At Home Residential Habilitation
Daily Service Documentation Note

Agency Name: _____ Date of Service _____

Individual's Name: _____ Medicaid ID: _____

Service Location: _____

Does the service start, stop or delivered at Home? (check yes or no) Yes: ☐ No: ☐

Enter Service Start Time: _____ Enter Service Stop Time: _____

Total Duration: _____

Billing Tally: Countable Units (15 minutes = 1 unit): _____

If served in a group, check the total number in that group including the identified individual: 2 ☐ 3 ☐ 4 ☐

Description of Services:

(attach additional sheets if needed)

Staff Signature:_____Date Note Written:_____

Staff Title:

A note should be completed for each continuous period of time, i.e. "session".
For billing purposes, if multiple "sessions" occur on the same day, "roll up" the duration from each "session" note and convert that total to units.
At least one note written during the calendar month should summarize the implementation of the person's At Home Residential Habilitation Plan, address the consumer's response to services and discuss any issues or concerns.