



County

VERIFICATION OF SERVICE DELIVERY
Environmental Modifications (S5165)

Member Name			
	<i>Last</i>	<i>First</i>	<i>Middle</i>
Address			
	<i>Street</i>	<i>City</i>	<i>State Zip</i>
Medicaid #			

A. PROVIDER			
Provider Name		Provider #	
Service Dates			

B. DESCRIPTION OF PRODUCTS AND SERVICES

If attached Itemized Invoice is used for this description, provide the Invoice Number.

By my signature below, I attest to the following: (1) The above described, or invoice attached, products/services have been constructed or delivered and installed in my home by the above named provider; and (2) this Verification of Service Delivery document has been presented and explained to me by my ADvantage Case Manager.

Member Signature <i>(If consumer signs with a mark, two witnesses required)</i>			Date
Signature of Witness	Date	Signature of Witness	Date

By my signature below, I attest that I have reviewed the above described, or invoice attached, products/services that have been constructed or delivered and installed in the above named Member's home and find them to meet the needs of this Member as identified in the assessment of home modification needs done on _____.

Therapist Signature [Note: Therapist signature not required for grab bars or hand held showers.]			Date