**Service and Daily Progress Log**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Time In/Out** | **Total Hours** | **Setting****(Home, School, etc)** | **Summary of Services Provided and Significant Behaviors or Caregiver Performance Observed or Reported** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  | **Total hours** | :\_\_\_\_\_\_\_\_ |  |

**Client’s Name: Analyst Name:**

**Medicaid #: Residence:**

|  |
| --- |
| **Physical, Behavioral, and Emotional Health Ongoing Verification****The unit file was reviewed during the time period mentioned above in order to ascertain all pertinent and relevant physical, behavioral, and emotional factors contributed to this month’s progress in achieving desired STO’s and outcomes outlined in the SP as well as the behavior support plan. Incidents of baker act, hospitalizations, medication changes, and any other therapeutic and psychiatric interventions as well as direct interviews with support staff involved in the consumer’s circle of supports are also taken account on a monthly basis.** |

**Validations:** **Analyst:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Caregiver / Guardian / Consumer Name, Certification/License #**

**This service is developed and revised according to consumer's desires and goals with consent and participation of the consumer to ensure that services are provided at mutually agreed times, setting. The programs and activities reflect the consumer’s/guardians desires according to the support plan goals. The above included signatures validate services are provided at agreed mutual times.**

**Office Use Only: Total Amount Billed: \_\_\_\_\_\_\_\_\_\_ HCBS Provider #685428196 / 98**

**Procedure Code: BX - H2019 / SMH - H0046**