MONTHLY SUMMARY NOTE - COMMUNITY HABILITATION

AGENCY: _____ **MONTH / YR OF SERV. DELIVERY :** _____

INDIVIDUAL'S NAME: _____ **TABS ID :** _____ **MEDICAID # :** _____

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

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SIGNATURE OF STAFF PERSON WRITING THE NOTE *(required)*	***TITLE***	***DATE (mth/dy/yr)***
SIGNATURE OF STAFF PERSON REVIEWING THE NOTE	***TITLE***	***DATE (mth/dy/yr)***