below, I certify under pain and penalty of perjury that I have received MassHealthself-directed services from the DCW during the times described on this activity form.

By signing below, I certify under pain and penalty of perjury that I have provided MassHealthself-directed services to the waiver participant during the times described on this activity form.

Employer/Surrogate's signature _____

Date _____

DCW's Signature _____

Date _____