# 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:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | 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 |        |        | [ ]        |        | [ ]  | [ ]  | [ ]  | [ ]  | [ ]        |        |        |        |        |
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|  |  | 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