

Employee: \_\_\_\_\_

*Print Full Name*

Consumer: \_\_\_\_\_

*Print Full Name*

Case: \_\_\_\_\_

Support Coordinator/Agency: \_\_\_\_\_

Phone #: \_\_\_\_\_

FI Name: \_\_\_\_\_

Pay Period: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please identify only one authorized code per page to document service provided:	CLS					
	H2015	1:1	<input type="checkbox"/>	2:1	<input type="checkbox"/>	3:1
	H0043	<input type="checkbox"/>	TT	<input type="checkbox"/>		
	RESPIRE					
T1005	1.1	<input type="checkbox"/>	2.1	<input type="checkbox"/>	3.1	<input type="checkbox"/>

*Write Legibly using blue or black ink	
*Narrative of services must support time billed (use as many lines as necessary)	
* Services must not overlap with other State Plan services (e.g. Home Help or medical appointments)	
DECREASE	D
SAME	S
INCREASE	I

CLS ONLY: Use this GOAL / OBJ. PROGRESS KEY to document progress of the IPOS goal/Objective worked on per shift

Date	Start Time	Stop Time	Hours/Units	Service Note - Narrative Statement of Supports Provided	GOAL / OBJ. from IPOS	CLS PROGRESS (D, S, I)
					/	—
					/	—
					/	—
					/	—
					/	—
					/	—
					/	—
					/	—
					/	—

Totals: \_\_\_\_\_  
Hours/Units

*My signature below certifies that I have reviewed this information and to the best of my knowledge it is true and complete. It also certifies that I, the Consumer or Consumer Representative, knowingly provide service note information to my Fiscal Intermediary, waiving any confidentiality claims.*

Consumer Representative or Consumer Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Employee Signature: \_\_\_\_\_ Aide Date: \_\_\_\_\_

For Primary Case Holder Use Only:	Indicate quality of notes by checking, as applicable:	Satisfactory <input type="checkbox"/> Needs Improvement <input type="checkbox"/> Unsatisfactory <input type="checkbox"/>	Follow-up Requested (explain):
	Date of Review: _____ Initial: _____		