

## Direct Care Services

**Client Name:** \_\_\_\_\_

**Provider Name:** \_\_\_\_\_

**Agency:** \_\_\_\_\_

**Service Category:** \_\_\_\_\_

Date of Service:		Primary Service:	Secondary Service:	Agency Sub-Service:
___/___/___	Face-to-Face			
<b>Units of Service:</b> #: _____	Non Face-to-Face			
<b>Funding Source:</b>	Care A   Care B   Care C	HOPWA   CMP	MCWP   WEIP	Other: _____
___/___/___	Face-to-Face			
<b>Units of Service:</b> #: _____	Non Face-to-Face			
<b>Funding Source:</b>	Care A   Care B   Care C	HOPWA   CMP	MCWP   WEIP	Other: _____
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