Community Habilitation Phase II Monthly Summary Note

AGENCY NAME : _____

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

MEDICAID CIN # _____ **Primary Service Location:** _____

Provide a narrative that summarizes the implementation of the individual's Community 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***