



Community Habilitation
Daily Service Documentation Note

Agency Name:	Date of Service:
Individuals Name:	Medicaid ID:
Service Location:	
Service start time: _____	Total Duration:
Service stop time: _____	
If served in a group , check the total number in that group including the identified individual:	<input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

GOAL/s worked on today	complete	Incomplete
Example: Money Management	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Description of services: (Individual's response to service)

Staff Signature: _____

Date Note Written: _____