HCBS WAIVER SERVICE DOCUMENTATION
IRA RES HAB DAILY CHECKLIST

AGENCY: _____

CONSUMER NAME: _____

MEDICAID CIN # : _____

MONTH / YR OF SERVICE DELIVERY : _____

IRA ADDRESS: _____

BILLING DEPARTMENT DATA				
CHECK (✓) APPROPRIATE BOX FOR UNIT OF SERVICE TO BILL :				
Full Month	Semi Monthly (1st half)	**OR**	Semi Monthly (2nd half)	No Billing
☐	☐		☐	☐

CONSUMER ENROLLMENT DATA

☐ Supervised IRA

☐ Supportive IRA

(✓ appropriate setting)

☐ Enrolled in program full month

☐ Enrolled in program **less than** full month

Date enrolled this month : _____

Date discharged this month : _____

DESCRIPTION OF THE INDIVIDUALIZED STAFF SERVICE / ACTION PROVIDED based on the consumer's Residential Habilitation Plan	**Staff providing the service or action initial the date the service or action was provided. [*Note: By entering initials, staff are attesting that the service or action was provided on that day. Initialing must 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
Staff service or action :																															
Staff service or action :																															
Staff service or action :																															

** 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

INITIALS	***STAFF NAME***	***TITLE***	***SIGNATURE***	***INITIALS***	***STAFF NAME***	***TITLE***	***SIGNATURE***

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

PLEASE COMPLETE THE MONTHLY SUMMARY NOTE ON PAGE 2

IRA RES HAB MONTHLY SUMMARY NOTE

AGENCY NAME : _____

CONSUMER NAME: _____ **MONTH / YEAR :** _____

MEDICAID CIN # _____ **IRA ADDRESS:** _____

Provide a narrative that summarizes the implementation of the individual's Residential Habilitation plan, and addresses the consumer's response to the services provided and any issues or concerns.

_____ _____ _____

SIGNATURE OF STAFF PERSON WRITING THE NOTE ***TITLE*** ***DATE***