Monthly Summary Note

Individual's Name: _____ **Date:** _____/_____/_____
Last name First Name

Individual's Medicaid CIN: _____ **Fiscal Intermediary (FI) Agency:** _____

This form should be completed monthly **by you** with help, as needed, from your designee or staff. The Monthly Summary Note includes:

1. **Service** – check the service you participated in this month. This service should relate to your valued outcomes.
2. **Progress** – describe what progress you made towards your personal goals and valued outcomes.
3. **Follow-up** – state whether you would like any changes to your services and supports, or whether you have any service-related concerns.
4. Sign and date the form once it's complete.
5. Send the complete form to your Fiscal Intermediary by the date agreed upon within your FI Memorandum of Understanding (MOU).

Service(s) (check all that apply): ☐ Community Habilitation ☐ Supported Employment (SEMP) ☐ Other: _____

Progress

These services and supports helped me:
☐ Improve my independence at home and in my community
☐ Live safely at home
☐ Be more involved in my community
☐ Improve my health
☐ Engage in meaningful activities such as: _____
☐ Work towards the following goals/valued outcomes: _____
_____
_____

Brief summary of implementation of the Habilitation Plan (if applicable):

Follow-up

Would you like to change anything about your services and supports? ☐ No ☐ Yes
If yes, please describe here:

Do you have any service-related concerns that need to be addressed? ☐ No ☐ Yes
If yes, please describe here:

Signing and submitting false information may lead to a charge of Medicaid fraud.

By signing this document, I confirm that I received the services and supports described above and that statements made about them are true:	The person identified below helped me to complete this form:
Signature of Individual **Date (Mo/Day/Yr)**	**Signature of Designee/Staff** **Date (Mo/Day/Yr)**
Print name	**Print name** **Title**