**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Quality Assurance

F-62648A (06/10)

**PERSONAL CARE AGENCY SAMPLE SELECTION**

**NOTE: Sample selection must not include any clients receiving supportive home care services via contract with a Family Care Managed**

**Care Organization.**

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| --- | --- | --- | --- | --- | --- | --- |
| Name – Agency | | | | | | Approval Number |
| Name – Surveyor (s) | | | | | | Date Worksheet Completed |
| **Identifier** | **Start**  **of**  **Care** | **Client Name** | **Open-Closed** | **Home Visit Miles**  *Agency*  *to Home* | **Total Time Spent Conducting Home Visit**  *Include*  *travel time.* | **Concerns and Comments** |
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