TEXAS Health and Human Services

Community Living Assistance and Support Services (CLASS) and Community First Choice (CFC)

Documentation of Services Delivered

Form 3625
July 2025

Section A – Person Information

1. Service Month and Year	2. Person's Name	3. Medicaid No.	4. Social Security No., **for applicants only**
November 2025	Client		

Section B – Case Management Agency (CMA) or Direct Services Agency (DSA) Provider Agency Information

5. Agency Type	6. Agency Name	7. Contract No.
◯ CMA ◉ DSA	Astrocare Home Healthcare	1015857

Section C – Pre-Enrollment Assessment Fees for CMA or DSA

8. CMA Services: ◯ Partial Assessment ◯ Full Assessment 9. DSA Services: ☐ Full Assessment

Section D – Case Management Services

10. Case Manager Name: 11. Case Management Services: ☐ Ongoing

Section E – Direct Services

12. Method of Delivery

◯ **Employee**, Name of DSA Employee:

◯ **Subcontractor,** Name of Contracted Service Provider: Therapist Name

Name of Contracted Service Provider Company:

◯ **Direct Purchase**, Use only for service codes 15 and 16

Authorized Service

13. Service Category	14. Service Code	15. Bill Code
Specialized Therapy - Aquatic	42D	G0493
16. Requisition Fee, applicable to specialized therapies only	**17. Requisition Fee Service Code**	**18. Requisition Fee Bill Code**
7.74	41F	G0648

Comments, required for telehealth services.

Section F – Record of Time

Day	Time In or Time Out Units or Amounts	Day	Time In or Time Out Units or Amounts	Day	Time In or Time Out Units or Amounts	Day	Time In or Time Out Units or Amounts
1		2		3		4	
5		6		7		8	
9		10		11		12	
13		14		15		16	
17		18		19	10:00-11:00	20	
21		22		23		24	
25		26		27		28	
29		30		31		Total Units or Amounts:	1

Section G – Certification

This is to certify that I, the service provider, have provided the service(s) recorded above. This is to certify that I, the timekeeper, am not the service provider and have verified the accuracy of the information recorded above. The following below are signatures of:

Applicant, Person or Legally Authorized Representative **Date**

Therapist Signature

Service Provider **Date**

Timekeeper **Date**