

**Residential Habilitation
Historical Utilization
Coversheet**

Date Completed: _____

Participant Name: _____

Participant DOB: _____

Participant Medicaid ID: _____

Person Completing the Form: _____

Participant Lives in:

- Home owned or rented by participant
- Home owned, rented and/or operated by licensed Residential Provider
- Home owned or rented by a Shared Living Provider
- Other: _____

Number of total Participants residing in the Home: _____

Participant does not receive services daily on a regular basis due to:

- Does not need a service every day
- Regularly leaves to visit family or friends
- Regularly declines services
- Other: _____