

Intensive Behavioral Services  
Daily Service Documentation Note

Agency Name: \_\_\_\_\_ Date of Service (mth/day/yr): \_\_\_\_\_

Individual's Name: \_\_\_\_\_ Medicaid ID (CIN): \_\_\_\_\_

Primary Service  
Location: \_\_\_\_\_

Enter Service Start Time: \_\_\_\_\_ Enter Service Stop Time: \_\_\_\_\_

Enter Service Start Time: \_\_\_\_\_ Enter Service Stop Time: \_\_\_\_\_

Enter Service Start Time: \_\_\_\_\_ Enter Service Stop Time: \_\_\_\_\_

Total Duration: \_\_\_\_\_

**Billing Tally:** Countable Units (15 minutes = 1 unit): \_\_\_\_\_

Description of Services  
(Staff service(s)/actions(s) provided based on the individual's BSP and the individual's response to the service when appropriate)

(attach additional sheets if needed)

Staff Name: \_\_\_\_\_ Staff Title: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date Note Written (mth/day/yr) \_\_\_\_\_

\_\_\_\_\_