

SERVICE DOCUMENTATION DAILY CHECKLIST COMMUNITY HABILITATION PHASE II

<i>BILLING DEPARTMENT DATA</i>			
CHECK (✓) BOX FOR APPROPRIATE UNIT OF SERVICE TO BILL:			
Full Month <input type="checkbox"/>	Half Month (1st half) <input type="checkbox"/>	OR	Half Month (2nd half) <input type="checkbox"/> No Billing <input type="checkbox"/>

AGENCY: _____

INDIVIDUAL'S NAME: _____

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

PRIMARY SERVICE LOCATION: _____

MONTH / YR OF SERVICE DELIVERY : _____

DESCRIPTION OF THE INDIVIDUALIZED STAFF SERVICE / ACTION PROVIDED based on the individual's Community Habilitation Plan	Staff providing the service or action <u>initial the date</u> the service or action was provided. [Note: By entering initials, staff are attesting that the service or action was provided on that day. Initialing should 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	

**** 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

<u>INITIALS</u>	<u>STAFF NAME</u>	<u>TITLE</u>	<u>SIGNATURE</u>	. <th style="text-align: left; padding: 5px;"><u>INITIALS</u></th> <th style="text-align: left; padding: 5px;"><u>STAFF NAME</u></th> <th style="text-align: left; padding: 5px;"><u>TITLE</u></th> <th style="text-align: left; padding: 5px;"><u>SIGNATURE</u></th>	<u>INITIALS</u>	<u>STAFF NAME</u>	<u>TITLE</u>	<u>SIGNATURE</u>
_____	_____	_____	_____	.	_____	_____	_____	_____
_____	_____	_____	_____	.	_____	_____	_____	_____
_____	_____	_____	_____	.	_____	_____	_____	_____

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

REMEMBER TO COMPLETE THE MONTHLY NARRATIVE NOTE DOCUMENT ONCE MONTH IS OVER