# ATTACHMENT C: Client Record Review and Unit Verification Page      of

# HOME-DELIVERED THERAPEUTIC DIET MEALS

# DATE OF ASSESSMENT:       NUTRITION PROVIDER:

# MONTH AND YEAR REVIEWED:       FUND SOURCE:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Client Name | | S/R/W Code | Eligible HDM client? Write in DOB and any documentation reviewed for special eligibility. | Date of most recent CRF? | Is CRF complete? | Has CRF been updated at least every 6 months? | CRF updated IN HOME at least every 12 months? | MD prescription on file? | Prescription reordered every 6 mos? Write date of most recent | # units reported (A) | # units verified (B) | # units unverified (C) | Notes (Dates of unverified units, as applicable, other comments, etc.) |
| 1 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 9 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 11 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 13 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
| 15 |  | |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  | | | | | | | | Totals |  |  |  |  |
|  | |  | | | | | | | | Percent of unverified units = Total unverified units (C)       ÷ Total units reported (A)       x 100 =      % | | | | |
|  | |  | | | | | | | | If 10% or more, expand sample and select another month for review. | | | | |

**Notes:**

# Signature of reviewer(s)       Date