Service Documentation Daily Checklist
Supervised IRA OR CR Residential Habilitation

AGENCY: _____

INDIVIDUAL NAME: _____

MEDICAID CIN #: _____
(not mandatory if listed in ISP or res hab plan)

MONTH / YR OF SERVICE DELIVERY: _____

TABS ID #: _____
(Optional)

PRIMARY SERVICE LOCATION: _____

DESCRIPTION OF THE INDIVIDUALIZED STAFF SERVICE / ACTION PROVIDED based on the individual's Residential Habilitation Plan	**Staff providing the service or action initial the date the service or action was provided.** (Note: By entering initials, staff are attesting that the service or action was provided on that day. Initialing must occur at the same time as service delivery.)																														
Staff service or action: DAY OF MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Staff service or action:																															
Staff service or action:																															
Staff service or action:																															
Presence Status: (P=Present, T=Therapeutic Leave, R=Retainer Day)																															

** INITIALS KEY: For each staff person who provided a service or action this month, include the staff name, title and signature next to the staff person's initials

INITIALS	***STAFF NAME***	***TITLE***	***SIGNATURE***	***INITIALS***	***STAFF NAME***	***TITLE***	***SIGNATURE***

*** Initials Key may be maintained as a separate document*

PLEASE COMPLETE THE MONTHLY SUMMARY NOTE ON THE REVERSE SIDE

Supervised IRA or CR Residential Habilitation Monthly Summary Note

AGENCY NAME : _____

INDIVIDUAL NAME : _____ **MONTH / YEAR :** _____

MEDICAID CIN # : _____ **PRIMARY SERVICE LOCATION :** _____

Provide a narrative that summarizes the implementation of the individual's Residential Habilitation plan, and addresses the individual's response to the services provided and any issues or concerns.

_____ _____ _____

SIGNATURE OF STAFF PERSON WRITING THE NOTE ***TITLE*** ***DATE****

*** Must** be written as M/D/Y