SERVICE DOCUMENTATION DAILY CHECKLIST
IRA OR CR RESIDENTIAL HABILITATION

AGENCY: _____

INDIVIDUAL NAME: _____

MEDICAID CIN # : _____ (not mandatory if listed in ISP or res hab plan)

MONTH / YR OF SERVICE DELIVERY : _____

PRIMARY SERVICE LOCATION: _____

BILLING DEPARTMENT DATA

CHECK (✓) BOX CORRESPONDING TO THE RESIDENTIAL PROGRAM TYPE:

☐ Supervised IRA ☐ Supervised CR ☐ Supportive IRA ☐ Supportive CR

CHECK (✓) BOX CORRESPONDING TO THE APPROPRIATE ENROLLMENT STATUS:

☐ Enrolled in program **at least 22 days** ☐ Enrolled in program **less than 22 days but more than 11 days**

CHECK (✓) BOX FOR APPROPRIATE UNIT OF SERVICE TO BILL:

Full Month ☐ | Half Month (1st half) ☐ | **OR** | Half Month (2nd half) ☐ | No Billing ☐

DESCRIPTION OF THE INDIVIDUALIZED STAFF SERVICE / ACTION PROVIDED based on the individual'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 :																															
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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 THE REVERSE SIDE

IRA OR CR RESIDENTIAL HABILITATION MONTHLY SUMMARY NOTE

AGENCY NAME : _____

INDIVIDUAL NAME : _____ **MONTH / YEAR :** _____

MEDICAID CIN # : _____ **PRIMARY SERVICE LOCATION :** _____

(not mandatory if listed in ISP or res hab plan)

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

_____ _____ _____

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

*** Must** be written as M/D/Y