BRIDGES
REMOVING BARRIERS, ADVANCING AUTONOMY

Community Habilitation
Monthly Summary Note

Agency:	Month/YR serv. Delivery:	
Individual's Name:	TABS ID:	Medicaid #:

Provide a narrative that summarizes the implementation of the Community Habilitation Plan, and addresses the consumer's response to the services provided and any issues or concerns.

Signature of staff person writing the note:	Title:	Date:(mth/dy/yr)
Signature of person reviewing the note:	Title:	Date:(mth/dy/yr)